

**For Immediate
Release:**

Tuesday, November 02, 2010

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202-690-6145

FINAL 2011 POLICY, PAY CHANGES IN MEDICARE PHYSICIAN FEE SCHEDULE

Final 2011 Policy, Pay Changes in Medicare Physician Fee Schedule

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on Nov. 2, 2010 that updates payment policies and Medicare payment rates under the Medicare Physician Fee Schedule (MPFS) for physicians' services furnished in CY 2011. In addition to payment policy and payment rate updates, the MPFS addresses a number of provisions of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the "Affordable Care Act"). Although most of the provisions included in the final rule directly affect payments provided under the MPFS, the rule also addresses a number of policies that are not directly related to this payment system.

BACKGROUND

Since 1992, Medicare has paid for the services of physicians, NPPs, and certain other suppliers under the MPFS, a system that pays for covered physicians' services furnished to a person enrolled under Medicare Part B. Under the MPFS, in general, a relative value is assigned to each of more than 7,000 services to capture the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice insurance expenses typically involved in furnishing the service. The higher the number of relative value units (RVUs) assigned to a service, the higher the payment. The RVUs for a particular service are multiplied by a fixed-dollar conversion factor and a geographic adjustment factor to determine the payment amount for each service.

Affordable Care Act Provisions INCLUDED IN THE CY 2011 MPFS FINAL RULE

Primary Care & Prevention

- Elimination Of Deductible And Coinsurance For Most Preventive Services: Effective Jan. 1, 2011, the Affordable Care Act waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services. Specifically, the provision waives both the deductible and coinsurance for Medicare-covered preventive services that have been recommended with a grade of A ("strongly recommends") or B ("recommends") by the U.S. Preventive Services Task Force (USPSTF), as well as the initial preventive physical examination and the new annual wellness visit. The Affordable Care Act also waives the Part B deductible for tests that begin as colorectal cancer screening tests but, based on findings during the test, become diagnostic or therapeutic services.
- Coverage Of Annual Wellness Visit Providing A Personalized Prevention Plan: The Affordable Care Act extends the preventive focus of Medicare coverage, which currently pays for a one-time initial preventive physical examination (IPPE or the "Welcome to Medicare Visit"), to provide coverage for annual wellness visits in which beneficiaries will receive personalized prevention plan services (PPPS). The law states that the annual wellness visit may include at least the following six elements, as determined by the Secretary of Health and Human Services:
 - Establish or update the individual's medical and family history.
 - List the individual's current medical providers and suppliers and all prescribed medications.
 - Record measurements of height, weight, body mass index, blood pressure and other routine measurements.
 - Detect any cognitive impairment.
 - Establish or update a screening schedule for the next 5 to 10 years including screenings appropriate for the general population, and any

additional screenings that may be appropriate because of the individual patient's risk factors.

- Furnish personalized health advice and appropriate referrals to health education or preventive services.

CMS has developed two separate Level II HCPCS codes for the first annual wellness visit (G0438 - Annual wellness visit, including personalized prevention plan services, first visit), to be paid at the rate of a level 4 office visit for a new patient (similar to the IPPE), and for subsequent annual wellness visits (G0439 - Annual wellness visit, including personalized prevention plan services, subsequent visit), to be paid at the rate of a level 4 office visit for an established patient.

- *Incentive Payments To Primary Care Practitioners For Primary Care Services:* The Affordable Care Act provides for incentive payments equal to 10 percent of a primary care practitioner's allowed charges for primary care services under Part B. Under the final policy, primary care practitioners are: (1) physicians who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner's MPFS allowed charges for a prior period as determined by the Secretary of Health and Human Services. The law also defines primary care services as limited to new and established patient office or other outpatient visits (CPT codes 99201 through 99215); nursing facility care visits, and domiciliary, rest home, or home care plan oversight services (CPT codes 99304 through 99340); and patient home visits (CPT codes 99341 through 99350).

In the final rule with comment period, CMS excluded consideration of allowed charges for hospital inpatient care and emergency department visits in determining whether the 60 percent primary care threshold is met. These exclusions will make it easier for providers in rural areas to become eligible for the payment incentive program. The incentive payments will be made quarterly based on the primary care services furnished in CY 2011 by the primary care practitioner, in addition to any physician bonus payments for services furnished in Health Professional Shortage Areas (HPSAs).

CMS will determine a practitioner's eligibility for incentive payments in CY 2011 using claims data and the provider's specialty designation from CY 2009 for practitioners enrolled in CY 2009. For newly enrolled practitioners, CMS will use claims data from CY 2010 to make an eligibility determination regarding CY 2011 incentive payments. For subsequent years, CMS will revise the list of primary care practitioners on a yearly basis, based on updated data regarding an individual's specialty designation and percentage of allowed charges for primary care services.

Improving Payment

- *Incentive Payments For Major Surgical Procedures In Health Professional Shortage Areas*: The Affordable Care Act also calls for a payment incentive program to improve access to major surgical procedures – defined as those with a 10-day or 90-day global period under the MPFS – that are furnished by physicians in Health Professional Shortage Areas (HPSAs) between Jan. 1, 2011 and Dec. 31, 2016. To be eligible for the incentive payment, the physician must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the MPFS payment for the surgical services furnished by the general surgeon. The incentive payments will be made quarterly to the general surgeon when the major surgical procedure is furnished in a zip code that is located in a HPSA. CMS will use the same list of HPSAs that it has used under the existing HPSA bonus program
- *Medicare Economic Index (MEI)*: The MEI is an inflation index for physician practice costs that is used as part of the formula to calculate annual updates to MPFS rates. For CY 2011, CMS is rebasing and revising the MEI to use a 2006 base year in place of a 2000 base year. This update to the MEI is the first time it has been rebased and revised since 2004. In addition, the final rule with comment period announces CMS' plans to convene a technical advisory panel to review all aspects of the MEI, including inputs, input weights, price-measurement proxies, and productivity adjustment; and indicates that CMS will consider the panel's analysis and recommendations in future rulemaking.

- Revisions To The Practice Expense Geographic Adjustment: As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice insurance cost components of each of more than 7,000 types of physicians' services. The final rule with comment period discusses CMS' analysis of PE GPCI data and methods, and incorporates new data as part of the sixth GPCI update, while keeping the GPCI cost share weights the same pending the results of further CMS and Institute of Medicine studies.

The Affordable Care Act establishes a permanent 1.0 floor for the PE GPCI for frontier states (currently, Montana , Wyoming , Nevada , North Dakota , and South Dakota). The Affordable Care Act limits recognition of local differences in employee wages and office rents in the PE GPCIs for CYs 2011 and 2012 as compared to the national average. Localities are held harmless for any decrease in CYs 2011 and 2012 in their PE GPCIs that would result from the limited recognition of cost differences. CMS will continue to review the GPCIs in CY 2011, in accordance with the Affordable Care Act provision that requires the Secretary of Health and Human Services to analyze current methods of establishing PE GPCIs in order to make adjustments that fairly and reliably distinguish the costs of operating a medical practice in the different fee schedule areas.

- Permitting Physician Assistants To Order Post-Hospital Extended Care Services: The Affordable Care Act newly authorizes physician assistants to perform the level of care certification that is one of the requirements for coverage under Medicare's skilled nursing facility (SNF) benefit.
- Payment For Bone Density Tests: The Affordable Care Act increases the payment for two dual-energy x-ray absorptiometry (DXA) CPT

codes for measuring bone density for CYs 2010 and 2011. This provision requires payments for these preventive services to be based on 70 percent of their CY 2006 RVUs and the 2006 conversion factor, and the current year geographic adjustment.

- *Improved Access To Certified Nurse-Midwife Services:* The Affordable Care Act increases the Medicare payment for certified nurse-midwife services from 65 percent of the PFS amount for the same service furnished by a physician to 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less). The increased payment amount is effective for services furnished on or after Jan. 1, 2011.
- *Extension Of Medicare Reasonable Cost Payments For Certain Clinical Diagnostic Laboratory Tests Furnished To Hospital Patients In Certain Rural Areas:* The Affordable Care Act reinstates reasonable cost payment for clinical diagnostic laboratory tests performed by hospitals with fewer than 50 beds that are located in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010 through June 30, 2011. For some hospitals whose cost reports begin as late as June 30, 2011, this could affect services performed as late as June 29, 2012, because this is the date those cost reports will close.
- *Physician Self-Referral Disclosure Requirement For Certain Imaging Services:* The Affordable Care Act amends the in-office ancillary services exception to the physician self-referral law as applied to magnetic resonance imaging, computed tomography, and positron emission tomography, to require a physician to disclose to a patient in writing at the time of the referral that the patient may obtain these services from another supplier. CMS will require that the referring physician provide the patient with a list of five alternative suppliers within a 25-mile radius of the physician's office location at the time of the referral who provide the imaging services ordered.

- *Adjustments To The Medicare Durable Medical Equipment, Prosthetics, Orthotics, And Supplies Competitive Bidding Program:* The Affordable Care Act expands round 2 of the durable medical equipment (DME) competitive bidding program from 70 metropolitan statistical areas (MSAs) to 91 MSAs by adding the next 21 largest MSAs by total population not already selected for rounds 1 or 2. The 2009 annual population estimates from the U.S. Census Bureau are the most recent estimates of population that will be available prior to the round 2 competition mandated to take place in CY 2011.

Improving Payment Accuracy

- *Misvalued Codes Under The Physician Fee Schedule:* The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. The final rule with comment period identifies additional categories of services that may be misvalued, including codes with low work RVUs commonly billed in multiple units per single encounter and codes with high volume and low work RVUs. The final rule also includes CMS' response to recommendations from the American Medical Association (AMA) Relative Value Update Committee (RUC) for CY 2011 regarding the work or direct practice expense inputs for 325 CPT codes.
- *Multiple Procedure Payment Reduction Policy for Therapy Services:* The Affordable Care Act requires CMS to identify and make adjustments to the relative values for multiple services that are frequently billed together when a comprehensive service is furnished. Although not part of the Affordable Care Act, to more appropriately recognize the efficiencies when combinations of therapy services are furnished together, CMS is adopting a multiple procedure payment

reduction policy for therapy services that will reduce by 25 percent the payment for the practice expense component of the second and subsequent therapy services furnished by a single provider to a beneficiary on a single date of service. This policy will apply to all outpatient therapy services paid under Part B, including those furnished in office and facility settings.

- *Modification Of Equipment Utilization Factor and Modification of Multiple Procedure Payment Policy For Advanced Imaging Services:* The Affordable Care Act adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment and, as a result, reduces payment rates for the associated procedures relative to 2010. Effective Jan. 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.
- *Revision To Payment For Power-Driven Wheelchairs:* As required by the Affordable Care Act, CMS is adjusting the payment schedule for power-driven wheelchairs under the Medicare Part B fee schedule to pay 15 percent (instead of 10 percent) of the purchase price for the first three months of the 13 month rental period and 6 percent (instead of 7.5 percent) for the remaining months. Payment is based on the lower of the supplier's actual charge and the fee schedule amount.

In addition, the Affordable Care Act eliminates the lump sum (up-front) purchase payment option for standard power-driven wheelchairs. CMS has revised the regulations to conform to this new requirement, which permits payment only on a monthly rental basis for standard power-driven wheelchairs effective for items furnished on or after Jan. 1, 2011. For complex rehabilitative power-driven wheelchairs, the regulations continue to permit payment to be made on either a lump sum purchase method or a monthly rental method.

The Affordable Care Act also specifies that these changes do not apply to payments made for power-driven wheelchairs furnished pursuant to contracts entered into prior to Jan. 1, 2011 as part of the Medicare DMEPOS competitive bidding program.

- Maximum Period For Submission Of Medicare Claims Reduced To Not More Than 12 Months– The Affordable Care Act reduced the maximum time period for submission of Medicare fee-for-service claims to one calendar year after the date of service. This change, which applies to services furnished after Jan. 1, 2010, reflects a reduction to the prior maximum timely filing deadline of 15 to 27 months. The Affordable Care Act also mandated that providers and suppliers file claims for services furnished prior to Jan. 1, 2010 no later than December 31, 2010. The final rule revises the timely filing regulations to reflect these new requirements. It also establishes three new exceptions to the timely filing requirements for retroactive entitlement situations, dual-eligible beneficiary situations, and retroactive disenrollment from Medicare Advantage plans or PACE provider organizations.

The final rule with comment period will appear in the Nov. 29, 2010, *Federal Register*. CMS will accept comments on certain aspects of the final rule with comment period until Jan. 3, 2011, and will respond to them in a final rule to be issued on or about Nov. 1, 2011 that sets forth the policies and payment rates effective for services furnished to Medicare beneficiaries on or after Jan. 1, 2012.

For more information, see: www.federalregister.gov/inspection.aspx#special