OBER | KALER
Attorneys at Law

Payment Matters®
Update on Medicare and Medicaid Payment Issues

Subscribe | Payment Group | Payment Matters Archive

July 14, 2011

www.ober.com

IN THIS ISSUE

Editors: Leslie Demaree Goldsmith and Carel T. Hedlund

CMS Releases its Calendar Year 2012 Physician Fee Schedule Proposed Rule

By: Mark A. Stanley

CMS has released its Calendar Year (CY) 2012 Proposed Rule for practitioners who are paid under the Physician Fee Schedule (PFS). The proposed rule would impact a variety of methodologies used to calculate physician payment, including the adjustment for geographic differences in practice expenses and the payment rates for the professional component of multiple advanced diagnostic imaging procedures. The proposed rule may be viewed here [PDF].

CMS anticipates that the Sustainable Growth Rate (SGR) adjustment to physician reimbursement will result in a 29.5 percent cut in payment rates for 2012. This adjustment has historically been reversed through congressional intervention, but clashes over deficit spending in Washington add extra drama this year. As a result, there is a very real possibility that a substantial reduction in physician reimbursement will occur with the CY 2012 PFS.

Among other changes, the proposed rule would:

- **Expand the potentially misvalued code initiative**. Section 3134(a) of the Affordable Care Act (ACA) mandates that CMS must identify, and adjust payment for, potentially misvalued codes. Beginning in CY 2012, the proposed rule would consolidate existing five year reviews of the work and practice expense relative value units (RVUs) into the annual review of potentially misvalued codes established pursuant to the ACA. Section 3134(a) of the ACA also requires CMS to establish a methodology that utilizes consistent criteria for identifying potentially misvalued codes. In its CY 2011 PFS final rule with comment period, CMS requested input from stakeholders regarding the features of such a methodology. CMS has again requested input regarding the data sources and possible methodologies for developing a validation process for reviewing code values. In particular, CMS would like comments on the sources of data that may be used in validating estimates of the physician time

***Payment Matters*® is not to be construed as legal or financial advice, and the review of this information does not create an attorney-client relationship.**

Copyright© 2011, Ober, Kaler, Grimes & Shriver

and intensity that can be factored into the work RVUs. Finally, CMS has proposed a public nomination process for the identification of potentially misvalued codes for annual review, including specific documentation requirements for proposed codes.

- **Change the methodology and data applied when determining the adjustment of geographic practice cost indices (GPCIs)**. The new methodology would maintain the current data sources for the physician work costs. However, CMS anticipates that physician work GPCIs will be adjusted to account for the expiration of the 1.0 work GPCI floor on December 31, 2011. The GPCI floors established for Alaska (1.5) and frontier states (1.0) survive the expiration of the GPCI floor later this year. CMS is proposing to replace certain data sources used to establish practice expenses. For instance, the proposed rule would replace HUD rental data, which is currently used as a proxy for the office rent component of practice expenses, in favor of data from the American Community Survey.
- **Apply the multiple procedure payment reduction (MPPR) to include the professional component of advanced imaging services**. Prior to CY 2011, CMS only applied the MPPR to multiple codes within the same family and only reduced the technical component of advanced imaging services. The CY 2011 PFS final rule with comment period expanded the MPPR to apply to the technical component of advanced imaging services across (rather than within) families of codes. The CY 2012 rule would take the change one step further by reducing reimbursement for the professional component of advanced diagnostic imaging services when multiple procedures are furnished in the same session.
- **Reduce physician payment for physician practices that are wholly owned or operated by a hospital where hospital admission occurs within three days of physician service**. CMS proposes to establish a modifier to identify the affected claims, which will then be paid at the facility rate. For codes with a technical component, the physician will be paid only the professional component. For other codes, only the facility rate will be paid. Special rules apply to surgical services.

Payment Matters® **is not to be construed as legal or financial advice, and the review of this information does not create an attorney-client relationship.**

Copyright© 2011, Ober, Kaler, Grimes & Shriver

- **Create new criteria for the health risk assessments (HRAs), which are to be utilized in tandem with the annual wellness visits**. The HRAs are a required component of patients' "personalized prevention plans," as established by the Medicare statute. The Centers for Disease Control and Prevention (CDC) have issued interim guidance for the HRAs, which may be viewed here [PDF].
- **Expand the list of services eligible for coverage as telehealth services**. The proposed rule would add smoking cessation treat to the list of services eligible for telehealth coverage and would adjust the way additional services are added to the list of telehealth-eligible services.
- **Update physician incentive programs, including the Physician Quality Reporting System (PQRS) and the ePrescribing (eRx) Incentive Program**. The proposed rule would establish a self-nomination process for group practices that seek to participate in the PQRS or eRx Incentive Programs. Group practices that wish to self-nominate would need to do so by January 31 of the year in which they wish to participate in the Incentive Program. Groups that have previously participated would be automatically eligible for participation in CY 2012 and in future years.
- **Update the Electronic Health Records (EHR) Incentive Program**. The proposed rule would establish a pilot program, which would allow physicians to meet the clinical quality measure (CQM) reporting requirements of the EHR Incentive Program via electronic submission. CMS has proposed two alternate methods for participants in the pilot program to submit their CQMs. The proposed methods for electronic submission of CQM data are based on existing platforms of the PQRS.
- **Establish new quality and cost measures that would ultimately lead to the establishment of a value-based modifier to physician payment**. CMS anticipates that it will establish the value-based modifier in CY 2013, using quality measures from the PQRS reports and Physician Feedback reports this year.
- **Continue the transition to the new practice expense relative value units, which began transitioning to data from the Physician Practice Information Survey (PPIS) with the CY 2010 PFS final rule.**

***Payment Matters*® is not to be construed as legal or financial advice, and the review of this information does not create an attorney-client relationship.**

Copyright© 2011, Ober, Kaler, Grimes & Shriver

Comments on the Proposed Rule must be received by CMS no later than 5 PM EDT on **August 30, 2011**.

Payment Matters® **is not to be construed as legal or financial advice, and the review of this information does not create an attorney-client relationship.**

Copyright© 2011, Ober, Kaler, Grimes & Shriver