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IN THIS ISSUE

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Proposed CY 2011 Physician Fee Schedule Offers Glimpse of Changes to Come Under Health Care Reform

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CMS recently released its calendar year (CY) 2011 Proposed Rule for the Medicare Physician Fee Schedule (MPFS). The Proposed Rule, which can be viewed here [PDF], includes many of the changes mandated under the health care reform legislation passed earlier this year, including changes to the Physician Quality Reporting Initiative. Comments to the Proposed Rule are due by August 24, 2010, with the final rule expected on or around November 1, 2010.

Medicare Physician Fee Schedule (MPFS)

The CY 2011 MPFS proposed rule would continue significant changes to physician payment that were started with the CY 2010 MPFS. Under the proposed rule, CMS would:

- Continue its adoption of the Physician Practice Information Survey (PPIS) data for determining the RVUs for physician practice expenses. CMS has acknowledged the criticism of PPIS data, but the proposed rule does not indicate that CMS intends to correct the flaws in the PPIS data. Instead, the proposed rule summarizes the criticisms of the PPIS data, and solicits comments on CMS's "summary of the issues raised by the commenters on the CY 2010 final rule with comment period."
- Rebase and revise the Medicare Economic Index (MEI) for CY 2011. The new MEI would include an additional nine cost categories, which were previously aggregated under "Office Expenses."
- Add the following services to the list of telehealth services for CY 2011:
  - individual and group kidney disease education services;
  - individual and group diabetes self-management training (DSMT) services,

provided that a minimum one hour instruction is provided to the patient within a year of the initial DSMT service;

- group medical nutrition therapy services;
- group health and behavior intervention services;
- subsequent hospital care services (on a category 1 basis), with a limit for the patient's admitting practitioner of one telehealth visit every three days; and
- subsequent nursing facility care services (on a category 1 basis), with a limit for the patient's admitting practitioner of one telehealth visit every 30 days.

2010 Health Care Reform Legislation

Several provisions in the recent health care reform legislation offer additional funding for primary care and prevention. Under the Proposed Rule, CMS would:

- Eliminate deductibles and coinsurance payments that would otherwise be applicable to preventative services.
- Provide for a yearly "wellness visit," which will be paid at the rate of a level 4 office visit for a new or established patient.
- Make incentive payments to primary care practitioners, which would equal 10 percent of practitioners' allowed Part B charges. The incentive payments would be available to nurse practitioners, physician assistants, and physicians who have a primary care specialty designation of family, internal, geriatric, or pediatric medicine. In order to qualify, primary care services must have accounted for at least 60% of the physician's (or non-physician practitioner's) allowable Part B charges during CY 2009.

The recent health care legislation established several measures for expanding access to medical care, which were also included in the Proposed Rule. Under the Proposed Rule, CMS would:

- Establish of an incentive payment — equal to 10% of the MPFS amount — for major surgical procedures that are performed by a general surgeon in a

designated health professional shortage area (HPSA). Eligibility for incentive payments would be determined based on the list of HPSAs that are utilized under the existing bonus program.

- Revise the methodology for determining the practice expense geographic adjustment. Specifically, the recent legislation limits the extent to which local differences in wages and office rents (as compared to the national average) may be utilized to determine practice expense adjustments. During CYs 2011 and 2012, practitioners who have a decrease in their recognized practice expenses under the new methodology would be held harmless.
- Establish payment for bone density tests.
- Increase Medicare payments for certified nurse-midwife services.
- Extend reasonable cost payments for clinical diagnostic laboratory tests performed in small hospitals in certain rural areas.
- Establish disclosure rules for physician self-referrals (allowed under the in-office ancillary services exception) for diagnostic imaging services.
- Expand the durable medical equipment competitive bidding program to 91 metropolitan statistical areas.

The Proposed Rule would also implement legislative provisions related to "improving payment accuracy." Under the relevant provisions, CMS would:

- Establish a framework for identifying and correcting reimbursement for "misvalued codes."
- Modify the equipment utilization factor to assign an assumed 75% utilization rate for expensive diagnostic imaging equipment used in CT and MRI imaging. The utilization assumptions mandated under the new laws replace the assumed 90% utilization rate that CMS established under the CY 2010 MPFS. CMS also would increase the MPFS multiple procedure payment for the technical component of single-session imaging services to consecutive body areas.

- Revise the payment schedule and eliminate the lump sum purchase payment option for standard power-driven wheelchairs.
- Reduce the maximum period for submission of Medicare claims to 12 months.

Physician Quality Reporting Initiative (PQRI)

The Proposed Rule would extend and modify the physician quality reporting initiative (PQRI), including several changes that were mandated under recent health care reform legislation. Under the Proposed Rule, CMS would:

- Add 20 individual PQRI measures, twelve of which would be available for reporting through electronic health records systems.
- Reduce the reporting sample requirements for claims-based reporting of individual measures to 50%.
- Create a new group practice reporting option that would allow participation by group practices with fewer than 200 EPs.
- Establish additional procedures for correcting unsatisfactory quality reporting, including interim feedback reports and an informal review process when CMS has determined that an EP did not satisfactorily submit PQRI data.
- Allow an additional 0.5% incentive payment to EPs who submit PQRI data and participate in a Maintenance of Certification program (including a practice assessment) as required by a recognized physician specialty organization for continued certification.
- Establish a new Physician Compare website.
- Integrate PQRI reporting with reporting elements that are established separately under regulations implementing the Electronic Health Record incentive program.

Electronic Prescribing (eRx) Incentive Program

CMS also proposed changes to the Electronic Prescribing incentive program. The Proposed Rule would:

- Establish a 10% incentive payment for successful e-prescribers in CY 2011.
- Exclude EPs who receive an incentive payment under the Medicare Electronic

Health Records (EHR) Incentive Program from receiving a separate e-prescribing incentive payment. EPs who successfully participate in the EHR program could still be subject to a penalty in CY 2012 for not participating in the eRx program during CY 2011.

- Allow group practices with fewer than 200 members to participate in the eRx program.
- Establish criteria for penalizing EPs and group practices that do not successfully participate in the eRx program during CYs 2011 and 2012.