

# What surgeons should know about...

## The 2009 Medicare fee schedule

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**O**n October 31, 2008, the Centers for Medicare & Medicaid Services (CMS) released the Medicare physician fee schedule final rule for 2009. This final rule responds to comments that the American College of Surgeons and other physician groups submitted regarding the proposed rule issued early last summer.

Some key provisions in the final regulation address the following issues of interest to surgeons: the conversion factor updates, effective dates for enrollment in the Medicare program, regulatory requirements of independent diagnostic testing facilities (IDTFs), the Physician Quality Reporting Initiative (PQRI), anti-markup provisions, incentive payments and shared savings programs, and potentially misvalued codes. In addition, the rule includes a section related to the provision of the Medicare Improvements for Patients and Providers Act (MIPPA), H.R. 6331, pertaining to electronic prescribing. To view the final rule, go to <http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf>.

The following article answers some questions surgeons may have about the final rule and the College's views on its provisions.

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### What is the conversion factor for 2009?

The fee schedule update factor for 2009 is set at an average of 1.1 percent. In addition, MIPPA requires that budget neutrality adjustments previously applied to work relative value units (RVU) now must be applied to the conversion factor. Consequently, the conversion factor for 2009 will be \$36.0666, compared with \$38.0870 in 2008. Hence, the combined effect on total allowable charges for general surgery—taking into account all changes to work RVUs, practice expense changes, and MIPPA mandates—is expected to average approximately 2 percent.

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### How will the final rule affect Medicare billing privileges?

The final rule makes significant changes to the process for establishing an effective date for Medicare billing privileges for physician and nonphysician provider (NPP) organizations. CMS adopted an approach that established an effective date of billing for physicians, NPPs, and physician and NPP organizations—that is, whichever occurs later: the date of filing of a Medicare enrollment application or the date a physician, NPP, or physician and NPP organization first started furnishing services at a new location. Physicians, NPPs, and physician and NPP organizations may bill retroactively for services up to 30 days before the effective date of billing when the physician or NPP organization has met all other program requirements and when services were furnished at the enrolled practice location before the date of filing, and circumstances precluded enrollment in advance of providing the services.

Under the last set of rules, once enrolled, physicians could retroactively bill the Medicare program for services rendered up to 27 months before enrollment. In the proposed rule, CMS sought to change the initial Medicare enrollment date for physicians and NPPs to either the date that an enrollment application is approved by a Medicare contractor, or whichever occurred later: the filing date of the enrollment application that was later approved by a fee-for-service contractor or the date that an enrolled supplier first furnished services at a new practice location.

The College strongly opposed efforts to establish the initial enrollment date as the date on which a Medicare contractor approves an enrollment application. The College also recommended that CMS keep in place the concept of allowing retroactive billing for services rendered before enrollment in the Medicare program but change the time period for retroactive billing from 27 months to 12 months or another reasonable period of time.

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### Is CMS moving ahead with its plans to require physician offices that do diagnostic testing to enroll as IDTFs?

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CMS is deferring the implementation of proposed IDTF provisions until the agency completes its review of public comments pertaining to this provision. CMS will consider finalizing this aspect of the proposed rule in a future effort, if deemed necessary.

In the proposed rule, CMS sought to require that a physician or NPP furnishing diagnostic testing services other than diagnostic mammography services enroll as an IDTF for each practice location furnishing these services. These enrollees would be subject to certain regulatory requirements related to IDTFs. The College strongly opposed this proposal and noted that some procedures, such as certain ultrasound procedures, are not always used for diagnostic purposes yet could fall under the requirements of this proposal.

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#### **What effect will the rule have on the 2009 PQRI?**

In the final rule, CMS restated its intention of finalizing and publishing the detailed specifications for all 2009 PQRI measures on the agency's Web site by December 31, 2008. The final rule also retains the option to participate in PQRI for the second half of 2009 under certain claims-based and registry-based reporting options. In the proposed rule, CMS called for extending PQRI through 2009 with the potential addition of 64 new measures and continuing the alternative reporting options started in 2008. Although the proposed regulation did not provide for incentive payments for reporting, MIPPA extends the PQRI through 2010 and includes 2 percent bonus payments for 2009 and 2010.

The College supported the continuation of the additional reporting options. The College also believes data registries are a critical resource in the evaluation of surgical care and health outcomes and appreciates the proposed extension of data registry reporting options and the proposed inclusion of measures from key repositories. The ACS also supported the option of reporting measures for 30 consecutive patients because reporting for consecutive patients may reduce opportunities for selective reporting.

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#### **Does the rule contain any provisions per-**

#### **taining to publishing the names of reporting providers?**

The final rule seeks to implement MIPPA requirements that CMS publish the names of successful reporters by posting the names of eligible professionals who have submitted data on the 2009 PQRI quality measures through the claims-based reporting mechanism or through registry-based reporting, met one of the satisfactory reporting criteria for the 2009 PQRI, and received a PQRI incentive payment for covered professional services between January 1 through December 31. Thus, no names are likely to be listed on the CMS Web site until some point in 2010.

The regulation also makes clear that CMS intends to launch a Physician and Other Health Care Professional Compare Web site, beginning with a listing of the names of professionals who successfully participate in the 2009 PQRI, and expects to add more information to the site over time.

The proposed rule also called for possibly establishing a Physician and Other Health Care Professional Compare Web site, comparable to its existing Hospital Compare site, which allows the public to compare the performance of those and other providers. The College strongly urged CMS to proceed with the utmost caution in developing comparative information because reporting potentially inaccurate or misleading information could unintentionally harm both providers and patients. The ACS also strongly recommended that CMS consider alternative data sets for reporting, such as board certification, patient surveys, and participation in a clinical data registry.

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#### **Does the regulation contain provisions that would affect MIPPA's incentives for electronic prescribing?**

MIPPA provides for new incentive payments for health professionals who successfully prescribe electronically. The bonuses would be 2 percent in 2009 and 2010, 1 percent in 2011 and 2012, and 0.5 percent in 2013. The payments would not be available to professionals for whom the services subject to the electronic

prescribing performance measure total less than 10 percent of their Medicare allowed charges during a reporting period. Under the final rule, physicians and other eligible professionals may use G codes to report the electronic prescribing measure without any requirement to use e-prescribing for controlled substances without regard to final action that the U.S. Drug Enforcement Administration may take on this subject.

In 2009, only physicians for whom the denominator codes (mainly evaluation and management [E/M] services) comprise at least 10 percent of total Part B allowed charges will be eligible for the e-prescribing incentive. CMS says that an alternative eligibility criterion, based on submitting “a sufficient number of prescriptions (as determined by the Secretary [of the U.S. Department of Health and Human Services]) under Medicare Part D,” is infeasible for 2009. However, in 2010, CMS will post the names of successful 2009 e-prescribers on its planned Physician and Other Health Care Professional Compare Web site.

The College recommended revising the e-prescribing measure to clarify that the 10 percent requirement refers to the percentage of allowed charges, rather than the percentage of claims submitted. If CMS interpreted this 10 percent requirement to mean percentage of claims submitted rather than percentage of allowable charges, many surgeons would be excluded from receiving bonus payments because the majority of their prescribing activity is associated with procedure codes, not E/M codes. Interpreting the requirement based on a percentage of allowable charges will be more inclusive, because surgeons receive a significant percentage of Medicare revenues from E/M codes.

In addition, the College recommended that the Secretary use the discretionary authority provided under MIPPA to exempt the e-prescribing of controlled substances from the MIPPA e-prescribing calculation.

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### **Does the final regulation implement the plans to revise the anti-markup rule?**

CMS proposed to revise the anti-markup rule, which was finalized last year in the 2008 physician fee schedule regulation but delayed until

January 1 because of unintended consequences. According to the anti-markup rule, a physician cannot mark up his or her cost when billing for the technical component or professional component of a diagnostic test not performed in the “office of the billing physician or other supplier.” In the final rule, CMS is adopting an approach that incorporates both alternatives in the proposed rule and described in the paragraphs that follow. CMS is finalizing Alternative 1 with some modifications, and retaining with some modifications the present site-of-service approach described in Alternative 2.

Arrangements should first be analyzed using Alternative 1. Thus, in instances where the performing physician (the physician who supervises the technical component, or performs the professional component, or does both) performs at least 75 percent of his or her professional services for the billing physician or other supplier, none of the services furnished by the physician on behalf of the billing physician or other supplier will be subject to the anti-markup provision. In other words, a physician could furnish up to 25 percent of his or her professional services through other arrangements, such as acting as a locum tenens physician, but could still only “share a practice” for anti-markup rule purposes with one physician or other supplier.

If the performing physician does not meet the “substantially all” services requirement of Alternative 1, an analysis under the Alternative 2 requirements may be applied on a test-by-test basis. CMS concluded that adoption of both Alternatives 1 and 2 made it unnecessary to adopt the exception related to physician organizations that do not have any owners who have the right to receive profit distributions. CMS retained the January 1 effective date for the anti-markup provisions, including changes made in the final rule.

In the proposed rule, CMS described two options for revising the anti-markup rule. Under the first alternative, CMS abandoned the site-of-service approach and proposed that the anti-markup provision apply in all cases where the professional component or technical component is either purchased from an outside supplier or performed or supervised by a physician who does not share a practice with the billing physician

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or organization. However, more than two physicians are prohibited from sharing a practice for anti-markup purposes. CMS' second alternative continued the existing site-of-service method for determining whether a physician shares a practice but expanded the definition of "office of the billing physician or other supplier" to include the entire building where his or her office is located.

The College recommended that CMS withdraw the proposed and delayed anti-markup provisions because they exceed the agency's statutory authority in this situation. In the event that CMS refused to withdraw the proposed and delayed provisions, the College supported specific changes to the anti-markup policy, including allowing multiple physician relationships to be considered as sharing a practice, expanding the definition of "office of the billing physician or other supplier" to the entire building where the office of the billing physician is located, and exempting from the anti-markup rule diagnostic tests ordered by a physician in an organization that does not have any owners who have rights to receive profit distributions.

#### **How does the rule affect the Stark law regarding self-referrals?**

CMS proposed a Medicare physician self-referral statute or Stark law exception pertaining to incentive payments—also known as pay for performance—and shared savings, or gain-sharing. The pay-for-performance programs addressed in the proposed rules are those in which insurers pay hospitals for meeting certain quality standards. In gainsharing arrangements, hospitals share with physicians the cost savings achieved through efforts to reduce the cost of patient care. A pay-for-performance or gain-sharing program that involves payment from a hospital to a physician would create a financial relationship, and referrals by the participating physician to the hospital would violate the Stark law unless an exception applies.

In the final rule, CMS states that it received too few public comments pertaining to this section of the proposed rule for the agency to finalize an alternative that expands the proposed exception in any meaningful way. Therefore,

**“The final rule makes significant changes to the process for establishing an effective date for Medicare billing privileges for physician and nonphysician provider organizations.”**

CMS is reopening the public comment period to obtain additional information to create a workable exception.

The proposed exception to the Stark law set forth in the proposed rule is very narrow, and the numerous conditions and requirements included in the exception risk obviating the exception itself. Hence, the College fully supported the proposal to create the exception but recommended relaxing some of the safeguards to make the exception more workable. Specifically, the College supported the following requirements: physicians participating in the program must have access to items and supplies that they deem medically necessary, the program term shall have a minimum of one year and a maximum of three years, and hospitals must offer the opportunity to participate in the program to all physicians on staff or who practice in the specialty relevant to the program. The College opposed the proposed requirement that limited payments to physicians

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by rebasing and scaling at the end of each year of a multiple-year program.

The College also recommended that CMS create an exception to the requirement that physicians participating in the program must do so in pools of five or more participants and that CMS create an exception to the program that would limit participation in the program to those physicians who are members of the hospital's staff at commencement of the program.

### **Does the final rule potentially address misvalued and Harvard-valued codes?**

The final rule responds to American Medical Association Relative Value Update Committee (AMA RUC) recommendations regarding certain potentially misvalued codes. CMS also indicates it will continue to work with the RUC, the Medicare Payment Advisory Commission (MedPAC), and the specialty societies on this issue. CMS acknowledges its proposed approaches are long term and will require time and collaborative effort to complete.

The proposed rule recognized both continuing concerns regarding misvalued services under the Medicare physician fee schedule and ongoing work by AMA RUC to address these concerns by creating a five-year review identification workgroup. The College supports the RUC's efforts to identify and review potentially misvalued codes but objects to doing so in a fashion that is inconsistent with critical elements of past five-year review activities and the RUC's long-standing, data-supported deliberative process. Specifically, the College opposes the RUC's recent ad hoc review process that counters the cycle that CMS has established and used for the past 15 years and may not allow for public comment.

With regard to Harvard-valued codes, the final rule provides that CMS take no specific actions on codes that have never been reviewed by the RUC but may be potentially misvalued. Rather, the regulation calls for CMS' continued work with the AMA RUC, MedPAC, and the specialty societies on this issue.

The proposed rule indicated that Harvard previously valued more than 2,800 codes that the RUC has never reviewed. According to CMS, these codes are potentially misvalued and should

be reviewed by the RUC. The College supported reviewing a relatively small number of services that account for most allowable charges under Medicare; however, the ACS posited that reviewing all the Harvard-valued codes would require an inordinate amount of time and financial resources of the specialty societies that would conduct the surveys for review of these codes. In addition, the College said that CMS must be willing to consider, in an unbiased and objective manner, the possibility that a Harvard code's work value may increase or decrease after undergoing reconsideration.

### **Does CMS intend to update the process for determining the value of high-cost supplies?**

CMS has decided not to finalize the proposed process to update high-cost supplies of more than \$150 at this time and not to revise the prices for identified supplies. CMS will consider the possibility of using an independent contractor to obtain accurate pricing information. A revised process will be proposed in future rulemaking. CMS proposed a process to update supplies that cost more than \$150 every two years and listed the top 65 high-cost resource that needed specialty input for price updates. <sup>10</sup>