

**2010
MEDICARE
PHYSICIAN FEE SCHEDULE
FINAL RULE**
*contains
important changes*

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The Centers for Medicare & Medicaid Services (CMS) released the Medicare physician fee schedule final rule for calendar year (CY) 2010 on October 30, 2009. This final rule enacts certain concepts set forth in the Medicare physician fee schedule proposed rule issued early last summer. The final rule also responds to comments that the American College of Surgeons and other physician groups submitted regarding the proposed rule.

This article summarizes key provisions of interest to surgeons and describes the College's views on these provisions.

2010 conversion factor

The final rule states that the update to the physician fee schedule conversion factor (CF) is a little less than -21.3 percent for CY 2010. This results in a reduction in the current CY 2009 CF of \$36.0666 to the CY 2010 CF of \$28.4061. This 21.2 percent cut is required by the Balanced Budget Act of 1997, which established the sustainable growth rate (SGR) formula. However, at press time, Congress was expected to intervene to block this payment cut.

E/M codes for consultations

Effective January 1, CMS will eliminate the use of all evaluation and management (E/M) codes for consultations, directing specialists to instead bill office, hospital, and nursing home visit E/M codes for both new and established patients. However, CMS is also increasing the payment for office, hospital, and nursing home visit E/M codes to offset the change for disallowing consultation codes. For more information, see page 9 of this issue, "What surgeons should know about...2010 changes to Medicare payment for consultation services."

Practice information survey

The final rule implements CMS' proposal to use the American Medical Association (AMA) Physician Practice Information Survey (PPIS) in place of the AMA's Socioeconomic Monitoring Survey (SMS) data and supplemental survey data to develop practice expense (PE) relative value units (RVUs). Based on comments recommending a transition due to the significant payment reductions for some specialties, CMS will transition to the PPIS data over four years. In our comments, the College fully supported the use of the PPIS to update practice expense RVUs. Implementation of the PPIS data to develop practice expense RVUs results in a slight increase in payment for surgeons.

The PPIS is a highly scientific and controlled survey instrument that expanded the SMS instrument. The College, along with the Government Accountability Office and the Medicare Payment Advisory Commission (MedPAC), recognized the need for CMS to update PE data. In its June 2005 Report to the Congress, MedPAC indicated that the data source that CMS uses to estimate total practice costs is dated and may not reflect cur-

rent practice patterns. Up-to-date and accurate data are needed for all specialties. The report also notes that concerns have been raised regarding the use of the SMS data to derive PE RVUs. The SMS data represent practice costs from 1995 to 1999, and do not account for the increased costs that practices now face.

Physician-administered drugs and the definition of "physician services"

The final rule implements CMS' proposal to remove physician-administered drugs from the definition of "physician services" for the purposes of computing the SGR and levels of allowed expenditures and actual expenditures in all future years. CMS also finalized its proposal to remove physician-administered drugs from the calculation of allowed and actual expenditures for all prior years. This change would not affect the nearly -21.3 percent update for CY 2010, but would likely reduce the number of years in which physicians are expected to receive a negative update.

The College strongly supported CMS' proposal to remove physician-administered drugs from the definition of "physician services" for the purposes of computing the SGR, and agreed that the inclusion of drugs has had a significant and disproportionate effect on the SGR system. Physician fee schedule rates are updated using the SGR formula, which requires that growth in total expenditures for physicians' services be limited to sustainable levels. Under the SGR system, physicians' services include items and services, specified by the Secretary of the U.S. Department of Health and Human Services, that are commonly performed by a physician or in a physician's office. At the time that CMS decided to include physician-administered drugs in the definition of "physician services," these drugs represented a much smaller volume of Medicare spending, but in subsequent years the growth in cost of physician-administered drugs has far outpaced growth in the cost of other physician services. As a result, CMS finalized its proposal to remove physician-administered drugs from the definition of physician services.

Advanced imaging services

Section 135 of the Medicare Improvements for Patients and Providers Act (MIPPA) requires that, beginning January 1, 2012, Medicare

payment may only be made for the technical component (TC) of advanced diagnostic imaging services for which payment is made under the fee schedule to a supplier who is accredited by an accreditation organization (AO) designated by the Secretary. “Advanced diagnostic imaging” is defined as diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography. MIPPA also required that by January 1, CMS designate AOs to accredit suppliers furnishing the TC of advanced diagnostic imaging services.

In the final rule, CMS stated that it still expected to meet the January 1 statutory deadline to designate AOs to accredit suppliers furnishing the TC of advanced diagnostic imaging services. In response to comments, CMS confirmed that ultrasound is specifically excluded by MIPPA from the accreditation requirement. CMS also stated that the agency would make certain that all AOs have provisions for reducing the accreditation burden and costs for small and rural suppliers. CMS also stated its belief that at least three entities would apply to become AOs for advanced diagnostic imaging: the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission.

Resources use

As required by MIPPA, CMS established, and is in the process of implementing, the Physician Resource Use Measurement and Reporting Program, using Medicare claims and other data to provide Medicare physicians with confidential feedback reports that measure their resource use. CMS previously stated that this would be a multi-year program. In the final rule, CMS moves forward with several aspects of Phase I of the program, including specifying the conditions, physician specialties, and geographic areas on which the program will focus, and the episode-of-care methodologies and cost-of-service categories that the program will employ.

In the final rule, CMS added diabetes to the episodes of care included in the program. The current list now includes:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Prostate cancer
- Cholecystitis

- Coronary artery disease with acute myocardial infarction
- Hip fracture
- Community-acquired pneumonia
- Urinary tract infection
- Diabetes

In response to comments, CMS also stated that the agency will offer the following:

- Paper and electronic delivery of feedback reports
 - Investigation of the feasibility of capturing readmissions in the feedback reports
 - The pursuit of further research to determine how to accurately attribute E/M services in surgical bundles for purposes of attributing patients to specific physicians or groups
 - Investigation of the feasibility of using a Medicare-specific public domain episode grouper in the program

The College supports the use of physician feedback reports that measure resources used in furnishing care to Medicare beneficiaries. In addition, we recommended that CMS (or its contractor) develop algorithms for specialty-specific pathways, such as for surgery that would include the treatment of conditions such as hip fracture and appendicitis. The ACS also suggested that collaboration with the member boards of the American Board of Medical Specialties, as well as with the College and other professional organizations, could lead to integration of the Physician Resource Use Reporting process into the Maintenance of Certification process. This would bring government, payor, and physician needs into alignment and reduce the burden of data collection and reporting for physicians while helping to maintain and improve quality.

In the proposed rule, CMS had also indicated that the agency is reviewing and considering multiple attribution methodologies for assigning costs to be measured by the program. The College commented that the attribution methodologies used should be transparent. Specifically, we recommended that the entire algorithm used to generate the reports be in the public domain, along with clear plans for evaluating the impact of the reports. In addition, physicians should be closely involved with the program from the beginning, in order to review the methodology for creating the reports and to provide input.

The College also believes that the attribution methodologies used should be risk-adjusted to prevent physicians from being penalized for caring for sicker patients. Risk adjustment should include the recognition that a patient population's socioeconomic factors and co-morbidity affect a provider's ability to achieve ideal patient outcome goals. These recommendations correspond with MedPAC's guiding policy principles for the program.

Physician Quality Reporting Initiative (PQRI)

The final rule makes a number of changes to the PQRI. CMS finalized a proposal to move forward with electronic health records (EHR)-based reporting, but because the agency has not yet completed the 2009 EHR data submission testing process at this time, CMS cannot guarantee that qualified EHR vendors will be available for 2010 reporting. Nonetheless, CMS does anticipate continuing to offer claims-based reporting options for PQRI beyond 2010. CMS did not finalize a proposal to add a minimum patient sample size criterion for satisfactory reporting of data on individual quality measures, but did finalize a minimum patient sample size requirement of 15 and eight for 12-month and six-month reporting for measures groups, respectively.

CMS also finalized a proposal to allow eligible professionals to report on measures groups for any 30 patients, rather than a consecutive patient sample. In addition, CMS finalized a proposal that would allow physician practices of 200 or more individual eligible professionals to report PQRI measure data as a group. CMS also finalized its proposal to include the following three new measures applicable to surgery for 2010 PQRI:

- Cataracts: 20/40 or better visual acuity within 90 days following cataract surgery (registry)
- Cataracts: Complications within 30 days following cataract surgery requiring additional surgical procedures (registry)
- Perioperative temperature management (claims, registry)

E-prescribing

CMS finalized its plan to use a single numerator G-code for reporting e-prescribing events in 2010 (rather than the three current codes). The only

applicable code for 2010 will be assigned at some point this year. At least one prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system. A new G-code will be assigned by CMS for 2010 and will be included in the measure specifications. The removal of code G8446 makes it difficult for surgeons to participate in the incentive program for 2010, because this code provided a means to report the prescription of controlled substances that cannot be e-prescribed due to Drug Enforcement Administration rules. CMS also finalized a proposal to allow three reporting mechanisms (claims, registry, and EHR-based) for 2010 e-prescribing. In addition, CMS finalized its proposal to permit certain group practices with 200 or more eligible professionals to qualify as a group for e-prescribing incentive payments, provided that the group has been selected to participate in the PQRI group practice reporting options.

To qualify for e-prescribing incentive payments, at least 10 percent of an eligible professional's Medicare-allowed charges for services provided during the reporting period must be for services reported by the recognized denominator codes, which include codes for office and other outpatient services. In the final rule, CMS rejected requests to lower this 10 percent threshold. CMS also finalized a proposal to define a successful e-prescriber for 2010 as one who reports at least 25 e-prescribing events during the reporting period.

Panel to review the work of the RUC

CMS took no action in the final rule on MedPAC's recommendation to establish a panel of experts separate from the AMA Relative Value System Update Committee (RUC) to review RVUs. CMS indicated that it will take comments into consideration as it continues to explore this issue. In its March 2008 Report to the Congress, MedPAC recommended that CMS establish such a group of experts to augment the RUC.

The College strongly opposes the establishment of such a panel and believes that the current RUC structure has adequate representation and applies a thoughtful and deliberative process for evaluating relative work RVUs. The College also believes that an additional panel could evolve into an extra layer of bureaucracy without adding real value to the process of determining work RVUs.

Potentially misvalued services

The AMA RUC is involved in an ongoing effort to identify potentially misvalued services through identifying codes with site-of-service anomalies, high intraservice work per unit time, and services with high-volume growth. Two of the issues addressed in the final rule of interest to surgeons include site-of-service anomalies and 24-hour stays.

Site-of-service anomalies


The final rule does not implement CMS' proposal to change the work RVUs for certain codes with site-of-service anomalies; rather, CMS accepted the RUC-recommended work RVUs for these codes. In the proposed rule, CMS had expressed concern regarding the valuation methodology that the RUC used to review certain services, and that may have resulted in the removal of hospital days and the deletion or reallocation of office visits without extraction of the associated work RVUs from the valuation of the code. Accordingly, CMS proposed changes to several of the codes for which valuation has been adjusted to reflect changes in site-of-services. Specifically, CMS proposes to change the codes for which the AMA RUC review process deleted or reallocated preservice and postservice times, hospital days, office visits, and discharge day management services, but for which the agency believed the AMA RUC-recommended values do not reflect the extraction of the associated RVUs.

In its comment letter, the College strongly opposed CMS' recalculation of work RVUs and supported the use of the RUC-recommended values for the codes at issue. We support the RUC's thoughtful and deliberative process for evaluating codes, which uses standard physician work estimation surveys to set physician work RVUs relative to reference codes, both within and between specialties; and the College believes that CMS' recalculation method discounts the key criteria that both Harvard and the RUC have used in making work RVU recommendations, namely, relative total work.

23-hour stay

The final rule does not finalize CMS' proposal that would have disallowed additional E/M services to be billed for care furnished during the postprocedure period, when care is furnished for an outpatient service requiring less than a 24-hour hospital stay. Because CMS considers services that are performed in the outpatient setting and that require a hospital stay of less than 24 hours to be outpatient services, the agency believes that the use of inpatient E/M codes for services rendered in the postservice period for procedures requiring less than a 24-hour hospital stay would result in overpayment for preservice and intraservice work that would not be provided. Accordingly, CMS proposed to disallow inpatient E/M services for an outpatient service requiring less than a 24-hour stay.

In its comment letter, the College disagreed with CMS' rationale and opposed the agency's proposal regarding 23-hour stay because it would result in surgeons not being paid for the work they perform. The College's letter also clarified that the phrase "23-hour stay" for many of the codes in question are not actually 24 hours or less, and all of the codes affected by the proposal require at least an overnight stay in a hospital. As a result, the services associated with these codes require additional work in a facility on the day of the procedure, combined with discharge services one or more days after the procedure. Therefore, because all of the codes at issue require at least an overnight stay, and because the standard of care requires a surgeon to follow up with the patient, the College opposed CMS' proposal, and believes it is inappropriate for CMS not to recognize surgeons' work while the patient is in the hospital. As a result of the comments CMS received regarding this proposal, the agency has decided to work with the RUC and the Current Procedural Terminology* Editorial Panel on alternative E/M coding solutions.

To view the final rule, go to <http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf>. 

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