PROPOSED 2009 CHANGES TO PAYMENT POLICIES AND RATES UNDER MEDICARE PHYSICIAN FEE SCHEDULE

OVERVIEW:
On June 30, the Centers for Medicare & Medicaid Services (CMS) issued proposed changes to the Medicare Physician Fee Schedule (MPFS) for 2009. CMS issues annual updates for the MPFS to set payment policies and the payment rates for services furnished by physicians and non-physician practitioners (NPPs) to people with Medicare. The proposed rule is one step in an annual process intended to ensure that CMS pays appropriately for these services, based on a methodology set out in the Medicare statute. After reviewing public comments, CMS will publish a final rule by November 1, 2008, to become effective for services furnished during calendar year (CY) 2009.

BACKGROUND:
The MPFS CY 2009 proposed rule continues an initiative of the Administration to transform the Medicare fee-for-service program into a prudent purchaser of health care services, paying for quality of care, not just quantity.

Since 1992, Medicare has paid for the services of physicians and NPPs under the MPFS, a system that pays for covered physicians’ services furnished to a person with Medicare Part B. Under the MPFS, a relative value is assigned to each of more than 7,000 types of services to capture the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice premiums typically involved in furnishing the service. The higher the number of relative value units (RVUs) assigned to a service, the higher the payment.

The RVUs for a particular service are multiplied by a fixed-dollar conversion factor to determine the payment amount for each service. CMS updates the conversion factor annually using a statutory formula adopted in the Balanced Budget Act of 1997 (BBA) that was intended to constrain the rapid growth in spending for physician and NPP services by setting a target rate of
spending for a year, and then adjusting the update in subsequent years to keep actual spending over time in line with the target. Since 2002, the formula has yielded a negative update to the conversion factor, and every year since 2003, Congress has enacted legislation to prevent the negative update from taking effect for the year.

In the Tax Relief and Health Care Act of 2006 (TRHCA), Congress authorized CMS for the first time to an incentive payment to eligible professionals who satisfactorily report certain quality data under the Physician Quality Reporting Initiative (PQRI). While providing a financial incentive in certain years to eligible professionals to be aware of the quality measures during treatment decisions, this program will also provide valuable information as Medicare moves toward paying for quality of care, not just quantity of services. The program has been expanded and streamlined for services furnished on or after July 1, 2008, based on provisions in the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). The MPFS CY 2009 proposed rule includes proposals for additional improvements to the program for purposes of reporting data on quality measures in 2009.

**SIGNIFICANT ISSUES IN THE MPFS CY 2009 PROPOSED RULE:**

**Proposed Payment Changes:**

*Proposed Update for Physician Fees for Services in CY 2009:* The proposed rule includes a projected update to the fee schedule conversion factor of negative 5.4 percent under a formula specified in the Medicare law. The update will be revised in the final rule to reflect the law in effect at that time.

*Potentially Misvalued Services under the MPFS:* The American Medical Association’s Relative Value System Update Committee (RUC) provides recommendations to CMS for the valuation of new and revised codes as well as codes identified as misvalued under the Five-Year Review of Work. Historically, the RUC recommends far more increases in RVUs than decreases. The Medicare Payment Advisory Commission (MedPAC) and other stakeholders, most notable primary care physicians and Congress, have expressed concern that CMS’s current process of reviewing physician fee schedule RVUs is not effective for identifying potentially overvalued procedures and that CMS favors specialized services over primary care services.

The proposed rule identifies the fastest growing higher cost procedures, including services with potentially unexplained high RVUs and procedures that have not been reviewed by the RUC since the fee schedule was created. CMS has requested that the RUC begin reviewing the
identified codes immediately, but anticipates that this process may take a number of years due to the large number of services involved.

CMS is also proposing to create a process to update the prices for high cost supply items that are paid under the practice expense methodology. The process is discussed in the proposed rule and high cost supply items have been identified.

**Physician Payment Locality Options:** The Medicare statute requires CMS to adjust MPFS payments for services furnished in different parts of the country using geographic practice cost indices (GPCIs) to reflect different resource costs compared to the national average. In recent years, physicians in certain areas of the country have expressed concern that the configuration of certain localities no longer reflects the costs incurred by the physicians those areas.

In response to these concerns, CMS has awarded a contract to Acumen, LLC to analyze potential options for reconfiguring localities. This rule provides a brief description of the alternative payment locality configurations. CMS plans to post an interim report on the results of this research on its Web site and to invite public comment on the data presented and to suggest possible alternatives. At this time, CMS is not proposing a change in the localities. Any change in localities would only be done through future proposed rulemaking that would be subject to further public comment.

**Payment for Follow-Up Inpatient Telehealth Consultations:** Prior to 2006, follow-up inpatient consultations were approved for payment when furnished remotely using telehealth services. In 2006, the CPT Editorial Panel of the American Medical Association (AMA) deleted the codes for follow-up inpatient consultations and advised practitioners to bill for these services using the codes for subsequent hospital care. Because the subsequent hospital care codes describe a broader range of services than follow-up inpatient consultations, including some services that may be inappropriate for delivery through telehealth, CMS did not add them to the list of Medicare approved telehealth services for 2007.

For CY 2009, CMS is proposing to add new HCPCS codes specific to the telehealth delivery of follow up inpatient consultations. The new codes will enable practitioners to bill for follow-up inpatient consultations delivered via telehealth. These codes are intended for use by physicians or NPPs who are consulted by the patient’s attending physician regarding the patient’s care but who are not available for a face-to-face encounter. The codes are not intended for use in billing for ongoing evaluation and management of a hospital inpatient.
Proposals to Improve Quality of Services to People with Medicare

Physician Quality Reporting Initiative (PQRI): The MMSEA amended the statute to require CMS to use a rulemaking process to select quality measures for the 2009 PQRI. In addition, the MMSEA amendments require CMS to establish for 2009 alternative reporting criteria and alternative reporting periods for reporting of measures groups and for registry-based reporting. Current law does not authorize an incentive payment for the satisfactory reporting of data on quality measures for services furnished on or after January 1, 2009.

- Proposed measures - The proposed rule proposes a total of 175 measures for reporting in 2009, an increase of 56 measures from 2008. Of these, 111 are current measures, and 64 are new measures either endorsed by the National Quality Forum (NQF), adopted by the AQA Alliance (AQA), or measures currently under consideration by the NQF or the AQA. CMS is also proposing to include measures that were reviewed but not selected for the 2009 PQRI in a 2009 New Measures Testing Process similar to 2008. No financial incentive payment would be associated with submission of these new test measures for either 2008 or 2009, or for reporting data on (non-test) quality measures under the proposed 2009 PQRI.

- Reporting options - The proposed rule would allow claims-based reporting either for individual measures or for Measures Groups.

  o For individual measures, CMS is proposing to require reporting of three individual measures (or less than three if only one or two are applicable to an eligible professionals) for 80 percent of applicable cases during the calendar year.

  o For Measures Groups, CMS is proposing to require professionals who report for the full calendar year to report measures for 30 consecutive patients for whom all measures of one Measures Group apply, or 80 percent of patients to whom all measures of one Measures Group apply with a minimum of 30 patients.

  o For the July 1, 2009 – December 31, 2009 reporting period, CMS is proposing to require reporting on 80 percent of applicable patients, with a minimum of 15 patients.

- Measures Groups - CMS is proposing Measures Groups for Diabetes Mellitus, Chronic Kidney Disease (CKD), Preventive Care, Coronary Artery Disease, HIV/AIDS, Coronary Artery Bypass Surgery, Rheumatoid Arthritis, Perioperative Care, and Back Pain. The Back Pain Measures Group is reportable solely as a Measures Group and not by individual measures.
• **Clinical Registry Data Reporting** – CMS is proposing to conduct another self-nomination process so that additional registries can potentially be approved for submitting quality measures data. Under the proposal, CMS would begin accepting data submission from clinical data registries starting January 1, 2010 for PQRI measures for services furnished in CY 2009. The criteria for registry reporting would be similar to those for claims based reporting.

• **Electronic Health Record (EHR) Reporting** – If the 2008 Measure Testing Process is successful, CMS is proposing to begin accepting data from EHRs for a limited subset of the proposed 2009 PQRI quality measures starting January 1, 2009 for the CY 2009 reporting period. Under the proposal, EHR reporting would be available only for reporting individual measures not Measures Groups.

**Quality Standards for Physicians and NPPs Providing Diagnostic Testing Services:**
CMS is proposing to require that physicians and NPPs who furnish diagnostic testing services meet most of the quality and performance standards required for Independent Diagnostic Testing Facilities (IDTF), including:

• Having technical staff on duty with the appropriate credentials to perform tests.
• Limiting a supervising physician to providing general supervision to no more than three IDTF sites.
• Requiring a supervising physician to prove proficiency in the performance and interpretation of each type of diagnostic procedure furnished in the office.
• Keeping equipment calibrated, maintaining it as indicated in the manual, and maintaining an inventory of diagnostic testing equipment.
• Complying with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.
• Providing complete and accurate information on Medicare enrollment applications, and reporting to the administrative contractor any changes in ownership, location, and general supervision, as well as any adverse legal actions, within 30 days. Other changes to information on the enrollment application would have to be reported within 90 days.
• Maintaining a physical facility with space for equipment appropriate to the services designated on the enrollment application, adequate patient privacy accommodations, and storage of both business records and current medical records within the office setting.
• Maintaining a primary business phone under the name of the physician or NPP.
• Having proper storage for medical records and being able to retrieve medical records upon request from CMS or its fee-for-service contractor within 2 business days.
• Permitting unannounced and on-site inspections to confirm compliance with these standards.

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CMS is specifically soliciting comments on whether to limit this enrollment requirement to less than the full range of diagnostic testing services, and, if so what criteria should be used to limit this provision. Examples of possible limitations include:

- Applying only to procedures that generally involve more costly testing and equipment;
- Applying only to imaging services or to only advanced imaging services, such as diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography); or
- Excluding diagnostic testing services such as electrocardiograms or other diagnostic testing services frequently furnished by primary care physicians.

CMS is proposing to give physicians and NPPs who are currently enrolled in Medicare until September 30, 2009 to comply with these standards, rather than the January 1, 2009 effective date for the 2009 final rule.

**Proposed Changes to Physician Self-Referral and Anti-Markup Provisions**

*Exception for Incentive Payment and Shared Savings Programs:* The Medicare program and private industry stakeholders are increasingly exploring the benefits of various types of gainsharing, pay-for-performance, value-based purchasing, and similarly-styled incentive payment or shared savings programs that use economic incentives to foster high quality, cost-effective care. Many of these programs involve payments from hospitals to physicians which may implicate the physician self-referral law. This rule proposes an exception to the prohibition on physician self-referral that would permit remuneration provided by a hospital to physicians on its medical staff under incentive payment or shared savings programs, provided that specified conditions are satisfied. Many of the conditions mirror those found important by the Health and Human Services Office of the Inspector General in ten favorable advisory opinions it has issued to date for gainsharing programs.

*Anti-markup Provisions:* This proposed rule proposes two alternatives to revising the anti-markup rule in §414.50. The first alternative would not require application of the anti-markup rule to diagnostic testing services provided by a physician who shares a practice with a single physician or physician organization. In all other cases, the anti-markup rule would apply. The second alternative would clarify anti-markup provisions that were finalized in the MPFS CY 2008 final rule by providing guidance pertaining to various terms of the rule, including what would constitute the “office of the billing physician or other supplier” and other concepts such as “outside supplier.”
In addition, CMS is soliciting comments on:

- Defining “net charge”;
- Whether, in addition to or in lieu of the anti-markup provision, CMS should prohibit reassignment in certain situations and require the physician supervising the technical component or performing the professional component to bill Medicare directly; and
- Whether CMS should delay beyond January 1, 2009, the effective date of certain anti-markup provisions published in the MPFS CY 2008 final rule, or delay the effective date of any proposed revisions to that rule, to the extent that they are finalized in the MPFS CY 2009 final rule, or both.

**Beneficiary Signature Requirements for Non-Emergency Ambulance Services:** This rule proposes changes to the beneficiary signature requirements for non-emergency ambulance claims. Specifically, in instances where no other individual is available and authorized to sign a non-emergency ambulance transport claim on behalf of a beneficiary who is physically or mentally incapable of signing, the ambulance provider or supplier would be permitted to submit the claim without the beneficiary’s signature, provided that specified documentation requirements are met.

**Solicitation of Comments and Data Relating to Organ Retrieval Services:** CMS currently limits payment amounts to physicians for cadaveric kidney donor retrieval services. This proposed rule solicits comments and data that could be used to analyze the payment rate to physicians for kidney retrieval as well as other types of physician organ retrieval services.

**Proposed Changes to Enrollment and Billing Rules**

The proposed rule includes a number of changes in enrollment and billing requirements, including:

- Soliciting comments regarding two approaches for establishing the effective date for Medicare billing privileges for physician and nonphysician organizations and for individual practitioners. The first approach would establish the initial enrollment date as the date that Medicare approves the enrollment application. The second approach would establish the initial enrollment date for physician and nonphysician organizations and individual practitioners as the later of: (1) the date of filing, or (2) the date an enrolled supplier started rendering services at the new practice location.
- Prohibiting physicians and NPPs from obtaining additional billing privileges if their billing privileges have been suspended or they have an existing overpayment.
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- Requiring physicians and NPPs to notify within 30 days their designated contractor of a: change of ownership, adverse legal action or change of location that would have an effect on a payment amount. Failure to comply would result in an overpayment from the date of the reportable change related to an adverse legal action or a change of location.
- Requiring physicians and NPPs to maintain written ordering and referring documentation.
- Requiring providers and suppliers to submit all outstanding claims within 15 days of the date notice of revocation of billing privileges has been sent. If a revocation is based upon a Federal exclusion or debarment, felony conviction, or license suspension or revocation, or if the practice location has been deemed non-operational, then the revocation will become effective on the date of the notification.

OTHER PROPOSALS:

**Competitive Acquisition Program (CAP) Revisions:** The CAP is an alternative to the ASP (buy and bill) method of obtaining certain Part B drugs administered in physicians’ offices. Physicians who choose to participate in the CAP obtain approximately 190 drugs on the CAP drug list from an approved CAP vendor that was selected through a competitive bidding process and approved by CMS. A physician bills Medicare for administering a CAP drug. An approved CAP vendor bills Medicare for the CAP drug and collects applicable cost-sharing amounts from a beneficiary.

The proposed rule contains a number of proposed refinements to the CAP, including clarifying the annual payment amount update calculation; clarifying the definition of a physician for CAP purposes; easing the restriction on physicians transporting CAP drugs between their practice locations; and clarifying what happens if a CAP physician or vendor is suspended from participation in the CAP.

**E-Prescribing:** In the MPFS 2008 Final Rule, CMS amended an exemption that will limit the use of computer-generated faxes to e-prescribe Part D covered drugs for Part D eligible individuals to instances in which temporary/transient transmission failure or communication problems preclude the use of the adopted NCPDP SCRIPT standard. This amendment is scheduled to take effect on January 1, 2009.

In the MPFS 2009 Proposed Rule, CMS is proposing to retain the provisions that would allow for use of computer-generated faxes in instances of temporary/transient transmission failure or communication problems that preclude the use of the adopted NCPDP SCRIPT standard, and add an exemption for computer-generated faxes used by dispensers to request refills from providers that are not capable of receiving and processing refill requests using the adopted NCPDP SCRIPT standard.

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End Stage Renal Disease (ESRD) Facility Payment: For calendar year (CY) 2009, CMS is proposing to update the wage data and to complete the four-year transition to a wage index based on core-based statistical areas. CMS is also proposing to reduce the wage index floor from 0.75 to 0.70 for 2009.

Although total drug expenditures for CY 2009 are projected to decline 2.9 percent (based on a projected price decline of 1.9 percent and a projected 1 percent drop in per patient utilization), CMS is proposing a zero percent update to the drug add-on payment, leaving the adjustment at 15.5 percent for 2009. CMS also is seeking public comment on alternative methods to calculate the drug-add on adjustment.

CMS will accept comments on the proposed rule until August 29, 2008, and will respond to those comments in a final rule to be issued by November 1, 2008.

For more information, see: www.cms.hhs.gov/center/physician.asp.