

The Business of Interventional Pulmonology

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• Interventional pulmonology • Billing • Coding • Reimbursement • Practice building • Insurance

KEY POINTS

- Future changes are inevitable in funding and reimbursement arrangements.
- Understanding and effectively using the current systems of reimbursement is critical.
- It will be imperative for interventional pulmonology practices to be nimble and adapt to the changing landscape of medical need, legislative mandates, and reimbursement policy.
- Interventional pulmonologists are regularly asked to perform more complicated and advanced procedures, but the reimbursement for time, effort, and skill involved in these procedures has not kept up with reimbursement for other procedural specialties.

INTRODUCTION

Health care finance, in particular, reimbursement for services rendered, is complex and there are multiple means by which physicians are reimbursed for services. To appreciate the potential barriers to procedural reimbursement, it is essential to first understand the means by which care costs are currently being covered and then predict the impact of health care reform on the business of interventional pulmonology (IP).

INSURANCE AND HOW IT IMPACTS REIMBURSEMENT

Private Insurance

Most working Americans obtain health insurance through their employers in the form of an employment benefits package.¹ Employers and employees enjoy a tax advantage as a result of offering and receiving health insurance benefits through the employment relationship. Most employers offer their workers a selection of health

insurance plans to choose from; these plans vary in scope of coverage, costs of premiums, and the amount of co-insurance and deductible to be paid by the employee.^{2,3} Employers and employees generally share the costs of the insurance. Employer-provided group insurance usually costs less and offers more benefits than individual health insurance plans.

Employer-sponsored health insurance plans are typically either fee-for-service or various types of managed care plans (health maintenance organizations, HMOs, or preferred provider organizations). Fee-for-service insurance is a traditional form of health insurance in which, after providing health care services, the health care provider (or sometimes the patient) sends a bill to the insurance company. A typical fee-for-service plan may pay 80% of a medical bill, leaving 20% to be paid by the individual, known as “co-insurance,” or may follow some other kind of pre-negotiated payment arrangement. This form of insurance, which was also known as indemnity

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insurance, declined sharply in the 1990s as various forms of managed care organizations were introduced into the health insurance marketplace.^{4,5}

HMOs are prepaid health insurance plans to which members pay a monthly premium. In exchange, the HMO provides comprehensive coverage, including physician visits, hospital stays, laboratory tests, and therapy. In most HMOs, members are assigned or choose a physician who serves as their primary care physician. The primary care physician monitors the patient's health and provides basic medical care and is also responsible for referring patients to a specialist and other health care professionals as needed. Most HMOs do not require a deductible each year, but they do generally require a small copayment for each medical encounter. Because HMOs receive a fixed fee per member per month, they may focus more on providing preventative health care services, such as immunizations, mammograms, and physicals, and may be more restrictive of more advanced or experimental treatments. They may require "preauthorization" for advanced procedures. Procedures such as electromagnetic navigational bronchoscopy often fall into the category of "experimental" despite the growing evidence to support its use for peripheral nodules and the approval process may be challenging. Preferred provider organizations are a variation on HMOs that are generally less flexible than traditional fee-for-service insurance plans, but more flexible than HMOs in terms of restrictions on where and from whom patients can receive care.⁶

Medicare and Medicaid

Medicare and Medicaid are the 2 most important government-sponsored health insurance programs. Title XVIII of the Social Security Act of 1965 established Medicare. It is a federal health care program that covers most individuals 65 years or older as well as those under age 65 with certain disabilities, and patients of all ages requiring dialysis or renal transplant.

Medicare Part A provides basic coverage for hospital stays, posthospital skilled nursing facility care, home health care, and hospice care and is financed from employee and employer contributions. Medicare Part B is medical insurance, which can be purchased by paying an additional monthly premium. It pays for physician and laboratory costs as well as some outpatient medical services, such as medical equipment and supplies, home health care, and physical therapy. Medicare Part C is an alternative in which individuals with Parts A and B can voluntarily choose to receive all of their health care services from a Medicare-

managed care plan provided through private insurance companies.^{7,8} Medicare Part D is a voluntary supplemental prescription drug program that requires an additional monthly premium.

For the most part, Medicare makes payments to providers on a fee-for-service basis, but it negotiates deep discounts for many services and procedures compared with most private insurance plans. Some private insurance companies use similar relative value unitlike reimbursement schedules, as discussed in detail later in this article. Newer payment incentives are being proposed that would adjust payments by markers of quality, efficiency, and outcomes.

Medicaid, on the other hand, is a joint federal-state health insurance program for individuals and families with low incomes and limited resources.⁹ Although the federal government establishes broad guidelines for the Medicaid program, each state establishes its own eligibility standards, benefit packages, payment rates, and program administration. As a result, there are essentially 56 different Medicaid programs—one for each state, territory, and the District of Columbia. Medicaid programs generally cover physician services, inpatient and outpatient hospital care, nursing facility services, prescription drugs, dental care, physical therapy, rehabilitation services, and hospice care. Medicaid also pays providers primarily on a fee-for-service basis after negotiated discounts. Payment rates vary on a state-by-state basis and may fail to cover the actual cost of an interventional pulmonary procedure.

REIMBURSEMENT FOR PULMONARY PROCEDURES

The most common means of reimbursement in North America is fee-for-service. In essence physicians are paid for each individual service rendered in this model of payment. Alternate means of reimbursement for physicians include relative value units (RVUs), capitation, pay for performance, and salary. In the advent of health care reform and cost containment in the United States and Canada, respectively, alternatives to fee-for-service are being sought and the means by which physicians will be reimbursed for services may be in flux over the next several years. Many provinces of Canada have alternate funding plans, a pay-for-performance-like incentive structure whereby physicians receive a base salary and in addition receive a performance-based incentive. The province negotiates salaries for various physician groups with the health care organization. In the United States, pay for performance, medical home, and accountable care organizations (ACO)

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