

CMS Releases Final 2010 Medicare Physician Fee Schedule Update

November 23, 2009

The Centers for Medicare and Medicaid Services (CMS) on October 30, 2009, released for public inspection the final 2010 Medicare Physician Fee Schedule update (2010 MPFS Update), slated for publication in the November 26, 2009, *Federal Register*. More than just a physician payment update, the annual MPFS update includes all or nearly all of CMS's Medicare Part B rulemaking for the year, taking up hundreds of pages in the *Federal Register*. This year is no exception, with CMS taking up a broad array of Medicare Part B issues. This *White Paper* summarizes certain key provisions of the 2010 MPFS Update, including the following:

- The negative payment update for physicians
- The elimination of payment for physician consultation codes (except certain telehealth consultations)
- The new Medicare benefits for cardiac rehabilitation programs, pulmonary rehabilitation programs and kidney disease education
- CMS's request for comments on the Stark law's new restrictions on "under arrangements" transactions with physician-owned entities

Requested comments are due by December 29, 2009.

Medicare Physician Fee Schedule Receives a Negative Update

As of this article's publication date, physicians are facing a -21.2 percent payment update for calendar year 2010. Because of a provision of the Balanced Budget Act of 1997 that restrains the growth of Medicare spending under the MPFS, the MPFS has faced a formula-driven, negative payment update every year since calendar year 2002. These negative updates have been averted each time by legislative or administrative fixes. However, these annual fixes have only increased the size of the following year's negative update. Accordingly, there has been increasing discussion of a permanent fix. A permanent fix to the physician payment formula that was originally attached to the Affordable Health Care for America Act (H.R. 3962) was stripped before the bill passed the House on November 8, 2009. Thus, the American Medical Association is currently pressing for passage of the Medicare Physician Payment Reform Act (H.R. 3961), a stand-alone bill that would also fix the formula-driven update methodology. H.R. 3961 calls for a 1.2 percent update for calendar year 2010. A cut in Medicare payments to physicians for 2010 would be highly controversial, and is unlikely, but in light of the congressional attention on health care reform, Congress might not get around to a legislative fix until sometime in 2010.

Other Physician Payment Developments

ELIMINATION OF REIMBURSEMENT FOR CONSULTATION SERVICES

CMS finalized its proposal to eliminate reimbursement for the consultation codes (except for telehealth consultation codes) currently used by specialists. CMS also finalized its proposal to use all of the savings to pay higher reimbursement for new and established patient office visits and the 10-day and 90-day global surgical codes, which include payment for office visits. Specialists will have to start billing for consultations under the office and hospital visit codes.

MEDICARE TELEHEALTH SERVICES

CMS finalized its proposals to add certain services to the list of approved Medicare telehealth services, including individual health and behavior assessment and intervention (HBAI) services described by HCPCS codes 96150 through 96152. CMS did not add group HBAI or family-with-patient HBAI to the list of approved Medicare telehealth services. CMS also finalized regulations prohibiting skilled nursing facilities (SNFs) and nursing facilities (NFs) from using telehealth to furnish the periodic attending physician visits that SNFs and NFs are required, by law, to provide in-person. However, CMS revised §410.78 to clarify that covered follow-up inpatient telehealth consultations include follow-up telehealth consultations furnished to beneficiaries in hospitals and SNFs.

New Benefits for Cardiac, Intensive Cardiac and Pulmonary Rehabilitation Programs

COVERAGE FOR CARDIAC AND INTENSIVE CARDIAC PROGRAMS

The 2010 MPFS Update implements Section 144(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which establishes coverage of cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) programs under Medicare Part B. CR is defined as a physician-supervised program that furnishes physician-prescribed exercise, cardiac-risk-factor modification, psychosocial assessment and outcomes assessment. ICR is defined as physician-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements. The CR/ICR benefit is available to patients with certain medical histories, including an acute myocardial infarction within the preceding 12 months, coronary bypass surgery and stable angina pectoris, among others. It applies to CR/ICR programs provided in either a physician's office or a hospital outpatient setting, so long as there is direct physician supervision. Approved ICR programs will be identified through the National Coverage Determination (NCD) process, posted on the CMS website and listed in the *Federal Register*. Prospective ICR sites must apply to enroll as approved ICR program sites. The CR benefit is limited to a maximum of two one-hour sessions per day for up to 36 sessions over 36 weeks, though a Medicare contractor has the discretion to approve an additional 36 sessions. The ICR benefit is limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks.

PULMONARY REHABILITATION SERVICES

Section 144(a) of MIPPA also establishes the Medicare Part B benefit of pulmonary rehabilitation (PR). The 2010 MPFS Update implements the PR benefit, defining PR as a physician-supervised program for chronic obstructive pulmonary disease (COPD) and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. The benefit will initially only cover PR for patients with moderate to very severe COPD, though additional indications for coverage may be established by a NCD.

Components of PR programs include physician-prescribed exercise, education/training, psychosocial assessment, outcomes assessment and an individual treatment plan. The benefit applies to PR programs provided in either a physician's office or a hospital outpatient setting, so long there is "direct supervision" by a physician. The PR benefit is limited to a maximum of 36 sessions, with no more than two sessions per day, though a Medicare contractor has the discretion to approve an additional 36 sessions.

Other Rehabilitation-Related Developments

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND REHABILITATION AGENCY ISSUES

CMS conditions of participation and coverage of Comprehensive Outpatient Rehabilitation Facility (CORF) services provide that only those respiratory therapy services provided by respiratory therapists that meet the qualification requirements set forth in the definition of "respiratory therapist" at 42 CFR § 485.70(j) are eligible for Medicare payment. Last year, CMS revised the definition of "respiratory therapist" for purposes of CORF payment in order to improve accuracy in references to respiratory therapists eligible to receive reimbursement under the program and to make the definition consistent with industry requirements for education, training and practice. However, since then, CMS became aware that the revised definition excluded Certified Respiratory Therapists (CRTs), respiratory therapists who have completed a nationally accredited educational program and are eligible to sit for the national registry examination, but who have not yet passed the examination. This exclusion limited the ability of Medicare beneficiaries in CORFs to access respiratory therapy services. To fix this problem, CMS revised the definition of "respiratory therapists" to allow CRTs to provide respiratory therapy services in CORFs.

2010 THERAPY CAPS

The Medicare program imposes an annual cap on beneficiary expenses incurred for outpatient physical therapy and speech-language therapy services under Part A and a separate cap for outpatient occupational therapy services under Part B. For calendar year 2010, the per-beneficiary cap will be \$1,860. Since 2006, a series of legislative provisions have given CMS the authority to grant exceptions to the cap. The current provision will expire on December 31, 2009. If Congress does not extend the authority for the exception process, beginning on January 1, 2010, the only exceptions to therapy caps will be for hospital outpatient services.

New Medicare Benefit for Kidney Disease Education

The 2010 MPFS Update implements the new Kidney Disease Patient Education (KDE) services benefit added to Medicare Part B by Section 152(b) of MIPPA. KDE services are defined as face-to-face educational services provided to patients with Stage IV chronic kidney disease. KDE is covered when provided by a physician, physician assistant, nurse practitioner or clinical nurse specialist. Additionally, KDE services are covered when provided by a hospital, critical access hospital, SNF, home health agency or hospice that is located in a rural area (or in a hospital or critical access hospital treated as being rural under the regulations).

KDE topics include the management of comorbidities; the prevention of uremic complications; therapeutic options, treatment modalities and settings; and opportunities to participate in the choice of therapy. In addition, providers of KDE services must develop outcomes assessments designed to measure beneficiary knowledge about chronic kidney disease and its treatment. KDE sessions are to be one hour long and provided in either individual settings or group settings of two to 20 individuals who need not all be Medicare beneficiaries. The benefit is limited to six sessions of KDE services.

Stark-Related Developments

CMS CLARIFIES “STAND IN THE SHOES” PROVISION

A number of the Stark law’s compensation exceptions include a requirement that the compensation arrangement be the subject of a signed writing “between the parties,” and a prohibition on compensation that takes into account the volume or value of referrals “between the parties.” These references to “parties” created uncertainty regarding the application of the compensation exceptions when CMS amended the Stark regulations to provide that, for purposes of determining the nature of a physician’s compensation arrangements with entities furnishing Stark-covered services, physician-owners are deemed to stand in the shoes of their medical practice entities. (Non-owner physicians can elect to stand in the shoes of their medical practice entities.) Consistent with a previously published FAQ, CMS clarifies that the signature requirement is met when the writing is signed by an authorized representative of the medical practice; not every physician who stands in the shoes of the practice must sign the writing. Importantly, CMS also clarifies that, when a physician stands in the shoes of a medical practice, the prohibition on compensation taking into account the volume or value of referrals “between the parties” refers to referrals by all physician owners, employees and contractors of the practice entity, not just the referrals of the physician standing in the shoes of the practice.

CMS SOLICITS COMMENTS REGARDING THE NEW RESTRICTIONS ON “UNDER ARRANGEMENTS”

The 2009 inpatient PPS rule modified the Stark definition of DHS entity to include entities that “perform services that are billed as DHS.” Hearing that the health industry is struggling to discern when an entity “performs services that are billed as DHS,” CMS has requested comments on whether it should define or clarify this term, and, if so, how. Additionally, CMS welcomes any information concerning how the industry interpreted and applied the definition of DHS entity and how under arrangement agreements have been restructured in order to comply with the definition.

Imaging-Related Developments

SIGNIFICANT PAYMENT REDUCTION FOR ADVANCED DIAGNOSTIC IMAGING

A substantial part of the payment for the technical (non-physician service) component of advanced diagnostic imaging, such as magnetic resonance imaging (MRI) and computed tomography (CT), is attributable to CMC’s recognition of the cost of the equipment at the physician office or imaging center service level. This equipment cost, in turn, is derived in significant part from CMC’s assumptions about the utilization rate for the equipment. CMS currently assumes a utilization rate of 50 percent, or about 25 hours out of a 50-hour work week. However, based on the results of two surveys of MRI and CT scanner utilization analyzed by MedPAC, the utilization of MRI and CT equipment is closer to 90 percent, or 45 hours out of a 50-hour work week, thereby suggesting a significantly lower equipment cost to physicians and imaging centers than CMS had assumed for Medicare payment purposes. As a result, CMS proposed to increase the assumed utilization rate to 90 percent for all medical equipment costing \$1 million or more, including therapeutic equipment. However, in the final rule, CMS is limiting use of the 90 percent utilization rate to MRI and CT, and is phasing in the new utilization rate over four years. Combined with other changes to practice expense values due to CMS’s controversial decision to start incorporating practice expense data from the Physician Practice Information

Survey, independent diagnostic testing facilities (IDTFs) and physician offices engaged in advanced imaging and nuclear medicine will see substantial cuts in payment for the technical component of these services. CMS projects a 36 percent reduction in payment to IDTFs after the new practice expense values are fully implemented in four years.

CMS SOLICITING APPLICATIONS FOR IMAGING SUPPLIER ACCREDITATION ORGANIZATIONS

Section 135 of MIPPA requires that, beginning January 1, 2012, payment for the technical (non-physician service) component of advanced diagnostic imaging services under the MPFS be made only to suppliers (*i.e.*, physicians and IDTFs) accredited by a CMS-approved accreditation organization (AO). (Hospital outpatient department imaging sites are not subject to this accreditation requirement.) The 2010 MPFS Update defines “advanced diagnostic imaging services” as MRI, CT, nuclear medicine and positron emission tomography. The rule sets forth the application criteria for organizations seeking CMS approval, and the reapplication and reconsideration procedures that organizations must follow to appeal a denial, removal or non-renewal of an organization’s approved AO status. CMS is soliciting applications for approved AO status and, in order to meet the statutory deadline of January 1, 2010, for approving AOs, is making the rules for AO approval effective October 30, 2009. To obtain approved AO status, an organization must describe how its accrediting standards will address the areas identified by Congress, including qualifications of technologists, qualifications and responsibilities of medical directors and supervising physicians (who may be the same person), and procedures to ensure the quality of diagnostic images. Approved AOs must agree to comply with a number of conditions, including a commitment to prioritize surveys for those suppliers needing to be accredited by January 12, 2012.

Physician Quality Reporting Initiative

The Final Rule provides a number of updates and modifications to the Physician Quality Reporting Initiative (PQRI), including 175 measures (including 30 new measures), 13 measures groups (including six new measures groups), revised reporting periods, the opportunity to receive incentive payments using electronic health record (EHR) reporting, and the addition of a group-practice level reporting option. Pursuant to MIPAA, the incentive payment amount is set at 2 percent of the estimated total MPFS-allowed charges for calendar year 2010.

CMS has continued the 12-month reporting periods for all reporting mechanisms—claims-based, registry and EHR-based. CMS also continued the six-month reporting period that has been available for registry reporting and elected to make this reporting option available to providers who used claims-based reporting for calendar year 2010. CMS did not finalize its proposal to require a minimum reporting volume for reporting individual quality measures because it found that this requirement would adversely affect a significant number of providers.

Although EHR-based reporting was available as a test program in 2008 and 2009, providers have not been eligible to receive PQRI incentive payments through this mechanism. For 2010, CMS will, for the first time, allow eligible professionals to count the measures reported through their EHRs towards eligibility for a PQRI payment. For 2010, CMS designated 10 individual measures for EHR reporting. This move towards more fully implementing EHR-based reporting is part of a larger effort to move away from claims-based reporting, although CMS noted that it does not expect to discontinue claims-based reporting in the near future.

In 2010, providers will also be able to participate in the PQRI at the group practice level, instead of just as individuals. For purposes of this provision, a “group practice” consists of a single Tax Identification Number with at least 200 individual eligible professionals (as identified by Individual National Provider Identifiers) who have reassigned their billing rights to the group. The incentive payment goes to the group practice, and the individual physicians in the group practice cannot receive duplicate incentive payments as individual participants in the PQRI. In order to be eligible for the incentive payment, the group practice must report on 26 measures that target high-cost chronic conditions and preventive care. In addition, group practices are required to report on the first 411 consecutively assigned and ranked Medicare beneficiaries per disease module or preventive care measure.

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