If You Build It, You Will Get Paid:  
A Primer for Physician Reimbursement  

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I. Introduction  

After climbing through medical school, then residency, then perhaps a fellowship, many physicians view the sources for payment for their services as an afterthought. Physicians today face a wide range of pressures in building, growing and sustaining a medical practice. At the top of the list of those pressures must be navigating the American healthcare insurance system. While there are direct fee-for-service practices, such as “concierge” medicine or other direct pay concepts, insurance represents the principal payor of medical services in the United States. Eighty-four percent (84%) of Americans are covered by some form of insurance, while 16% remain uninsured.¹  

Methods for payment varies from the original fee-for-service model, where a physician sets a charge for a service, performs that service and then the insurer pays for that service, to new fee-for-quality or fee-for-outcome payment models where an insurer, such as Medicare, is driving the system to provide incentives to physicians to control costs. A new physician could spend the first year of practice trying to learn the insurer payment system, rather than delivering health services.

This paper provides a primer on the primary sources of payment in the American healthcare system: (1) Medicare, (2) Medicaid, (3) privately-contracted health insurance, and (4)

employer-sponsored health insurance. The chart below depicts the percentage of Americans covered by each form of insurance:

![Chart: Categories of Health Insurance in the US]

While this paper is not intended to cover every possible topic in the four models of payment, it is intended to provide a preliminary background with regard to payment today and set the stage for further analysis and discussion on specific topics within each of the four models.

For those unfamiliar with the insurance payment process, let us stop for a moment to review the manner in which payment occurs. After a physician provides service and records notes of the service, typically a person responsible for coding the service prepares a claim to be submitted to an insurer. The physician then submits a claim for payment to the insurer and then the insurer pays the claim based on codes.²

There are three key steps in the physician reimbursement process: coding, coverage and payment. Coding is the process of tying the procedures delivered to the patient to a series of numerical values. In a physician office setting, CPT procedure codes are typically used. CPT codes (Current Procedure Terminology) were developed by the American Medical Association and are used to classify services rendered. For inpatient hospital services, ICD-9 procedure codes are used. ICD-9 procedure codes are based on diagnosis, rather than on services rendered. (ICD system is currently moving to a new system of coding referred to as “ICD-10,” which is to be implemented by October 1, 2014 for hospital inpatient procedures.) Coverage is the determination that a particular product or service is covered by the insurance policy under which the claim is made. Payment is the amount paid by the insurer to the physician for the services rendered.

²See Boston Scientific, Physician Reimbursement Primer for Cardiac Rhythm Management (2009) (discussing the physician reimbursement process).
II. **Medicare.**

*Background.* Medicare, established in 1965 through the passage of Title XVIII of the Social Security Act, is a federal health insurance program that provides medical coverage for individuals who are 65 or older, blind, disabled or who have renal disease. Medicare is administered by the Centers for Medicare & Medicaid Services ("CMS"), which is an administrative agency of the United States government under the Department of Health and Human Services.

Participation in Medicare is an elective option for physicians. The rules governing Medicare payment are complex and seemingly ever-changing. Physicians that participate in Medicare must keep current on the rules for payment. In particular, a physician must understand each of the four "Parts" of the Medicare program.

*Four Parts of Medicare.* Medicare has four key portions, labeled as Part A, Part B, Part C and Part D. Part A provides payment for hospital care, in patient care in a skilled nursing facility, home healthcare and hospice care. Part B pays for physician services, therapy, nurse midwives and clinical laboratory and diagnostic services. Part C was created in 1997 and is known as the Medicare Advantage program. The Medicare Advantage program provides beneficiaries the choice to participate in coordinated care or managed care programs, health maintenance organizations ("HMOs"), point of service plans ("POSs"), preferred provider organizations ("PPOs"), provider sponsored organizations ("PSOs") or an insurance plan offering in conjunction with a health savings account ("HSA"). These options provide at least the same level of coverage as in Parts A or B, but operate with limited or no co-payment obligations or deductibles. Medicare buys insurance coverage for its beneficiaries from private plans with payments made monthly. Beneficiaries must have Medicare Part A and Part B in order to be eligible for the Medicare Advantage Program. Medicare Part D, added in 2003, provides beneficiaries with an optional prescription drug plan.

*Funding.* In 2011, Medicare covered 48.7 million people. Total expenditures in 2011 were $549.1 billion. This money comes from two Medicare Trust Funds – the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund. The Hospital Insurance Trust Fund is funded through payroll taxes paid by most employees, employers and people who are self-employed, as well as other sources such as income taxes paid on Social Security benefits, interest earned on the trust fund investments, and Medicare Part A premiums from people who are not eligible for premium-free Part A benefits. The Hospital Insurance Trust Fund pays for Medicare Part A benefits and Medicare Program administration. In contrast, the Supplementary Medical Insurance Trust Fund receives funds authorized by Congress and premiums from people enrolled in Part B, Part D and other sources, such interest earned on the trust fund investments.

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The Supplementary Medical Insurance Trust Fund pays for Part B and Part D benefits and administrative costs.\(^5\)

**Payment.** Medicare payments take various forms depending on the type of program under which the services are rendered or products delivered. Many aspects of the payments for services are anticipated to change in the future as more emphasis is placed on fee-for-quality metrics.

Under Part A, 3,500 facilities contract with Medicare to provide acute inpatient care. In 2010, the inpatient prospective payment system (“IPPS”) accounted for approximately 25% of all Medicare spending.\(^6\) Medicare’s inpatient hospital benefit covers beneficiaries for 90 days of care per “spell of illness.” The 2012 deductible was $1,156 for the first hospital stay in an episode and daily co-payments of $289 beginning on the 61st day.

Under the IPPS, Medicare provides a single payment amount to hospitals for discharge. Medicare assigns discharges to severity diagnosis related groups, referred to as DRGs, which groups patients with similar conditions. Each DRG is assigned a relative weight that reflects the costliness of the treatment. Medicare also adjusts the rates for each DRG for each local market. Further adjustments include factors such as increased rates for facilities that operate an approved resident training program.\(^7\) Medicare sets per discharge payment rates for 751 severity-adjusted DRGs, based on patients’ clinical conditions and treatment strategies. Medicare’s payments are derived through a series of adjustments applied to separate operating and capital base payment rates. These two base rates are updated annually and adjusted to reflect patient conditions, market conditions and certain other factors.

Part B of Medicare pays for physician services, including office visits, surgical procedures and other diagnostic and surgical procedures. In 2011, Part B payments accounted for approximately $68 billion, which equated to about 12% of all Medicare spending.\(^8\)

Medicare pays physicians based on a list of services and their payment rates – referred to as a physician fee schedule. A physician will be reimbursed 80% of the established physician fee schedule or the physician’s billed charge, whichever is lower. In calculating the fee schedule, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice and liability insurance costs. These factors are adjusted by various market factors and geographic designations. Under the physician fee schedule, the unit of payment is generally the individual service. Payment rates are based on relative weights, called relative weights.\(^{5,6,7,8}\)

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\(^6\) MedPac Payment Basics, “Hospital Acute Inpatient Services Payment System,” October 2012.

\(^7\) CCH Medicare Explained\(^ \text{¶} \) 510 (2012).

\(^8\) MedPac Payment Basics, “Physician and Other Health Professionals Payment System” (October 2012).

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value units ("RVUs"), which account for the relative costliness of the inputs used to provide physician services: physician work, practice expenses and liability insurance expenses. RVUs for physician work reflect the relative levels of time, effort, skill and stress associated with providing each service. RVUs for practice expense are based on the expenses physicians incur in renting space, purchasing supplies and equipment and hire non-physician staff. Liability insurance RVUs are based on premiums physicians pay for professional liability insurance. Each of the three RVUs is adjusted to reflect the price level for related inputs in the local market where the service is furnished.

For most physician services, Medicare pays the provider 80% of the fee schedule amount and the beneficiary is responsible for the remaining 20% as coinsurance. Medicare payments can be adjusted upward or downward based on several factors includes the performance of certain services by non-physician practitioners or the provision of services in an underserved area. The Affordable Care Act established certain new incentives for primary care services and major surgical procedures.

Private local and regional insurance companies known as “Medicare Area Contractors” or MACs administer payment of claims under Part B. MACs are charged with making coverage determinations, conducting audits, investigating utilization, providing information to CMS and providing administrative appeals. A Medicare beneficiary never receives payment for Part A benefits, but a beneficiary may receive payment for Part B benefits, unless the payment has been assigned to the physician.

For Part D, a combination of stand-alone prescription drug plans and Medicare Advantage deliver the benefits. The standard 2013 drug benefit includes a $325 deductible, coverage of 75% of allowable drug expenses up to $2,940, a catastrophic limit of $4,750 and 5% coinsurance for drug spending. Part B subsidies take two forms: (a) a direct subsidy – a capitated payment to plans calculated as a share of the adjusted national average of plan bids, or (b) individual reinsurance – Medicare subsidizes 80% of drug spending above the out-of-pocket threshold.9

CMS publishes national coverage determinations (NCDs) to specify certain decisions regarding coverage (or a refusal to cover) certain services, procedures or products on a national basis. Local Medicare contractors are required to follow NCDs. When there is no NCD on point, local contractors may make coverage decisions for the geographic area that they cover – these decisions are referred to as LCDs or local coverage determinations.

Next, we turn to the nation’s principal coverage for low income persons: Medicaid.

III. Medicaid.

Background. Medicaid is a program of insurance for low income persons provided by states through state health plans that receive additional or matching funds from the federal government. Medicaid is provided to individuals and families, including children, who qualify

under a state plan as either “medically needed” or “financially needy.” States are permitted to establish their own eligibility criteria, covered services, payment and administration. The most recent statistics show that 62 million people are covered by Medicaid – 1 in 5 Americans and 1 in 3 children – 60% of people in nursing homes are covered by Medicaid. Under the Affordable Care Act, Medicaid will expand to reach millions more Americans – mostly uninsured. Children account for half of all Medicaid enrollees, but only half of Medicaid spending.

**Funding.** Federal and state governments finance Medicaid jointly. The federal government matches state spending on Medicaid. The federal financing share averages 57%, but varies based on per-capita income by state. In 2011, total Medicaid spending equated to $414 billion.

**Coverage.** Medicaid covers a wide range of services. In addition to acute health services, Medicaid covers nursing home care and home and community-based long-term services and supports that Medicare and most private insurance exclude or sharply limit. Medicaid programs are required to cover inpatient and outpatient hospital services; physician, midwife and nurse practitioner services; laboratory and x-ray services; nursing facility and home healthcare for individuals over age 21; early and periodic screening, diagnosis and treatment (EPSDT) for individuals under age 21; family planning services and supplies; and rural health clinic/federally qualified health centers. Many states also offer “optional” services, including prescription drugs (all states), dental care, durable medical equipment, and personal care services. Under EPSDT, children are entitled to all medically necessary Medicaid services, including services considered optional for adults. Premiums are prohibited and cost sharing is tightly limited for Medicaid beneficiaries at or below 150% federal poverty level. States have more flexibility regarding those at higher income levels, but total premiums and cost sharing cannot exceed 5% of quarterly or monthly family income for any Medicaid beneficiary. The broad spectrum of services that Medicaid covers is particularly important for people with chronic illnesses and disabilities who depend on Medicaid. Medicaid beneficiaries include pre-term babies, people with Alzheimer’s disease, children and adults with mental illness, intellectual and developmental disabilities, and physical disabilities, people with HIV, and many others with high needs. Medicaid covers services that reflect the diverse and often extensive needs of the people it covers. The program fills major gaps in coverage for mental health and long-term care services.

**Payment.** State Medicaid programs have their own way of reimbursing providers for services. Some states pay providers directly for the services they provide, while others contract with managed plans, which in turn pay providers. States set their own payment levels for providers and there can be significant variation in payment. Generally, Medicaid payment levels are lower than those paid by other insurers. Three-quarters of Medicaid beneficiaries are now

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11 Id.


13 Kaiser Family Foundation, supra.
enrolled in some type of managed care program.\textsuperscript{14} The two main models of managed care in Medicaid are managed care organizations (MCO) and primary care case management (PCCM). MCOs are paid on a capitation basis – that is, they are paid a monthly premium for each enrolled beneficiary in exchange for assuming the financial risk for providing comprehensive Medicaid benefits or a defined set of benefits (e.g., ambulatory care, dental services). About half of all Medicaid beneficiaries are enrolled in these risk-based managed care plans. In contrast, PCCM programs build on the fee-for-service system. Medicaid pays contracted primary care providers (PCP) a small monthly per-enrollee fee to provide case management services to Medicaid beneficiaries assigned to them, including coordination and monitoring of primary health services and referrals for specialist care.

The next category we will examine is privately contracted health insurance.

IV. \textit{Private Insurance}.

Most Americans obtain health insurance through their employer or through programs offered by the federal or state governments. For those individuals that are not eligible for their employers’ plans or the government programs, they are left to purchase health insurance on their own or contract with providers directly to provide health care services. Access to and the cost of coverage is dependent on a person’s health status, age, place of residence, and other factors.\textsuperscript{15}

\textit{Coverage}. A 2012 study by the United States Census Bureau concluded that 9.8% of Americans are covered by health insurance purchased directly from insurers.\textsuperscript{16} Generally, the range of insurance products available on the private market is similar to the products available through employer-sponsored plans. Price appears to be the largest factor driving selection of privately purchased health insurance.\textsuperscript{17} Currently, premiums vary by age and, in certain states, by health status. However, under the Affordable Care Act, in 2014, insurers will be prohibited from discriminating against or charging higher rates for individuals based on pre-existing medical conditions. There are currently an estimated 5 million Americans without health insurance that are considered to be “uninsurable” because of pre-existing conditions.

\textit{Regulation}. Private health insurance is regulated at the state level. How a state defines “insurance” can vary greatly state-to-state. While there have been efforts to promulgate national or uniform laws regarding insurance regulation, there is still variation among the states as to the nature and depth of insurance regulation. Generally, a state insurance agency is charged with monitoring the sale and delivery of insurance products within its borders. Federal laws,

\textsuperscript{17} D. Auerbach & S. Ohri, 43 Inquiry 2, Congressional Budget Office, “Price and the Demand for Nongroup Health Insurance,” (Summer 2006).
including, the Health Insurance Portability and Accountability Act, the Fair Credit Reporting Act and others also govern the provision of privately purchased health insurance.

**Exchanges.** Health insurance exchanges are a key component of the Affordable Care Act. Health insurance exchanges are intended to be a source for individuals and small businesses to shop for health insurance coverage – one-stop shopping for insurance coverage. The exchanges will offer a variety of plans with different coverage levels and prices to reflect required and desired health insurance benefits. Under the Affordable Care Act (and the United States Supreme Court’s interpretation of the Affordable Care Act\(^\text{18}\)), States can build a fully state-based exchange, enter into a state-federal partnership exchange, or default to a federally facilitated exchange.\(^\text{19}\) Seventeen states have declared their intention to develop a state-based exchange. Twenty-six states have indicated that they will not establish a state exchange and will rely on the establishment of a federal exchange. Seven states have announced their intent to pursue a state-federal partnership. The operation of health insurance exchanges continues to be an emerging topic. Several states were awarded “Early Innovator” grants and have already begun to develop systems to operate a health insurance exchange.\(^\text{20}\)

While privately purchased health insurance effects a large percentage of the population, employer-sponsored health plans are the largest source of health insurance in the United States.

V. **Employer-Sponsored Health Insurance Plans**

The most recent United States Census Bureau survey determined that 45.1% of Americans receive health insurance coverage through employer-sponsored health plans.\(^\text{21}\) The average annual premiums for employer-sponsored health insurance in 2012 are $5,615 for single coverage and $15,745 for family coverage.\(^\text{22}\) Premiums vary depending on benefits, cost savings and geographical cost differences. Employer contributions to premiums vary— average employer

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\(^{18}\) See *National Federation of Independent Business v. Sibelius*, 132 S.Ct. 2566, 2659 (2012) (holding that the Affordable Care Act, giving Health and Human Services the authority to penalize States that chose not to participate in expansion of Medicaid program by withholding all further Medicaid payments to a State if the Secretary determined the State failed to comply with the conditions attached to the offer of expanded federal funding of Medicaid, exceeded Congress’s power under the United States Constitution’s Spending Clause, by failing to offer States a genuine choice whether to accept the offer).


\(^{21}\) United States Census Bureau, *supra*.

\(^{22}\) The Henry J. Kaiser Family Foundation and the Health Research Educational Trust, Employer Health Benefits, 2012 Annual Survey; *but see* “Study Finds Substantial Decline in Employer-Sponsored Health Insurance,” American Health Lawyers Association (April 12, 2013) (reporting a study by the Robert Wood Johnson Foundation that found that employer-sponsored health insurance fell significantly over the 10-year period from 2000 to 2010).
contributions in 2012 were $951 for single coverage and $4,316 for family coverage.\textsuperscript{23} PPOs are the most common plan type, enrolling 56\% of workers. Nineteen percent of covered workers are enrolled in a high deductible plan, 16\% in an HMO, 9\% in a POS plan, and less than 1\% in a conventional plan.\textsuperscript{24} Sixty-one percent of firms offer health benefits to their employees. Of workers that are eligible, 81\% take advantage of their employer’s health benefit offering.\textsuperscript{25}

Employer sponsored health insurance is typically provided through two types of entities: state-licensed health insuring organizations or self-funded employee health benefit plans. State-licensed health insuring organizations include commercial health insurers, Blue Cross and Blue Shield plans, and health maintenance organizations. Self-funded employee health benefit plans operate under federal law and are health benefit arrangements sponsored by employers, employee organizations or a combination of the two. In self-funded arrangements, the plan sponsor assumes the risk of providing covered services to plan enrollees by paying directly for health care services of the plan participants. In some cases, the sponsor contracts with health insurers or HMOs for administrative services.\textsuperscript{26}

Both federal and state laws regulate the delivery of health insurance. State laws are generally the main source of regulation of the business of insurance. States license the entities that offer insurance, their finances and their obligations to the people they insure. However, the federal Employee Retirement Income and Security Act of 1974 (ERISA) establishes standards for employee benefit plans established or maintained by an employer or an employee organization. In certain situations, ERISA preempts state law, although the breadth of ERISA preemption remains a much-litigated subject. In addition, the federal Health Insurance Portability and Accountability Act provides significant constraints on health insurers, including standards related to access to coverage, portability, nondiscrimination and health benefits.

Physician payments under a health insurance plan depend on the terms and conditions of the plan. Physicians typically must be credentialed and go through an application process to become a provider under a particular health insurance plan.

VI. Conclusion

The four types of payment in the United States provide a wide array of potential traps for physicians. Knowledge of the payment systems is critical for a physician to survive in today’s climate for reducing health costs and changing payment systems. While a deep knowledge of payment systems cannot be gained overnight, a physician will be well served to spend time studying the payment system basics and carefully watching the changing standards in each system.

\textsuperscript{23} Id.
\textsuperscript{24} Id.
\textsuperscript{25} Id.