

considers to be the national average and results in no adjustment in payment. A factor >1.0 means the value is above the national average, and this higher factor results in a higher payment. A factor <1.0 means the value is below the national average, and this lower factor results in a lower payment.

These three adjustment factors are called Geographic Practice Cost Indices or GPCIs. Medicare assigns each locality its own three GPCIs (one for work, one for practice overhead and one for liability cost), in order to account for regional differences and thus make the RBRVS payment system equally fair to doctors everywhere.

Thus, the formula for payment for each service would look like this:

$$\begin{aligned} &[(\text{Work RVUs} \times \text{work GPCI}) + \\ &(\text{overhead RVUs} \times \text{overhead GPCI}) + \\ &(\text{liability RVUs} \times \text{liability GPCI})] \times \\ &\text{CF} = \text{payment} \end{aligned}$$

How Rhode Island stacks up

Rhode Island's current GPCI for the "work" component is 1.029; thus, it is above the national average and is identical, in fact, to the work GPCI for Metropolitan Boston. The rest of MA, at 1.007, is lower than Rhode Island; CT, at 1.038 for work, is higher than both Rhode Island and Metro Boston.

Rhode Island's "overhead"/living expense GPCI is 1.04; Metro Boston's is 1.311, and the rest of MA is 1.106. CT's is 1.179. Apparently, then, Medicare finds RI's overhead costs (office rent, etc.) are generally lower than those in MA and CT but still higher than the national average.

Rhode Island's liability GPCI is 0.946. Thus, Medicare finds RI's liability expense to be below the national average but higher than that of Metro Boston and the rest of MA, which are both pegged at 0.787, and also higher than CT at 0.934.

To compare Medicare's overall physician payment levels in RI, MA and CT, we have to take into account the different weighting of the three

factors (52% work, 44% overhead, 4% liability expense). Doing so, we can arrive at a rough composite geographic adjustment factor for RI of 1.03052, for CT of 1.09588, and for Metro Boston of 1.14340. (Note: these "composite" factors were generated by RIMS and are not known to be calculated or used by Medicare in any way.) It follows that Medicare pays doctors in all three states at rates that are above Medicare's national average.

Because the actual weighting varies slightly from code to code, these calculated composites are not precise, but they suggest that Medicare pays Metro Boston physicians at rates about 11% higher than what RI physicians receive, and that Medicare pays CT physicians at a rate about 6.6% higher than what it pays RI physicians.

These differences in payment rate are not insignificant, but they are narrower than many Rhode Island physicians may believe them to be. (Rhode Island physicians may tend to generalize from the commercial side,

where the discrepancies have been much greater, as the Massachusetts Medical Society's study released in 2003 demonstrated.)

For comparison's sake, add Arkansas to the mix

A state where the three components of RBRVS are lower provides some additional perspective on the range of payment differences that exists within the Medicare system. Arkansas, like CT and RI, is a single "locality" in Medicare's payment system. AR's GPCIs are 1.0 for professional work (thus, neither higher nor lower than the national average), 0.846 for practice overhead (below the national average), and 0.446 for liability insurance expense (well below the national average), which would yield a composite geographic adjustment of about 0.91008. From this calculation, one can infer that Medicare pays AR doctors at rates that are about 12% less than what RI doctors receive from Medicare and 23% less than what Metro Boston doctors receive. ❖

Will you be ready for PECOS by April 5?

An understated communications effort by CMS has left some medical practices in the dark about a looming deadline that could confront some doctors with a string of Medicare claims rejections starting April 5, 2010.

In a nutshell: all ordering and referring physicians must be enrolled in the Medicare Provider Enrollment Chain and Ownership System (PECOS) by April 5 of this year, or their claims will no longer be paid. (This requirement was originally slated to go into effect on January 4, 2010, but AMA prevailed upon CMS to delay the effective date in order to give physicians more time to comply.)

All physicians and non-physicians who order services or items for Medicare patients or refer Medicare

patients to other Medicare professionals or suppliers are included under the new requirement.

Doctors who signed up with Medicare after November 2003 are probably in the clear. However, doctors who enrolled in Medicare earlier and have not updated their Medicare enrollment since November 2003 must do so before April 5, 2010, or their Medicare claims will be automatically rejected starting on that date. During the current phase-in period, physicians who do not have a current enrollment record in PECOS are supposed to be receiving warnings when they submit claims, but for now their claims are still being paid – until April 5.

Medicare-enrolled physicians can enroll in PECOS or verify that their

March 17 is the new deadline for Medicare participation decisions

In response to the lingering uncertainty regarding the level of the Medicare conversion factor for 2010, CMS has extended the deadline for physicians to notify Medicare of a change in their participation status. The new deadline is March 17, 2010. As usual, physicians who do not wish to change their participation status need do nothing.

Congress acted in December 2009 to postpone from January 1 to March 1, 2010, the scheduled 21.2% reduction (from \$36.08 to \$28.39) in the conversion factor. That postponement was supposed to give Congress time to stop the cut, either with another legislative band-aid, as has become almost customary in recent years, or possibly by actually eliminating the troublesome SGR formula that for years has generated recurrent threats of ever more draconian cuts in Medicare Part B payments.

Thus, by March 1 at the latest, something will have happened to provide physicians with a clearer picture of how Medicare will be paying them in 2010. Physicians will then have until March 17 to consider whether to change their participation status. Any change, however, will be retroactive to January 1. That means, for example, that in the unlikely case that a physician opts to change from non-participating to participating, he or she might have to refund any amounts that had been balance billed to patients since January 1, 2010.

The familiar three options still exist: participation, whereby the physician agrees in advance to accept assignment all of the time for all Medicare beneficiaries who are admitted to the practice; non-participation, whereby the physician reserves the right to balance bill patients on a case-by-case basis, albeit under Medicare's limited rules for balance billing; and private contracting (also known as "opting out"), whereby the physician and all of the physician's patients eschew all Medicare payment for any services provided by that physician, with the possible exception of emergency services under certain conditions.

The AMA provides detailed guidance on physicians' Medicare participation options, including a sample private contract and affidavit, through the AMA website, www.ama-assn.org.

A note about Rhode Island: For a few years in the late 1980's and early 1990's, Rhode Island was among the states that prohibited doctors from balance billing Medicare beneficiaries. It is unlikely that the law ever had any practical impact for any patient, and no doctor was ever disciplined under it. While the law is technically still on the books, its language became obsolete and irrelevant with the advent of the RBRVS system in 1992. Medicare itself now effectively limits balance billing by non-participating physicians to no more than 9.25%. ❖

enrollment is up to date by visiting pecos.cms.hhs.gov and logging in as they would for the National Plan and Provider Enumeration System (NPPES), using their NPPES user ID and password; (one can call 1-800-465-3203 if one does not have these, or email customerservice@npienumerator.com). PECOS offers step-by-step on-screen instruction, but users should work along steadily, because PECOS will automatically log off any user who leaves the connection idle for more than fifteen minutes.

There is more. **Having updated their enrollment online in PECOS, physicians must still print out, physically sign and mail the two-page certification form within seven days of their online submission.**

They must also mail any supporting documentation that may be required, such as IRS CP-575 (the form that documents one's employer identification number) or CMS-588 (the form that authorizes electronic funds transfer). Before mailing, one should check to make sure that CMS provided the correct mailing address to Rhode Island's Medicare Contractor, NHIC, Corp. in Hingham, MA; CMS system errors have been known to occur at this point in the process. **Medicare contractors will not process on-line enrollments through PECOS until they also receive a hard copy of the 2-page Certification Statement by mail. Failure to complete this step has delayed the PECOS enrollment of many physicians.**

In case of technical trouble on the PECOS website, one can call the CMS Help Desk for "External Users Services" (EUS) at 1-866-484-8049 Monday through Friday between 7am and 7pm EST or email EUSsupport@cgi.com.

Physicians can also contact Deanna Batstone at NHIC, Corp. (781-741-3479 or deanna.batstone@eds.com) for information on PECOS.

Physicians who prefer not to work online with PECOS may update, enroll or re-enroll by competing and submitting a hard copy of CMS Form 855I. ❖