Medicare payment transparency

Implications for neurologists

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Abstract

In 2014, the Centers for Medicare and Medicaid Services began a now annual process of releasing payment data made to physicians and other providers from Medicare Part B. The unprecedented availability of detailed payment information has generated considerable interest among policymakers, the public, and the media, and raised concerns from a number of physician groups. In the current climate of financial transparency, publication of Medicare payment data will likely continue. In an effort to prepare neurologists for future releases of payment data, we review the background, limitations, potential benefits, and appropriate responses to Medicare payment data releases. **Neurol Clin Pract** 2016;6:73-80

Advancing transparency in physician payment is one of the methods implemented by policymakers to limit health care costs. For that reason, Centers for Medicare and Medicaid Services (CMS) has provided the public with information about payments made to providers for services rendered to Medicare beneficiaries. First, CMS published data on payments made to hospitals. Later, the agency published payment data for services provided by physicians and other suppliers. Providers who rendered services to more than 10 Medicare beneficiaries in 2012 or 2013 will note that the amount Medicare paid for these services is likely listed in a publicly accessible database including your name, address, and National Provider Identifier number.

Neurologists need to be prepared to practice in a highly transparent environment. The purpose of this article is to outline the information contained in the Medicare payment data file, review its limitations, discuss opportunities to use the data constructively, and describe how to respond to erroneous data and questions from colleagues, patients, payers, and the public.

Background

Following the disclosure of some Medicare provider payment data in 1977, the Florida Medical Association and the American Medical Association won a federal injunction in 1979 barring the release of further data on grounds that revealing payment data violated physician privacy protections. A series of challenges to this decision led a US District Court in Florida to lift the injunction in 2013, though the language of the ruling did not require the

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Table Total 2012 payments to neurologists by category of codes

Category of codes	Total Medicare payments to neurologists	Percent of total payment
E/M	\$693,235,394	54.6
Procedure	\$451,490,285	35.54
Biologics	\$95,642,556	7.52
Imaging	\$29,804,721	2.34
Anesthesia	\$5,373	0.0004
Total	\$1,270,178,333	100

Abbreviation: E/M = evaluation and management.

Analysis of the Medicare provider utilization and payment data: physician and other supplier public use file conducted by American Academy of Neurology (AAN) staff for the AAN Medicare part B data workgroup.

Department of Health and Human Services to release data that would indicate provider-specific payments.¹ Following a comment period in 2013, CMS ultimately released extensive Medicare Part B payment data in April 2014, detailing payments to more than 880,000 specific physicians and other providers participating in the Medicare program in 2012.² Part B provides coverage for a wide array of services including physician and nursing services, laboratory and imaging fees, physician-administered medication, and qualifying durable medical equipment. In May 2015, CMS published similar payment data for 2013 with clarification of pass-through payments made for medication purchase and administration.

The Medicare payment data releases have provided unprecedented public access to provider-level payment information.³ These releases have occurred in a context of increasing visibility of physician quality measurements and increasing transparency of physician financial relationships with industry.⁴ The desire for openness among policymakers and the public will likely intensify, and accordingly CMS has announced that it will continue to update Medicare payment data on a yearly basis.⁵

Overview of information contained in the data release

The initial April 2014 release included payment data from Medicare Part B for calendar year 2012. The data contained information on payments to more than 880,000 physicians and other providers, totaling \$77 billion out of the more than \$536 billion spent by Medicare in 2012.^{6,7} Included in the files were 3 general categories of information: (1) provider details, including name, sex, practice address, and specialty; (2) service details, including the total and types of services defined by Healthcare Common Procedure Coding System codes; and (3) payment details, including amount of charges and payment for each type of service. As noted above, similar 2013 Medicare Part B payment data were published in 2015.

What did the data reveal about the practice of neurology?

Payment data to more than 12,000 US neurologists were included in the 2014 release, and a similar number were included in the data published in 2015. Payments to neurologists from Medicare Part B totaled more than \$1.2 billion in 2012. Evaluation and management (E/M) services comprised more than half of this total, at about \$693 million. Procedural services represented about a third of payments to neurologists, at \$451 million (table). More than half of neurologists received less than \$100,000 in total payments, and more than three-quarters received less than \$200,000. Further systematic review of the data are ongoing, and may reveal more insights into the practice of neurologists participating in the Medicare program.

Since the data offer insight into utilization only, no conclusions can be drawn about care quality, and by extension the value of the care delivered.

Limitations of the data

The widespread media coverage following the publication of the 2014 Medicare physician payment data focused on providers who were outliers in regard to Medicare payments received.⁸ The potential for inaccuracies, on the other hand, was a real concern among individual providers and physician organizations.⁹ Possible mistakes in the data include provider address, specialty type, services provided, and payment amounts.

Data errors aside, there is a potential for misinterpretation of the meaning of accurately reported data due to the inherent limitations of this particular public data file.⁹ First, the data included only standard fee-for-service (FFS) Medicare Part B payments, leaving out inpatient and surgical providers who receive payments primarily or exclusively from Part A. Medicare Advantage and durable medical equipment payments were not included, nor were payments from other payers. As a result, the published payment data were not representative of many physicians' practices. In addition, only procedures that providers performed on more than 10 Medicare beneficiaries were counted to ensure patient anonymity. Therefore, the sum of the data in the file underestimates the true Part B FFS expenditures.

Second, the payment data contained in the 2014 release could be easily confused with physician income. Many of the larger Part B provider payments were attributable to global payments for ancillary services that include both technical and professional components. Examples include J-code payments for physician-administered medications in an outpatient infusion laboratory, imaging services that are incorporated into a neurology practice, and electrodiagnostic services billed globally under the physician. Providers may recoup a relatively small component of these payments, but the remainder of the drug or technical costs charged to Medicare remains in the provider's name. As a result, some physicians appeared to have very high income derived from Medicare payments when in fact these pass-through charges were largely used to pay for pharmaceuticals, staff, equipment, and other infrastructure costs. In effect, this creates a systematic overstatement of revenue for physicians who practice within a comprehensive outpatient group. See figures 1–3 for examples of this pay exaggeration. In response to critiques of this potential for misinterpretation, CMS included separate notation of these payments in the data published in 2015.

Third, the payment data do not reflect the quality of the care provided to Medicare beneficiaries. Since the data offer insight into utilization only, no conclusions can be drawn about care quality, and by extension the value of the care delivered. Further, the data do not provide any risk adjustment. A neurologist who primarily takes care of sicker or more complicated patients may have higher payments than a provider who sees a similar number of less complex patients.

In addition to these limitations, there are several others. It is important to note that the information disclosed by CMS does not indicate if multiple providers were billing under a single identification code, which could lead to a false impression of inflated charges. As described above, payments for patients enrolled in Medicare Advantage were not included in the data release, further limiting the generalizability of the payment information. Adjustments made in payments on the basis of geographic modifiers are not reflected in the data release. While the payment data may identify payment outliers, determining accuracy of billing requires individual chart review. Finally, many Medicare payments delivered through payment demonstration programs are not included in the data.

Figure 1 Example 1

HCPSC code	Description of the HCPSC code for the specific medical service	Number of services provided	Average amount paid by Medicare (\$)	Global CMS payment (\$)	Professional component (\$)
64612	Destroy nerve face muscle	27	158.61	4,282.00	4,282.00
64613	Destroy nerve neck muscle	30	139.60	4,188.00	4,188.00
95874	Guide nerv destr needle emg	28	39.48	1,105.00	442.00
95885	Musc tst done w/ nerv tst lim	22	39.00	858.00	343.00
95886	Musc test done w/n test comp	268	64.61	17,316.00	6,926.00
95900	Motor nerve conduction test	210	46.43	9,749.00	3,900.00
95903	Motor nerve conduction test	460	55.18	25,382.00	10,153.00
95904	Sense nerve conduction test	800	40.43	32,345.00	12,938.00
95934	H reflex test	138	67.26	9,281.00	3,712.00
J0585	Injection, onabotulinumtoxinA	10,950	3.87	42,359.00	—
CMS payments vs professional component				\$147,355.00	\$47,374.00

Neuromuscular specialist who operates an EMG laboratory and also performs chemodenervation therapy. Actual professional pay for this physician is \$100,000 less than implied by the Medicare payment data release. CMS = Centers for Medicare and Medicaid Services; HCPSC = Healthcare Common Procedure Coding System.

How to review the data, and what to do when discrepancies are found

The volume of data published in 2014 and 2015 was enormous. The CMS Web site contains source files that may be downloaded in different formats. CMS and other organizations have created online search and filtering tools that simplify the review of the data (see appendix e-1 at Neurology.org/cp for a detailed list of resources). However, the source files may reveal additional detail and opportunity to better analyze the data. Because of the large file sizes, the data are separated alphabetically into multiple files. Analysis may be more manageable if physician data are copied from the large spreadsheets into smaller individual datasets.

CMS has not offered a process or mechanism by which inaccuracies or discrepancies can be resolved. Physicians who find errors in their data are encouraged to report them to MedicareProviderData@cms.hhs.gov.

How to respond to questions from colleagues, payers, and patients

With recent and future data releases, neurologists need to be aware of the potential for questions from patients, colleagues, and payers, and should be prepared to correct any potential misinterpretations. The most important first step in responding to questions is for the physician to be armed with a firm grasp of his or her reported payment data, and to ensure (as outlined above) that any inaccuracies are noted. Patients and payers who inquire about high payments from Medicare can be made aware of the lack of quality or risk adjustment in the payments, the inclusion of pass-through nonphysician costs, and that payments among different providers may vary according to practice composition. For example, physicians who see a disproportionately large percentage of Medicare recipients or have a subspecialty expertise requiring more expensive diagnostic tests or therapies will have comparatively higher payments.

In general, preparation to answer questions regarding Medicare payment data will be sufficient for most practices. However, providers who receive a large number of queries, who are the subject of local media reports, or who are otherwise concerned about misinterpretation of their data may prepare a response to share more broadly (for example, brochures or online explanations on a practice Web site, templates for which are available from the American Medical Association). The American Academy of Neurology Web site also contains resources for those

Supplemental Data

Neurology.org/cp

Figure 2 Example 2

HCPSC code	Description of the HCPSC code for the specific medical service	Number of services provided	Average amount paid by Medicare (\$)	Global pay (\$)	Professional component (\$)
96365	Ther/proph/diag iv inf init	303	51.08	15,478.00	
96366	Ther/proph/diag iv inf addon	124	15.10	1,872.00	
96367	Tx/proph/dg addl seq iv inf	99	23.87	2,363.00	
96372	Ther/proph/diag inj sc/im	460	16.80	7,729.00	
96374	Ther/proph/diag inj iv push	159	39.50	6,280.00	
96375	Tx/pro/dx inj new drug addon	63	15.88	1,001.00	
96413	Chemo iv infusion 1 hr	421	95.90	40,372.00	18,866.00
96415	Chemo iv infusion addl hr	508	21.87	11,108.00	3,439.00
J0585	Injection, onabotulinumtoxinA	16,100	4.21	67,861.00	
J1100	Dexamethasone sodium phos	346	0.09	32.00	—
J1200	Diphenhydramine hcl injection	58	0.58	34.00	
J1569	Gammagard liquid injection	7,175	29.10	208,782.00	
J1745	Infliximab injection	4,990	48.84	243,690.00	
J1885	Ketorolac tromethamine inj	266	0.18	48.00	
J2405	Ondansetron hcl injection	256	0.11	28.00	
J2765	Metoclopramide hcl injection	13	0.20	3.00	
J2930	Methylprednisolone injection	723	2.04	1,476.00	
J3420	Vitamin B12 injection	252	0.37	92.00	
J3475	Inj magnesium sulfate	209	0.10	20.00	
J3490	Drugs unclassified injection	500	1.19	593.00	
J7050	Normal saline solution infus	598	0.21	127.00	
CMS payments vs professional component			\$608,989.00	\$22,305.00	

Global Medicare receipts for central infusion services in a large comprehensive outpatient practice. Claims are submitted under the supervising physician, who is readily available in the suite, but is not the ordering physician. Administration charges are primarily used to cover supplies, nursing time, and infrastructure, as well as some MD time for overseeing the administration of complex agents. Altogether, less than 4% of the Centers for Medicare and Medicaid Services (CMS) payments represent physician income. HCPSC = Healthcare Common Procedure Coding System.

seeking additional information on the Medicare payment data (accessible at <https://www.aan.com/practice/medicare/medicare-payments/>).

How can the payment data be useful to neurologists?

Publicly available Medicare payment data present a rare opportunity for neurologists to improve understanding of utilization in the profession. Notwithstanding the weaknesses in the data, review of the payment information can offer useful insights into individual practice patterns and, more importantly, billing patterns among large groups of providers spanning different specialties and geographic regions. Individual neurologists can benchmark their payment information against other providers in their community or at similar practices in other geographic areas. The data may also be used by practice administrators to determine if there are systematic billing errors. Analysis of cost information similar to what is included in these releases may help neurologists perform value calculations when valid quality measures become widely available, which in turn may be helpful in negotiating with payers. For physicians with exaggerated revenue profiles, analyses such as global vs professional charges can be made easily using the detailed data downloadable from CMS. Furthermore, as mentioned above, the data contained in the 2014 release demonstrates that the majority of payments to neurologists from Part B are for E/M services.¹⁰ Armed with this information, neurology advocates can prioritize efforts to appropriately value E/M codes.

Figure 3 Example 3

HCPSC code	Description of the HCPSC code for the specific medical service	Number of services provided	Average amount paid by Medicare (\$)	Global CMS payment (\$)	Professional component (\$)
70450	CT head/brain w/o dye	67	120.99	8,147.00	1,466.00
70470	CT head/brain w/o and w/dye	6	172.45	1,092.00	197.00
70496	CT angiography head	42	214.61	8,942.00	1,610.00
70498	CT angiography neck	25	265.39	6,546.00	1,178.00
70544	MR angiography head w/o dye	64	280.39	18,038.00	3,247.00
70549	MR angiograph neck w/o&w/dye	19	456.75	8,526.00	1,535.00
70551	MRI brain w/o dye	254	290.36	73,849.00	13,293.00
70553	MRI brain w/o & w/dye	167	451.19	75,199.00	13,536.00
72125	CT neck spine w/o dye	12	125.38	1,546.00	278.00
72131	CT lumbar spine w/o dye	26	122.15	3,217.00	579.00
72141	MRI neck spine w/o dye	52	263.62	13,708.00	2,467.00
72148	MRI lumbar spine w/o dye	51	275.42	13,955.00	2,512.00
72156	MRI neck spine w/o & w/dye	26	395.41	10,149.00	1,827.00
72157	MRI chest spine w/o & w/dye	11	319.15	3,404.00	613.00
72158	MRI lumbar spine w/o & w/dye	26	415.41	10,939.00	1,969.00
73200	CT upper extremity w/o dye	10	140.95	1,409.00	254.00
CMS payments vs professional component				\$258,667.00	\$46,560.00

Imaging services. This example demonstrates the actual professional pay for a neurologist who is also certified to interpret radiologic images, compared to the global payment reported by Centers for Medicare and Medicaid Services (CMS). The high technical component of imaging is required to cover the cost of expensive equipment, staff, facilities, and other infrastructure. The professional component is approximately 18% of the global. In this case, CMS would imply the neurologist received more than \$210,000 over actual physician compensation. HCPSC = Healthcare Common Procedure Coding System.

What's next?

CMS has announced that it will release Medicare payment information on an annual basis,⁵ though the precise contents of future releases could change. While the published data could continue to focus on Part B, the atmosphere of transparency currently embraced by policymakers and the widespread interest generated by the prior releases would suggest that more payment data could be included in future releases. For example, while Medicare Part A payments to hospitals have been publicly available for several years, future releases could tie payments to services and procedures performed by individual providers. Further, in April 2015, CMS published provider-level prescribing data under the Medicare Part D program. Several analysts have called for improvements in the data that have been released, namely by tying the payment data to CMS quality measures. The high degree of complexity of this task and tenuous validity of current CMS quality measures would suggest this latter change is likely premature, but could be possible in the future.

With the emerging shift from FFS payment models to approaches that combine shared savings and shared risks, neurologists may benefit from information regarding payments to other providers (for example, when considering joining an accountable care organization). Transparency in this setting could be helpful, though increased payment transparency from private insurers would be necessary to complement Medicare payment data.

As discussed above, greater transparency and availability of physician payments and quality measurement will likely continue. The recently passed Medicare Access and CHIP Reauthorization Act, in addition to repealing the sustainable growth rate, calls for the transfer of Medicare payment data into the Physician Compare Web site.¹¹ Physician

Individual neurologists can benchmark their payment information against other providers in their community or at similar practices in other geographic areas.

Compare is a CMS Web site that allows users to compare physician practices according to participation in CMS quality programs and performance on some quality measures. Including payment data in this context could exaggerate the perception of a relationship between payments and care quality.

CONCLUSION

The movement toward transparency in physician payment and performance will likely continue. Neurologists should be prepared for future releases of payment information from Medicare. While imperfections in the data and the potential for misinterpretation currently limit the utility of the information contained in the data, neurologists can use this review to educate colleagues, payers, and patients on the shortcomings in the data. Importantly, when clinical quality data become more widely available, the Medicare payment data may help neurologists demonstrate to payers, policymakers, and patients the nature and ultimately the value of the services provided. Neurologists have, and should, seize the opportunity to lead development of meaningful and accurate cost analyses that will help deliver high value care to patients.

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