Proposed 2010 Medicare physician fee schedule analysis
Exclusively for MGMA members

The Centers for Medicare & Medicaid Services (CMS) published the proposed 2010 Medicare fee schedule for physician services in the Federal Register on July 13. The fee schedule includes proposed payment rates for covered services and changes to Medicare policy. CMS also publishes an impact chart detailing the effects of the rule on each medical specialty and a table showing the effect of the proposed rule on selected HCPCS* codes.

Here is the Medical Group Management Association’s (MGMA’s) analysis of the proposed fee schedule. We will submit extensive comments to CMS on many aspects of the proposal by Aug. 31 and will make our comments available to members.

Medicare physician reimbursement

The regulation includes provisions that confirm a 21.5 percent reduction in 2010 Medicare physician payments unless Congress enacts legislation to reverse it. If Congress does not intervene, the 2010 conversion factor will be $28.3208. CMS estimates that continued reductions of 5 percent to 6.5 percent each year will take place over the next several years unless Congress repeals or changes the sustainable growth rate formula.

The regulation also proposes to remove physician-administered drugs from the definition of “physician services” for purposes of computing the physician update formula, a move that MGMA has long advocated. CMS would do this in anticipation of legislation that fundamentally reforms Medicare physician payments. Although this proposed change would not reduce the projected 21.5 percent cut in 2010, it would lessen projected cuts in future years, as well as the amount of funding Congress would need to fix the flawed Medicare physician payment policy.

Relative value unit (RVU) update

Practice expense (PE) RVUs

For 2010, all direct PE RVUs — the cost of resources required to provide services — will be calculated using the “bottom-up” method. CMS proposes to update the indirect PE inputs for 2010 using data from the national Physician Practice Information Survey (PPSI) conducted by the American Medical Association (AMA) and more than 70 other medical specialty societies. CMS will use this instead of the AMA’s Socioeconomic Monitoring Survey and supplemental surveys it relied on previously. The PPSI data would result in significant increases and decreases to the PE values of many codes. If the proposal is finalized, the net effect would be a major, budget-neutral payment shift among medical specialties, depending on the mix of services provided.

Equipment utilization rate

The practice expense calculation for allocating equipment costs includes an assumption on how frequently medical equipment is in use. The current formula assumes that equipment is in use 50 percent of the time, or 25 hours a week. CMS previously raised questions about this figure, indicating that it may not accurately reflect the actual usage rate for all equipment.

In this year’s proposal, the agency cites data and analysis included in MedPAC’s March 2009 Report to Congress. (The Medicare Payment Advisory Commission — or MedPAC — is an independent
congressional agency established to advise Congress on issues affecting the Medicare program.) Based on these data, CMS proposes increasing the equipment utilization assumption from the current 50 percent to 90 percent (or 45 hours a week) for equipment priced at more than $1 million. If this change is adopted, payment rates will decrease for the technical component (TC) of services using such equipment.

**Malpractice RVUs**

CMS proposes to implement its second major review and update of malpractice RVUs. The malpractice RVUs serve as one of the factors used to calculate payment for services. The proposed method incorporates data on malpractice premiums and bases malpractice RVUs on a weighted average of the risk factors of all specialties furnishing a given service. Under its proposal, CMS will compute a preliminary national average premium for each specialty and determine specialty-specific risk classes based on the types of procedures performed.

Each specialty will then receive a specialty risk factor. The factor’s calculation will be affected by a proposed change to the treatment of services with a TC. Under the current method, approximately 600 services have TC malpractice RVUs that are greater than the professional component (PC) malpractice RVUs. The Professional Liability Insurance Workgroup, a subset of the AMA Relative Uniform Value Committee (RUC), requested that CMS make changes to the malpractice RVUs because, it believes, it is illogical that the TC of a service would have higher malpractice RVUs than the PC. CMS has been unable to obtain data concerning malpractice costs associated with TC services. In this update, the agency proposes to use premium data for medical physicists as a proxy for malpractice rates of all entities performing TC services in calculating specialty-specific risk factors. Medical physicists provide complex TC services and, according to CMS, would therefore likely pay one of the highest malpractice premium rates for entities performing TC services.

CMS then proposes to calculate a malpractice RVU for each code by multiplying the percentage of services furnished by each specialty for each respective procedure code by each respective specialty’s risk factor. For TC services where there is no physician work, CMS will calculate the global and PC RVUs and the difference to establish the malpractice RVUs for TC services.

Finally, CMS’ proposed method rescales the malpractice RVUs to adjust for budget neutrality (keeping the total proposed malpractice RVUs equal to the total current malpractice RVUs, as required by statute).

CMS is particularly interested in receiving comments on its proposal to calculate malpractice RVUs for the TC of codes with no physician work.

**Geographic practice cost indices (GPCIs)**

As required by law, on Jan. 1, 2010, the 1.0 work GPCI floor will be removed; however, as a result of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), the 1.5 work GPCI floor will remain for Alaska. CMS indicates that it continues to review the PFS locality structure. So far CMS has not proposed any changes.

**Telehealth services**

CMS proposes to add individual Health and Behavior Assessment and Intervention codes to the list of approved telehealth services. It also intends to clarify that follow-up telehealth consultations furnished to beneficiaries in hospitals and skilled nursing facilities are included in the G-codes for follow-up inpatient telehealth consultations.
Coding issues

Consultation services

CMS proposes to stop using consultation codes on Jan. 1, 2010. This includes all inpatient and office/outpatient codes for various sites of service, with the exception of telehealth consultation G-codes. The change would be offset by increasing the work RVUs for new and established office visits by approximately 6 percent, increasing the work RVUs for initial hospital and facility visits by approximately 2 percent, and incorporating the greater use of these visits into PE and malpractice RVU calculations.

Because of Medicare payment policies on admitting physicians, CMS will develop a modifier to identify the admitting physician of record for hospital inpatient and nursing facilities if this proposal is adopted. The agency states that this would help differentiate admitting physicians overseeing beneficiary care from those furnishing specialty care. If it implements these proposals, CMS further proposes to create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations. RVUs for these proposed HCPCS G-codes would be set at the same rate as initial hospital care codes.

Site of service anomalies

CMS addresses recommendations made by the AMA RUC Five-Year Review Identification Workgroup, which was created to respond to potentially misvalued services. The workgroup revalued several codes to reflect changes in the site of service. CMS identified 29 revalued codes where it determined that hospital days were removed and office visits were deleted or reallocated without extraction of the associated RVUs from the valuation of the code.

CMS proposes new work RVUs for 24 of these codes and requests that the AMA RUC re-evaluate the remaining five codes which, using CMS’ method, would result in negative valuation. The agency will use the AMA RUC recommended values for these codes until it develops an alternative approach; it is seeking comment on such a method.

Mental health copayments

CMS is required by MIPPA to phase out the distinction between copayments for covered outpatient mental health services and those for all other covered services, also known as the outpatient mental health treatment limitation. This transition will occur over a four-year period beginning in 2010 and ending in 2014:

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>Patient responsibility</th>
<th>Medicare responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009 and prior years</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2010 and 2011</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>2012</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>2013</td>
<td>35%</td>
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<tr>
<td>2014</td>
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<td>80%</td>
</tr>
</tbody>
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Physician Quality Reporting Initiative (PQRI)

The proposed rule makes several modifications to the 2010 PQRI reporting period. Under MIPPA, successful participants in the 2010 PQRI will be eligible for an incentive payment equaling 2 percent of their total allowed charges for all covered professional services furnished during the reporting period.
The agency proposes adding 30 new PQRI measures for a total of 176, removing seven current measures and adding six new measures groups for a total of 13 group measures. CMS plans to post online the names of 2010 PQRI participating providers and group practices.

Like the 2009 PQRI, the 2010 program will have full-year and half-year reporting period options. CMS will accept quality data codes via both claims and registries. The agency proposes to allow PQRI participation via electronic health records (EHRs), as long as the 2009 EHR data submission testing is successful. The agency intends to post online PQRI-qualified EHR requirements for a limited number of applicable PQRI measures no later than Dec. 31, 2009. Also before the end of the year, it intends to post a list of qualified registries for the 2010 PQRI.

CMS proposes a new PQRI group practice reporting option modeled on the Physician Group Practice Demonstration Project. Practices with more than 200 providers (each with a National Provider Identifier) would report on 26 measures targeting high-cost chronic conditions and preventive care. Groups would be required to indicate their desire to participate using this method by sending a self-nomination letter to CMS. Further details on this facet of the program are expected no later than Nov. 15. CMS would post information on a medical group’s final performance online, and practices would be required to use a CMS-developed data collection tool.

**Physician Resource Use Measurement and Reporting Program**

As MIPPA requires, CMS is developing the Physician Resource Use Measurement and Reporting Program to assess efficiency and furnish providers with a confidential feedback report comparing their resource use with that of their peers. The rule discusses feedback received on Phase I of the program and proposes that Phase II include:

- More meaningful and actionable feedback reports;
- Feedback reports for group practices; and
- Quality measurement (possibly PQRI) information to the feedback reports.

**Value-based purchasing**

The regulation discusses but makes no substantive policy proposals regarding the MIPPA requirement that the Department of Health and Human Services (HHS) submit a formal plan to Congress on the transition of Medicare payments based on quantity of procedures provided to a transparent payment system based on quality of service provided. The agency discusses the next steps, including further public comment opportunities. The plan is due to Congress by May 1, 2010.

**E-Prescribing Incentive Program**

**Payments**

CMS proposes an e-prescribing incentive program similar to what it offered in 2009. The program would offer qualified professionals the opportunity to earn an incentive payment equaling 2 percent of the total estimated allowed charges (based on claims submitted by no later than Feb. 28, 2011) for all covered professional services furnished from Jan. 1, 2010 through Dec. 31, 2010.

For eligible professionals who do not prescribe electronically, the fee schedule payment for covered professional services will decrease:

- 1 percent for 2012;
- 1.5 percent for 2013; and
- 2 percent for 2014.
Eligibility

Eligible professionals include physicians and other qualified practitioners. Eligibility is further restricted by scope of practice to professionals with prescribing authority.

CMS also proposes to change the criteria for determining whether an eligible professional is a successful e-prescriber. Now the agency requires reporting of the e-prescribing measure in 50 percent of applicable cases; it proposes to change this to counting the number of times the eligible professional electronically prescribed.

For the 2010 incentive program, CMS proposes that each eligible professional report the G-code indicating that he/she electronically generated at least one prescription during an encounter in at least 25 instances during the reporting period.

Reporting options

For 2010, CMS proposes three reporting mechanisms for individual eligible professionals. The agency would:

- Retain the claims-based reporting mechanism used in the 2009 incentive program;
- Implement a registry-based reporting mechanism; and
- Make available an EHR-based reporting mechanism for reporting the e-prescribing measure if it finalizes the EHR-based reporting mechanism.

Under the proposal, only 2010 PQRI-qualified registries could submit measure results and numerator and denominator data on the e-prescribing measure. Practitioners may report both PQRI measures and the e-prescribing incentive code using the same registry if they use the registry reporting option. The agency expects to post additional details later.

Denominator codes

The e-prescribing measure, similar to PQRI measures, has two basic elements:

- A reporting denominator that defines the circumstances under which the measure is reportable; and
- A reporting numerator.

The denominator for the e-prescribing measure consists of specific billing codes for professional services. The measure becomes reportable when any of these procedure codes is billed by an eligible professional for a covered professional service. For 2009, the codes included in the measure’s denominator are typically billed in the office or outpatient setting for services furnished by physicians or other eligible professionals. There are no diagnosis codes or age/gender requirements to be included in the measure’s denominator — that is, reporting of the e-prescribing measure is not further limited to certain ages or one gender. However, eligible professionals are not required to report this measure in all cases in which it is reportable.

Physicians and other eligible professionals who do not bill for one of the procedure codes for covered professional services included in the measure’s denominator will have no occasion to report the e-prescribing measure. The denominator codes for the 2009 e-prescribing measure consist of the following Current Procedural Terminology (CPT) and G codes:
CMS proposes to expand the scope of the denominator codes for 2010 to professional services outside the professional office and outpatient setting, such as professional services furnished in skilled nursing facilities or the home care setting. They propose adding the following CPT codes to the denominator of the e-prescribing measure for 2010:

99304; 99305; 99306; 99307; 99308; 99309; 99310; 99315; 99316; 99341; 99342; 99343; 99344; 99345; 99347; 99348; 99349; 99350; and 90862.

Numerator (G) codes and reporting thresholds

For the 2010 e-prescribing program, CMS proposes to modify the first G-code (G8443) to indicate that a provider billed at least one electronically-prescribed prescription in connection with the visit. The agency also proposes eliminating the two remaining G-codes from the measure’s numerator:

- G8445 – Had a qualified e-prescribing system, but did not generate any prescriptions during the visit
- G8446 –
  - Had a qualified e-prescribing system, but prescribed narcotic or other controlled substances;
  - Had a qualified e-prescribing system, and state or federal law required the provider to phone in or print the prescription;
  - Had a qualified e-prescribing system, and the patient asked that the provider phone in or print the prescription; or
  - Had a qualified e-prescribing system, and the pharmacy system can’t receive electronic prescriptions.

The e-prescribing quality measure would not apply unless an eligible professional furnishes services indicated by one of the codes included in the measure’s denominator. For claims-based reporting, it is not necessary for an eligible professional to report the e-prescribing G-code on claims not containing one of the denominator codes. However, if a provider reports the G-code, CMS will consider the G-code data submission valid only if it appears on a claim containing one of the e-prescribing quality measure’s denominator codes.

CMS proposes that an eligible professional must report in 25 instances that at least one prescription for a Medicare Part B fee-for-service (FFS) patient created during an encounter represented by a denominator code was generated using a qualified e-prescribing system during the 2010 reporting period. CMS bases this minimum reporting threshold of 25 on the notion that an eligible professional would need to e-prescribe, on average, for approximately two Medicare Part B FFS patient encounters per month during the reporting period to be considered a successful e-prescriber. According to CMS, the proposed reporting threshold of 25 also recognizes that prescriptions are not generated with every Medicare Part B FFS patient encounter and that some prescriptions, such as narcotics, cannot be prescribed electronically.

New group practice reporting option

The proposed rule indicates that by Jan. 1, 2010, the “HHS Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as meeting the requirements for submitting data on e-prescribing quality measures for covered professional services for a reporting period (or, for purposes of the payment adjustment under subsection
(a)(5), for a reporting period for a year) if, in lieu of reporting the e-prescribing measure, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary.”

CMS proposes that physician groups selected to participate in the 2010 E-Prescribing Incentive Program through the group practice reporting option could choose to report the e-prescribing measure through claims, registries or — contingent on CMS finalizing this reporting mechanism for the 2010 PQRI — EHRs.

As with individual eligible professionals, only registries and EHR products qualified to participate in the 2010 PQRI would be qualified for purposes of the 2010 e-prescribing group practice reporting option. In order for a group practice to be considered a successful e-presenter, CMS proposes that a group practice report in a minimum of 2,500 instances that it generated at least one prescription during a patient encounter using a qualified e-prescribing system during the reporting period.

In the absence of information about the composition of the group practices seeking to participate in the program through the group practice reporting option rather than as individual eligible professionals, CMS assumes that the average group practice consists of 200 eligible professionals. It further assumes that as many as half of the members of an average group practice do not furnish the services represented by the e-prescribing measure’s denominator codes, and thus, would not have an opportunity to report the e-prescribing measure.

According to CMS, each eligible professional in a group practice should be required to report in 25 instances that he/she generated at least one electronic prescription during an encounter represented by a denominator code. Thus, based on the extrapolation from CMS’ assumption, the total number of reporting instances for the 100 remaining eligible professionals would be 2,500.

**Public reporting**

In 2010, CMS intends to post the names of eligible professionals who successfully e-prescribed for the 2009 E-Prescribing Incentive Program at www.medicare.gov. In addition, the agency will post the names of eligible professionals and group practices that are successful electronic prescribers on the Physician and Other Health Care Professionals Directory. Those names will be available in 2011 after the 2010 incentive payments are paid.

**Advanced diagnostic imaging accreditation**

MIPPA requires suppliers of the TC of advanced diagnostic imaging services to be accredited by an organization designated by the HHS Secretary by Jan. 1, 2012. CMS proposes to limit the definition of advanced diagnostic imaging services to magnetic resonance imaging, computed tomography, nuclear medicine and positron emission tomography, despite being given the statutory authority to include other diagnostic imaging services within that definition.

Under MIPPA, the Secretary has until Jan. 1, 2010, to designate and approve independent accreditation organizations to accredit such suppliers. The proposed rule sets forth the requirements and procedures that would apply to designated accreditation organizations. Applicants will have to provide CMS with details of how their organization’s accreditation criteria will meet the requirements of MIPPA. These include:

- Standards for the qualifications of nonphysician medical personnel;
- Standards for qualifications and responsibilities of medical directors and supervising physicians;
- Procedures to ensure the reliability, clarity and accuracy of the technical quality of images; and
• Procedures to ensure the safety of persons furnishing the TC services.

As part of CMS’ ongoing oversight of the accreditation organizations, the accreditation organizations will be required to, among other things:

• Provide CMS with information about complaints against suppliers and information about any remedial or adverse action the organization takes against a supplier;
• Allow their surveyors to serve as witnesses in any adverse action CMS takes against a supplier; and
• Provide CMS written notice within two days of identifying a supplier that poses immediate risk to a beneficiary or the general public.

CMS expects to publish a notice soliciting applications from entities seeking designation as accreditation organizations on the same day it publishes its 2010 final physician fee schedule, which is required on or before Nov. 1, 2009.

Anesthesia teaching provisions

CMS proposes to implement provisions of MIPPA relating to the special payment rule for teaching anesthesiologists. The provision allows payment to be made at 100 percent of the fee schedule rate for teaching anesthesiologists involved in the training of residents in one case or in two concurrent anesthesia cases. CMS proposes new regulatory language to specify the rule applies to resident cases under the following scenarios:

- The teaching anesthesiologist is involved in one resident case (which is not concurrent to any other anesthesia case);
- The teaching anesthesiologist is involved in each of two concurrent resident cases (which are not concurrent to any other anesthesia case); or
- The teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under medical direction payment rules.

CMS narrowly interprets the law and requires the teaching anesthesiologist to be present during all of the key or critical portions of the anesthesia procedure. Additionally, CMS proposes that another teaching anesthesiologist with whom the teaching anesthesiologist has an arrangement could be immediately available to furnish services during a non-critical or non-key portion of the procedure.

Part B drugs

Drug compendia changes

Under MIPPA, Congress required that the compendia used by CMS for Medicare coverage decisions be developed, no later than Jan. 1, 2010, in a publicly transparent process for evaluating therapies and identifying potential conflicts of interest.

In the proposed rule, the agency discusses that the legislative intent of this requirement is to increase transparency and address possible conflicts of interest. To comply, CMS proposes that compendia post online:

• All materials used in a drug’s evaluation process;
• The names of individuals who have substantively participated in the development of compendia recommendations; and
• Transcripts of meetings and records of votes.
Additionally, CMS proposes that compendia develop a process to make online information available regarding the financial and nonfinancial conflicts of individuals involved in making recommendations, as well as their immediate family members.

**Average sales price issues**

Citing lack of sufficient data to justify changing payment levels, the agency proposes to continue paying a threshold of 5 percent for the widely available market prices and available market prices for 2010. CMS suggests proceeding cautiously in potential payment policy changes.

**Competitive Acquisition Program for Part B Drugs and Biologicals (CAP)**

Although CMS postponed the CAP for 2009, the agency proposes reinstituting and modifying the 2010 program for both providers and vendors. Based on feedback from previous CAP participating physicians, CMS proposes adding drug categories such as antibiotics to the list of CAP-approved drugs. Other changes would allow CAP participating providers to acquire drugs outside the CAP program in certain circumstances if they use an electronic inventory control process. CMS proposes expanding the program to include nurse practitioners, certified nurses, physician assistants and other prescribers legally able to prescribe drugs when furnishing incident-to physician services. The agency again proposes to allow providers in certain circumstances to transport CAP drugs between practice offices if a voluntary agreement exists between the CAP vendor and the provider, subject to state and federal law.

Additionally, CMS proposes changing the frequency of its payments to a CAP vendor so the vendor can pay suppliers promptly. CMS recommends establishing a process to remove drugs from the CAP-approved list if the agency becomes aware of a drug’s long-term unavailability. The regulation would temporarily designate the CAP competitive acquisition area as the 48 contiguous states and the District of Columbia, addressing CAP vendor concerns about transportation costs to Alaska, Hawaii and U.S. territories.

**Physician self-referral (Stark) revisions**

CMS proposes to clarify the “stand in the shoes” provision in the Stark law. In general, the provision requires owner physicians to be treated the same as their physician organizations for purposes of analyzing financial relationships under the Stark law. CMS proposes modifying the text of the regulation to clarify that:

- A physician standing in the shoes of his or her group practice does not need to sign written agreements between the physician organization and an entity furnishing designated health services as long as an authorized signatory of the physician organization has signed the agreement.
- The relevant referrals for purposes of analyzing referrals generated between the physician organization and the entity furnishing designated health services are the referrals of all physicians in the physician organization.

* Healthcare Common Procedural Coding System