Document hosted at JDSupra
http://www.jdsupra.com/post/documentViewer.aspx?fid=c39d0a0d-4d6a-4432-a384-94b

OBER | KALER
Attorneys at Law

Payment Matters®
Update on Medicare and Medicaid payment issues

Subscribe
Reprints
Health Law Group
www.ober.com
Payment Matters

NOVEMBER 13, 2009

Physician Fee Schedule Promises Significant Reimbursement Changes in the Coming Year

Julie E. Kass
410-347-7314
jekass@ober.com

Mark A. Stanley
410-347-7353
mastanley@ober.com

CMS has released its Calendar Year (CY) 2010 Final Rule with Comment Period for practitioners who are paid under the Physician Fee Schedule (PFS). Some specialists can expect to see a substantial drop in Medicare payment rates under changes made in the final rule. The rule may be viewed **here [PDF]**.

Among other changes, the rule:

- Eliminates billing codes for consultation services except for telehealth services;
- Ties reimbursement under the PFS to the Physician Practice Information Survey (PPIS);
- Establishes a system for accreditation with respect to suppliers of the technical component (TC) of advanced diagnostic imaging services;
- Clarifies the definition for "stand in the shoes" under the physician self-referral rules;
- Revises the utilization estimates for certain high cost, non-therapeutic equipment; and
- Solicits comments regarding whether CMS should define the meaning of "performed the DHS" in the context of the self-referral rules, and which factors to consider if it adopts such a definition.

Elimination of Consultation Codes

Consultation codes are used for evaluation and management services that are provided by physicians, based on a request by another physician or appropriate source. The final rule eliminates consultation codes in the context of everything but initial visits for telehealth services. Any other services that are currently billed using consultation codes must now be billed as new or

In this Issue

Physician Fee Schedule Promises Significant Reimbursement Changes in the Coming Year

The OIG's 2010 Work Plan — What's Critical for Long-Term Care & Community-Based Providers

Payment Group

The Payment Group is a work group within Ober|Kaler's Health Law Group.

Principals

Thomas W. Coons
Leslie Demaree Goldsmith
Carel T. Hedlund
S. Craig Holden
Julie E. Kass
Paul W. Kim
Robert E. Mazer
Christine M. Morse
Laurence B. Russell
Donna J. Senft
Susan A. Turner

Associates

Document hosted at JDSupra
http://www.jdsupra.com/post/documentViewer.aspx?fid=c39d0a0d-4d6a-4432-a384-94b

Kristin Cilento Carter
Joshua J. Freemire
Mark A. Stanley
Lisa D. Stevenson

established office visits, initial hospital visits, or initial nursing facility visits. CMS will increase the relative value units (RVUs) associated with new and established office visits, and with initial facility visits for hospitals and nursing homes in order to offset the reimbursement effect of eliminating consultation codes. Physicians may notice that, while the proposed rule anticipated a 2% increase in RVUs for hospital and nursing facility visits, the final rule provides for only a 0.3% increase. The final rule offers no explanation for this significant discrepancy, but a CMS representative responded to an inquiry on the subject by indicating that a correction notice will be forthcoming "that will look more like" the proposed rule.

Establishment of Reimbursement Based on PPIS Data

Beginning with CY 2010, CMS will phase in new practice expense per hour (PE/HR) RVUs based on the PPIS survey data. The PPIS data will supplant, for purposes of determining PE/HR RVUs for all but a few specialties, the AMA's socioeconomic monitoring system (SMS) data and supplemental data submitted by specialty practice groups. CMS recognized that some specialties will experience a severe reduction in payments under the new survey data, and has established that the replacement of the SMS and supplemental data will be phased in over a four year period. The final rule exempts oncology, clinical laboratories, and independent diagnostic testing facilities from the new methodology.

Accreditation Requirement for Suppliers of Advanced Diagnostic Imaging Services

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandates that, starting in 2012, CMS may only make payment for the TC of diagnostic imaging services to accredited suppliers. The Secretary of Health and Human Services will designate accreditation organizations (AOs), but will not directly regulate the qualifications of accredited suppliers of diagnostic imaging services. The final rule establishes the criteria for designating and evaluating AOs, which CMS will name on January 1, 2010. Designation of AOs will be based, in part, on their proposed accreditation standards in the following four areas: (1) qualifications for nonphysician medical personnel, (2) qualifications of medical directors and supervising physicians, (3) safety procedures, and (4) reliability measures. CMS will require AOs to regularly perform surveys of accredited suppliers, and to provide notice to CMS of any changes in a supplier's accreditation status. In addition, CMS will perform audits of AOs by examining providers, which will be selected on the basis of either a random sample or allegations of noncompliance. Suppliers that fail to cooperate with such audits will risk losing accreditation. CMS declined to state whether medical directors and supervising physicians must be qualified in the modality for which a supplier seeks accreditation, but noted that it received comments arguing both sides of that issue.

Updates to Self-Referral Rules

The final rule clarifies that, for purposes of the "stand in the shoes" provisions of the self-referral rules, the "relevant referrals and other business generated" are such referrals "between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians)." In addition, the rule solicits comments about whether the concept of "performing services" should be defined for purposes of the "under arrangements" provisions of the self-referral rules. As of October 1, 2009, the rules restrict referrals between physicians and any entity that bills for or performs designated health services (DHS), with which the physician (or the physician's immediate family member) has a financial relationship.

CMS is also soliciting comments as to whether the concept of "performing DHS" is necessary, and, if so, which factors should be given consideration in determining who performs DHS. CMS suggests a number of factors that may

be appropriate for determining which entity performs a service, including:

Document hosted at JDSUPRA
http://www.jdsupra.com/post/documentViewer.aspx?fid=c39d0a0d-4d6a-4432-a384-94b

- Lease of space or equipment used for performance of the service;
- Supplies that are used in the performance of the service, but that are not separately billable;
- Management or billing services;
- Nonphysician services that are not separately billable.

Revision of Estimates for Equipment Utilization

Finally, the rule changes the utilization assumptions for services involving MRIs and CTs from 50 percent to 90 percent. While CMS had proposed changing its utilization assumptions for services involving a variety of high-cost equipment, it determined that the data only supported changing assumptions in the case of MRIs and CTs.

Ober|Kaler's Comments: Many physician specialists took a beating in this final rule. The elimination of consultation codes removes a reimbursement advantage previously enjoyed by physician specialists who provide consultation services, which have historically been paid at a higher rate than new and established office visits, initial hospital visits, or initial facility visits. The move from SMS and supplemental data to PPIS data for PE/HR RVUs also has a disproportionate effect on specialists, many of whom will see their reimbursement substantially diminished under the new survey. The rule leaves open a matter of critical importance for suppliers of diagnostic imaging services: whether a licensed physician other than a radiologist may be a supervising physician or medical director under the new accreditation regime. Those who want to weigh in on whether and how CMS should define "perform DHS" under the self-referral rules should submit comments at **regulations.gov**.

Copyright© 2009, Ober, Kaler, Grimes & Shriver