MONEY MATTERS IN MEDICINE

A look at the financial issues affecting the practice of retina.
Reimbursement Changes in Retina

Retina specialists face changes in reimbursement through Medicare in 2015. Will they affect the financial viability of medical practices?

By Bryan Bechtel, Editor-in-Chief

Cost is a necessary part of doing business, and medicine is certainly not immune. In most business models operating in the free market, rises in costs can be covered, at least in part, by a rise in the price of goods and/or services. In medicine, however, fixed reimbursement rates, especially from publicly funded health care, limit physicians’ ability to cover their overhead.

The rising costs of delivering health care are well known; recent health care reform measures, including the Patient Protection and Affordable Care Act, have largely been directed at containing costs. A new era is dawning in medicine where changing reimbursement streams are becoming a new reality. This is especially true for ophthalmologists, who have historically drawn as much as two-thirds of their revenue from Medicare. As the calendar turns to 2015, changes to reimbursement structures loom.

VITRECTOMY CODE CUTS

As part of its regular practices, the Centers for Medicare and Medicaid Services (CMS) evaluated the vitrectomy codes and determined it was appropriate to lower the level of compensation. Starting in 2015, retina specialists who perform these procedures will see cuts in reimbursement—as high as 27.5% in some cases (Table).

Under the resource-based relative value scale (RBRVS), shorter surgical time versus historical precedent equates to less time needed to deliver care. Reductions in surgical times, though, may result from greater experience with the procedure in question, as well as newer technologies that improve efficiency.

How the RBRVS rewards efficiency is questionable to some. According to Paul Tornambe, MD, of Retina Consultants of San Diego, the lowered reimbursement rates establish an alarming trend.

“Doctors have only 2 ‘products’ to ‘sell’: time and experience,” Dr. Tornambe said in an interview with New Retina MD. “CMS factors in time when determining these new surgery rates but ignores experience. As the surgeon becomes more proficient (ie, experienced) in performing sophisticated surgical procedures, the time required to perform the procedure decreases. The less experienced surgeon will have more complications, which will increase the time it takes to perform the operation, and the outcome will likely be compromised. On the other hand, the more experienced surgeon will perform the surgery without complications and require less time.”

In Dr. Tornambe’s view, the system penalizes high quality care because it takes less time to deliver.

“A diamond cutter is paid primarily for the experience he has in cutting precious stones, not the time it takes to cut the stone,” he said. “Experience must be put back into the equation.”

QUESTIONING VIABILITY

Ophthalmology has seen these kinds of cuts previously with cataract surgery. CMS cut reimbursement rates for the procedure, largely due to advances in surgical techniques that reduced procedure time. A similar situation is now occurring with vitrectomy.

“With sutureless and transconjunctival approaches for vitrectomy, it simply takes us less time to perform these procedures,” explained George Williams, MD. “That is the fundamental difficulty with the RBRVS system, is that the more efficient you become in performing a procedure, the less you will be paid to perform that procedure.”

Reimbursement cuts such as those proposed and adopted by CMS for cataract surgery and vitrectomy, however, do not function in isolation. If cuts in overall compensation according to the Medicare Sustainable Growth Rate (SGR) formula go into effect in 2015—and they have been held in abeyance for nearly a decade by repeated Congressional actions—physicians...
could see an additional 22% drop in all compensation from publicly funded health care.

And, if historical precedent holds, many third-party payers will base their rates at least in part on the levels of reimbursement offered by Medicare.

So, what can physicians do?

“I don’t think anyone is going to stop doing surgery,” Dr. Williams said, “but there might be some people who ask at what point does it not become financially viable to do surgery.”

That is a question that has already entered the mind of Dr. Tornambe. The new vitrectomy rates discredit experience in his opinion, but they also do not align with the other commodity surgeons have to offer: time.

Dr. Tornambe said his corporate overhead is about $400 per doctor per hour, which he calculates as expenses minus doctor salaries and benefits, divided first by the number of hours the office is open, and then again by the number of doctors.

In a hypothetical example where he does 2 consecutive vitrectomies for macular hole and receives $900 in reimbursement, but spends about 2.25 hours per patient in uncompensated time—inclusive of postoperative follow up, including an examination, paperwork, dictation, and charting travel time; and waiting time between cases—there is little to no financial wiggle room, Dr. Tornambe said. At $400 per doctor per hour, that $900 reimbursement is a wash.

“I think the only way to make a reasonable profit at this reimbursement rate is to operate after office hours in the evening or weekends, which is frowned upon in most surgery centers. But then questions arise regarding physician quality of life and physician burn out,” Dr. Tornambe said. “Another option is to have 1 doctor in the practice be the ‘OR doctor’ and do all the group’s surgeries, as is done in Europe where most retina specialists do medical retina and refer to 1 center for surgery.”

ADDITIONAL CUTS IN REIMBURSEMENT

Among the list of codes affected by reimbursement reductions in 2015 is 67028, which retina specialists will recognize as the billing code for intravitreal injections. At a 3% reduction, the loss in revenue will not be as dramatic compared with the vitrectomy codes; however, this may not be the final cut in injection reimbursement.

The Medicare Payment Advisory Commission (MedPAC), the agency designed to deliver to Congress ideas for policy advice on Medicare, has proposed a move to per-episode payments for therapeutics. The notion is guided by a suggestion that impact on functional status is relative to which therapeutics are delivered and how they are administered, and thus, reimbursement should be tied to the type of therapy coded for.

In a letter to MedPAC in December 2014 from the American Society of Retina Specialists (ASRS), the society pointed out that anti-VEGF therapy, the injectable most likely to be affected by per-episode payment, is largely driven by individual patient factors considered by their treating physicians.

Moreover, the ASRS said, different drugs exist within the anti-VEGF class and studies and anecdotal experience suggest that response to the individual agents is variable among patients.

The letter, signed by Tarek Hassan, MD, and John Thompson, MD, the President and Immediate Past President of the ASRS, respectively, went on to say that, “Ultimately, the retina specialist utilizes clinical judgment and the patient’s response to a particular drug to select the best treatment. The ability to individualize treatment is critical to safely maximizing recovery and maintaining visual function in our patients with blinding diseases of the retina. Since the intravitreal treatment of macular conditions does not follow a one-size-fits-all protocol, ASRS has serious concerns that a bundled per-episode payment model could promote under-treatment of macular degeneration and diabetic retinopathy, which is already the major culprit of vision loss due to these conditions in the United States and Europe. We, therefore, urge MedPAC to consider an incentive system that will encourage physicians to provide the best care for each individual patient and lower costs as much as possible.”

Another measure under consideration is a cut in the average sale price, or ASP, modifier, below the current +6% level. As the ASRS pointed out in its letter to the MedPAC, however, the ASP modifier does not represent a profit add-on, but instead is intended to cover shortfalls between the acquisition cost, which is highly variable across the US, and the reimbursed ASP. It is also intended to cover costs associated with handling and administering the drug—in essence accounting for the cost of doing business.

UNCERTAINTY

It is unknown whether Congress will act on MedPAC’s recommendations regarding reimbursement for injectable medications. And, although a fix to the SGR formula has been promised for years, the prospect of further cuts in physician reimbursement looms large.

Other codes, such as those for fundus photography, have also been cut in 2015. In addition, CMS has announced plans to eliminate global surgery periods over the coming few years, dropping postoperative care from surgical codes beginning in 2019. The agency has promised to work with physicians in accordance with the RBRVS to determine new reimbursement rates for pre- and postoperative care.

On the other hand, physicians who own or draw revenue from an ambulatory surgery center will see a slight uptick in payments pending a satisfactory report on certain quality measures. But amidst various declining and dwindling reimbursement rates, will a change in the ASC conversion factor from 43.471 to 44.071 make enough of a difference to account for the rising cost of doing business? ■