Member-Only Analysis of the 2008 Medicare Physician Fee Schedule

On Nov. 27, the Centers for Medicare & Medicaid Services (CMS) published the final 2007 Medicare fee schedule for physician services in the Federal Register. The schedule includes final payment rates for covered services and changes to Medicare policy. To view the impact of the fee schedule on your specialty or on specific codes, you can view the impact charts at mgma.com.

In addition, a useful file containing a Microsoft Excel spreadsheet of all covered codes with accompanying calculation values can also be obtained on the CMS Web site. The file name is RVU08A2.ZIP. It contains instructions on how to calculate payments for any given locality, as well as anesthesia payment information. Previous fee schedules are also available in the frequently asked questions area of the site.

Payment

In the final 2008 Medicare physician fee schedule, the Centers for Medicare & Medicaid Services (CMS) announced that the cut to physician payment for Medicare services has increased from 9.9 percent to 10.1 percent. Unless Congress takes action before Jan. 1, 2008, the conversion factor will drop to $34.0682 from $37.8975. The anesthesia conversion factor will decline to $16.3307 from $17.7594.

MedPAC estimates that payment will be cut every year unless changes are made, a trend that will have grave consequences for the entire health care system. If CMS does not take possible administrative actions and Congress does not act, physicians will receive payment rates lower than those of 1999 – yet, according to MGMA data, practice costs have increased by 42.5 percent since that time.

According to MGMA surveys, the cost of operating a group practice rose by an average 4.8 percent a year over the last 10 years. Between 2001 and 2006, operating costs increased more than 34 percent. During June and July, MGMA queried members regarding their intentions if the anticipated cut goes into effect on Jan. 1. If Medicare payment is cut 10 percent, more than 41 percent of respondents said they may have to limit the number of Medicare patients they see. More than 19 percent said they would be forced to stop accepting new Medicare patients. Beyond restricting access, medical groups also said:

- 57 percent would have to reduce staff health care benefits coverage to remain financially viable;
- 44 percent would cut administrative staffing levels;
- 33 percent would cut clinical staffing levels; and
- 9 percent would cut the number of physicians in their practice.

The poll also indicated that nearly 63 percent of respondents said private insurance companies with which they had contracts made changes to their 2006 payment rates based on the Medicare fee schedule. Of those affected practices:

- 51 percent experienced up to a 5 percent reduction in reimbursements;
- 22 percent experienced up to a 10 percent reduction in reimbursements; and
- Nearly 9 percent experienced up to a 25 percent reduction in reimbursement.
If Congress acts to prevent the 10.1 percent cut to Medicare payment before Dec. 31, CMS will issue instructions to the carriers as to what actions they should take. Any necessary revisions to payment rates will be posted in a timely fashion, both on carriers’ Web sites and CMS’ Web site. Additionally, as in past years, CMS will inform carriers regarding the necessary education and outreach in the event of a change to the law.

MGMA will continue to lobby Congress and the Bush administration to prevent a cut in physician reimbursement and will reiterate the need to permanently fix the physician reimbursement system. As discussed below, the alterations in RVUs, in addition to the other payment changes in the rule, mean that a majority of physicians face reductions of an estimated 5 percent to 20 percent.

**Anesthesiology payment update**

Anesthesiologists, unlike other physicians, are compensated using a code-specific base-unit and time-unit model. In part because of this unique approach, anesthesiologist payment has suffered. At the request of anesthesiologists and CMS, the Relative Value Uniform Committee (RUC) examined anesthesia payment and recommended that the work value of anesthesia payment should increase by 32 percent. CMS agreed to the RUC’s recommendations and adopted them as part of the 2008 final rule.

**RVU update**

CMS reiterated its adoption of a four-year plan implementing revisions to practice expense (PE) RVUs, including an altered methodology, use of supplemental survey data and elimination of the nonphysician work pool. The agency will calculate PE RVUs using a “bottom-up” approach rather than a “top-down” method. This means that CMS will determine direct costs of practice expenses by adding costs of typical resources, as opposed to developing a value and then determining the cost of resources. CMS accepted supplemental surveys in addition to supporting the American Medical Association’s (AMA’s) new multispecialty survey of practice expenses. 2008 marks the second year of the four-year transition.

Many of the tables containing the RVU values refer to a “fully implemented” PE RVU and a “transitional” PE RVU, since the changes will occur over four years. For the coming year, the transitional PE RVUs reflect the values for existing codes. The exact implication of the fully implemented PE RVU column depends on the code. Codes developed during the transition period will be valued using the fully implemented PE RVU. CMS provides the fully implemented PE RVU for all codes, old and new, to allow providers to compare the difference between the current method and the new one.

**Malpractice RVUs (TC/PC Issues)**

In the 2008 proposed fee schedule, CMS included a discussion regarding the radiology codes for which the technical component malpractice RVUs are higher than the professional component malpractice RVUs. CMS decided in the final rule that no proposal about malpractice RVU assignment will be made, but the agency is still considering possible changes. If CMS does decide to make proposals regarding the payment for those services, the changes will occur through the notice and comment rulemaking process.

**Budget neutrality adjuster**
As part of the 2007 Medicare physician fee schedule, CMS examined the work RVUs. By law, changes to the work RVUs can increase Medicare spending only by $20 million over what it would have been without the changes.

Because of that, CMS added to the payment calculation a factor referred to as the budget neutrality adjustor (BNA). Like other changes to the work RVUs, the changes to the work value for anesthesia payment must be budget-neutral. To compensate for the increase in Medicare spending associated with the change in the work value for anesthesia services, CMS has decreased the BNA to 0.8806.

The payment calculation for the coming year is as follows:

Payment = \[(\text{work RVU} \times \text{budget neutrality adjustor} \times \text{work GPCI}) + (\text{practice expense RVU} \times \text{practice expense GPCI}) + (\text{malpractice RVU} \times \text{malpractice GPCI})\] \times \text{conversion factor}

GPCI update

Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS set a floor of 1.0 for the value of the work geographic practice cost indices (GPCIs), which was to sunset on Dec. 31, 2006. The Tax Relief and Health Care Act of 2006 (TRHCA) extended this provision through Dec. 31, 2007. Without congressional action, on Jan. 1, 2008, the work GPCIs will revert to what they would have been without the floor.

In the proposed fee schedule, CMS solicited comments on three options for reconfiguring the GPCI level for areas of California in order to appropriately relate intralocality variations and redistributive impacts with any locality revision. CMS proposed implementing one of the reconfiguration options in California as a means of evaluating the impact of the implementation before applying the policy to nationwide. Due to an overwhelming number of comments, CMS has decided not to finalize any of the three proposed options at this time.

Telehealth

On review of the public comments, CMS added a neurobehavioral status exam to the list of Medicare Telehealth Services. CMS also determined that subsequent hospital care and neuropsychological testing do not constitute Medicare Telehealth Services. Services within the scope of subsequent hospital care were not considered to be similar to the current telehealth services. Neuropsychological testing is not being added to the list because it does not require an in-person encounter between the patient and physician. CMS set the 2008 telehealth originating site facility fee at $23.35.

DRA cap

CMS also added to the list of procedures capped by the Deficit Reduction Act of 2005 (DRA). Under the DRA, if the technical component of imaging procedures (before geographic adjustment) exceeds the Hospital Outpatient Prospective Payment System (OPPS) amount for the same service, the payment will be capped at the OPPS amount, and the Medicare physician fee schedule’s geographic adjustment will be applied to that amount. CMS has amended its interpretation of imaging services under the DRA to include six additional ophthalmologic procedures.

Multiple procedure payment reduction for Mohs
CMS finalized its proposal to apply the multiple procedure reduction to the performance of multiple Mohs surgical procedures (advanced treatment for skin cancer) during the same operative session by the same physician. Mohs surgery has been exempt from the multiple procedure reduction since 1991, but the AMA CPT Editorial Panel has recently revised the modifier -51 list to exclude Mohs surgery. CMS followed this recommendation by eliminating the -51 modifier exemption.

**Payment for IVIG**

CMS has decided to continue paying for pre-administration services associated with intravenous immune globulin (IVIG). Ensuring patient access to IVIG and fairly reimbursing providers for administration costs aligns with the agency’s goals of accurately paying for appropriate services.

**Part B drug payment**

**ASP issues**

In the final rule, CMS did not make any changes to the average sales price (ASP) method. CMS will continue to pay ASP at 5 percent in 2008. In the proposed rule, CMS mulled possible changes to payment methodology, including requiring manufacturers to report to HHS bundling price concessions and/or discounts the manufacturers offer for buying in bulk.

**CAP issues**

CMS extended the initial opt-out period for practices recently enrolled in the Competitive Acquisition Program (CAP) for Part B drugs and biologicals from 30 days in the proposed rule to 60 days in the final rule. Newly enrolled CAP-participating practices now have 60 days in 2008 to opt out if they demonstrate a “good faith” effort to participate but cannot due to unforeseen financial hardship. As required by TRHCA, the CAP vendor will pay CAP-participating physicians for administering a CAP drug without the CAP vendor first processing a provider-submitted administration code. However, by allowing the vendor authority to verify administration of the drug through a post-payment review process, the entire program remains unappealing and onerous. In the proposed rule, CMS requested feedback on the transportation of CAP drugs from one physician practice location to another in certain circumstances; however, no changes were made in the final rule.

**End-stage renal disease provisions**

Under the MMA, a drug payment add-on to the composite rate is required to account for changes in the drug payment method. This payment reflects the difference in the aggregate payments for end-stage renal disease (ESRD) drugs resulting from the 2005 and 2006 changes in drug payment methods and the average wholesale price method used in 2004. CMS must update this add-on every year to reflect estimated growth in expenditures for those drugs and biologicals. The drug add-on for 2008 will be 0.5 percent above last year for a total payment add-on of 15.5 percent.

CMS will use a new method to calculate the payment for 2008. It will continue using the producer price index for prescription drugs, a measure of drug pricing growth, in conjunction with claims data from 2004 and 2005 as an estimate of growth in per-patient use. CMS will review this method for 2010 when it will have enough trend data to consider integrating the information gathered on ASP-based historical trends.
In the 2006 Medicare physician fee schedule, CMS revised geographic designations used in the calculations of wage indexes for ESRD facilities, replacing the previous standards with ones issued by the OMB in June 2003 based on the 2000 Census, known as the core-based statistical areas (CBSAs). This change in method is being phased in over a four-year period. 2008 will mark the third year of the transition to the new method. Under this final rule, CMS clarified that any changes made by the OMB to the CBSAs will be incorporated for use in determining the hospital wage data as part of the ESRD wage index. Additionally, CMS will again reduce the wage index floor for the third consecutive year.

**IDTF issues**

CMS finalized revisions to the certification standards for independent diagnostic testing facilities (IDTFs). IDTF suppliers will now be required to provide contact information for the issuing insurance agent and underwriter, ensure that an insurance policy providing at least $300,000 in coverage per incident is in force at all times and notify CMS in writing of policy changes and cancellations. CMS also revised its regulation to clarify that only changes in ownership, changes in location, changes in general supervision and adverse legal actions need to be reported to CMS within 30 calendar days. All other changes to the enrollment application must be reported within 90 days. CMS also announced its intention to revise the CMS-855B form to clarify which reportable events must be reported in 30 and 90 days. Additionally, the agency published its intention to make electronic enrollment available for Medicare providers in most parts of the country in March 2008. Because there were questions about the certification standard relating to beneficiaries’ questions and complaints, CMS expanded this requirement to clarify it.

In clarification, CMS said the requirement that supervising physicians cannot provide supervision at more than three sites includes both fixed and mobile sites. It also will now prohibit hotels or motels from being considered an appropriate IDTF site and eliminated some of the physical requirements for IDTFs that do not see beneficiaries at their practice.

Also, CMS added two new certification standards. The first eliminates retroactive billing for IDTFs by establishing the effective date of an IDTF’s billing privileges as the later of either:

- The filing date of the Medicare enrollment application that was subsequently approved by a Medicare fee-for-service contractor; or
- The date the IDTF first started furnishing services at its new practice location.

In the second, CMS adopted a new standard that prohibits IDTFs from sharing space with another Medicare-enrolled individual or organization. Sharing space includes sharing a practice location, leasing or subleasing its operations or practice location, or sharing diagnostic equipment. CMS does not include a definition of a practice location in its regulations but has said it will evaluate this on a case-by-case basis. For example, a shared waiting room may or may not be allowed depending on the overall structure of the practice. For IDTFs currently sharing a practice location with another Medicare-enrolled provider, CMS will delay application of this requirement for one year. That delay was not written into the regulations, but CMS intends to include the delay in its instructions to carriers in the Provider Integrity Manual.

**PSA payments**
As required by law, the Physician Scarcity Area (PSA) bonus program expires on Dec. 31, 2007. This three-year program, created as part of the MMA, provided a 5 percent bonus to practices in areas designated as PSAs.

**Compendia for determination of medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemo regimen**

In the proposed rule, CMS discussed methods to revise the list of approved compendia but opted not to make any changes in the final rule. In January 2008, the Department of Health and Human Services (HHS) will accept requests to modify the list of approved compendia in such a fashion that the process will resemble a formal rulemaking.

**Physician self-referral issues**

CMS originally proposed 11 changes that would have affected the physician self-referral/Stark law. It did not finalize most of these proposals, though it has indicated it intends to do so in a future regulation.

CMS finalized modifications to the anti-markup rule limiting payment for purchased diagnostic tests. The current regulation limits a physician’s payment for the technical component of purchased tests to the lesser of:

- The supplier's net charge to the physician;
- The physician's actual charge; or
- The fee schedule amount for the test that would be allowed if the supplier billed directly.

Under the new regulation adopted by CMS, this payment limitation will now apply to both the technical and the professional component of diagnostic tests. It will apply to tests that are ordered by and billed for by a physician or other supplier if they were purchased from an outside supplier or performed at a site other than the office of the billing physician or other supplier. For a physician organization, the “office of the billing physician or other supplier” is space in which the physician organization provides substantially the full range of patient care services that the physician organization provides generally. In other words, the payment limitation will now apply to both purchased services and services that are not purchased but that are performed by employee technicians and physicians if they are performed at a location where the physician or medical group does not provide the full range of patient care services that the physician or group provides generally.

**Technical corrections**

*Medical Nutrition Therapy (MNT)*

CMS finalized a technical correction to the regulations regarding MNT as Medicare Telehealth Service to include an exception for certain services. The correction reads as follows: “Medicare Part B pays for MNT services provided by a registered dietitian or nutrition professional...Except as provided...services covered consist of face-to-face nutritional assessments and interventions in accordance with nationally accepted dietary or nutritional protocols.”

**Recalls and replacement devices**
CMS is examining the costs associated with the recall of medical devices and their replacement. Recent examples of such recalls include implantable cardioverter-defibrillators (ICDs) and cardiac resynchronization therapy defibrillators (CRT-Ds). While manufacturers may replace the devices for free, CMS is collecting information about the additional costs associated with such recalls, including those associated with additional physicians’ services and diagnostic testing. The costs of such devices and recalls are addressed in a separate rulemaking for inpatient and outpatient hospital settings. However, these costs have never been addressed in connection with physicians’ services. At this time, CMS has provided no specific language to address this concern. Instead, the agency will consider the concerns and suggestions raised by commenters as it develops a plan.

**Therapy standards and requirements**

The final fee schedule contains a number of provisions affecting therapy services. The first is a reminder that the process allowing for exceptions to the mandated therapy caps will expire on Dec. 31, 2007, unless Congress acts. The Balanced Budget Act of 1997 imposed a cap on outpatient therapy services and created two categories: one for outpatient physical therapy and speech language pathology services, and one for outpatient occupational therapy services. Congress placed a moratorium on the cap for a number of years, with the last one expiring Dec. 31, 2005. As part of the DRA of 2006, Congress instructed CMS to create a one-year exception process to the cap. The agency extended the exception process for another year through TRHCA; however, this additional year ends on Dec. 31, 2007. Under current law, the cap for therapy services for 2008 will be $1,810 for each category of therapy services without exception.

Additionally, under the 2008 final rule, CMS has revised the standards for licensure for physical therapists (PTs), occupational therapists (OTs), occupational therapist assistants (OTAs) and speech-language pathologists (SLPs) across Part A and Part B settings.

Individuals meeting their respective state qualifications as a PT, OT, physical therapy assistant (PTA) or OTA before Jan. 1, 2008, will be recognized as qualified for the purposes of the Medicare program where there are education or examination standards in place. However, in states where there are no licensure requirements in which services are furnished incident to a physician’s services and states where there are no particular regulations for practitioners of a particular discipline, practitioners must meet the guidelines described in the final rule. Individuals practicing as PTAs, OTs and OTAs at the time of the 2008 proposed Medicare physician fee schedule have until Jan. 1, 2010, to comply with these requirements.

Those individuals trained by the U.S. military must meet the same requirements as other U.S. trained OTs, PTs and OTAs. A substantial equivalency standard will be used to determine the qualifications of a U.S. military-trained PTA. Additionally, the rule sets forward requirements for practice in this country by foreign-trained PTs, PTAs, OTs and OTAs.

Along with the standardization of education and licensure requirements for therapy personnel, the final rule attempts to standardize other therapy-related policies. For instance, a plan for therapy services consistent with the plan required for outpatient therapy services will now be required in the inpatient setting. Clarifying instructions regarding documentation requirements will be issued as part of an update to the Medicare Internet-Only Manuals. The agency has agreed to delay implementation of this particular requirement until after the issuance of the clarifying instructions.
The last provision of the fee schedule concerning therapy addresses the certification requirements for plans of care. Under current guidelines, physicians are required to certify plans of care involving outpatient therapy services for 30 days, regardless of the appropriate treatment length. Where more than 30 days of therapy is required, the plan of care must be recertified every 30 days. In the final rule, CMS has opted to change the plan recertification schedule to a length appropriate to a patient’s needs, not to exceed 90 days.

Physician pathology services to hospital patients

For services furnished after Dec. 31, 2007, an independent laboratory may not bill the carrier for the technical component of physician pathology services furnished to a hospital inpatient or outpatient. This statutorily mandated change has been delayed a number of times. However, the latest delay is scheduled to expire at the end of 2007. Therefore, CMS is obligated to implement this provision unless Congress acts to prevent it.

E-prescribing exemption for computer-generated facsimiles

In the 2008 final rule, CMS has eliminated the exemption for computer-generated faxes from the e-prescribing standards effective Jan. 1, 2009. Through a final rule published November 2005, HHS adopted e-prescribing standards for use by physicians and suppliers in connection with prescriptions under Medicare Part D, effective Jan. 1, 2006. The final rule includes the National Council for Prescription Drug Program’s (NCPDP’s) SCRIPT standard for communications between physicians and pharmacies regarding prescription information. Entities that transmit prescriptions via computer-generated faxes (i.e., faxes generated by a physician’s computer and sent to a pharmacy’s fax machine) were exempt from using the SCRIPT standard. Without this exemption, entities using e-prescribing software that generated faxes would either have been required to comply with the SCRIPT standard or revert to paper prescribing.

CMS anticipated that entities using computer-generated fax software would adopt the SCRIPT standard over time, but that has not occurred to date. Computer-generated faxing retains some of the disadvantages of paper prescribing. For example, the pharmacy incurs the administrative cost of keying the prescription into the pharmacy system, and there is a potential for data entry errors that may affect patient safety. CMS said it believes it is important to take steps to encourage prescribers and dispensers to adopt the SCRIPT standard. Therefore, the agency will eliminate the computer-generated fax exemption for all physician/pharmacy transactions.

CMS has, however, developed a “viable contingency plan in the event that an [electronically] transmitted prescription fails due to “network transmission failure or similar, temporary communication problem that is episodic and non-repetitive in nature.” CMS will permit computer-generated faxes as a fallback measure to allow the prescription to be expedited to the pharmacy, ensuring timely dispensing of the medication and enhancing patient safety. Thus, they are permitting the use of computer-generated faxes, but only in instances of transmission failures or similar communication problems of a temporary/transient nature. This contingency is not intended to be a permanent substitute for ongoing electronic data interchange transmission problems.

This regulatory provision is part of CMS’ strategy to encourage adoption of e-prescribing. In 2006, CMS conducted a five-site pilot project to test additional e-prescribing standards, including transactions that can communicate formulary, benefit and medication history information to the prescriber at the point of care. CMS released findings from the pilot evaluation in a report to Congress in April 2007. On Nov. 16, 2007, CMS published a proposed rule to adopt the
additional standards shown effective in the pilot. Those include formulary and benefit information; prior authorization; medication history; structured and codified prescription information (SIG); and RxNorm (standard names for clinical drugs). This proposed regulation is expected to be released as a final rule in 2008.

2008 PQRI provisions

This rule also includes several provisions relating to the Physician Quality Reporting Initiative (PQRI). As required by TRHCA, changes to the 2008 PQRI must undergo a formal rule making. Thus, CMS included PQRI provisions in the proposed and final physician fee schedule rules.

The PQRI was authorized by TRHCA as a voluntary quality reporting opportunity for Part B participating providers. The 2007 PQRI contains 74 approved quality measures for the reporting period, which began July 1, 2007, and ends Dec. 31, 2007. Successful participation entails reporting on at least three quality measures at least 80 percent of the applicable time through existing Part B claims-processing systems. Around June 2008, successful participants in the 2007 program will receive a bonus equal to 1.5 percent of their entire Part B payments and a confidential 2007 PQRI feedback report.

Funding for the 2007 PQRI bonus program comes from the Medicare Part B Trust Fund. As part of TRHCA, Congress allocated $1.35 billion into a Physicians Assistance and Quality Initiative (PAQI) fund available for 2008 PQRI bonus payments or to offset pending Part B payment reductions. CMS exercised its administrative authority and dedicated those funds for 2008 PQRI bonus payments. At the time of this publication, Congress has not yet passed expected legislation affecting 2008 Medicare Part B payments, the PQRI and the PAQI fund.

PQRI quality measures are required to be endorsed or adopted by a consensus organization (such as the National Quality Forum [NQF] and the AQA Alliance), or submitted by physician specialty societies or deemed by HHS to have been developed through a consensus-based process. TRHCA also required the 2008 PQRI to contain at least two structural measures. CMS contracted with the Pennsylvania Quality Insights, the PA Quality Improvement Organization (QIO), to develop measures that will examine a practice’s use of electronic health records and e-prescribing technology, as well as measures for nonphysician eligible providers.

The 2008 PQRI will contain 119 measures:

- 59 measures endorsed by the National Quality Forum (NQF);
- 38 new measures developed through the American Medical Association Physician Consortium for Performance Improvement;
- 7 new measures for nonphysician eligible professionals developed through Pennsylvania Quality Improvement Organization contract (PA-QIO);
- 2 new structural measures also developed through the PA-QIO;
- 5 measures from the AQA Starter Set of quality measures that are largely preventive in nature;
- 6 NQF-endorsed measures addressing pharmacologic therapy; and
- 2 measures developed by the American Podiatric Medical Association.

TRHCA also requires that the 2008 PQRI use a registry-based mechanism for PQRI data submission. However, CMS has opted to experiment in 2008 only with incorporating existing registries into the 2008 PQRI. Registries must identify their desire to be included in the 2008 PQRI program. For the PQRI reporting to be counted in the 80 percent threshold, a practice using
a registry must submit information both through the registry and the existing claims-processing system.

In the final rule, CMS indicated its intentions to publish only confidential 2007 and 2008 PQRI feedback reports to participating practices. CMS also recognized providers’ desires for PQRI status reports, so a practice can determine its progress towards achieving the 80 percent threshold. The agency discussed its intention to offer this tool but concedes it is unlikely this will be available for the 2008 reporting period.