

2010 Medicare Physician Fee Schedule Final Rule Summary

On October 30, 2009 the Centers for Medicare and Medicaid Services (CMS) posted a display copy of the final Medicare physician fee schedule (MPFS) for 2010. The rule in its entirety can be found at: http://federalregister.gov/OFRUpload/OFRData/2009-26502_PI.pdf. The rule will be published in the Federal Register on November 25, 2009. CMS will accept comments on the final rule until December 29, 2009. Unless otherwise specified, the new payment rates and policies will apply to services furnished to Medicare beneficiaries on or after January 1, 2010.

Physician Fee Schedule Update

CY 2010 Physician Conversion Factor (CF)

» **The 2010 physician conversion factor (CF) is \$28.3769, a decrease from the 2009 CF of \$36.0666. Congressional action is necessary to avoid a payment cut. Negative updates have been expected every year since 2002, although Congressional action has averted payment reductions since 2003. It is anticipated that Congress will take action for 2010.**

While Medicare updates most of their payment rates each year for inflation, physician services are updated by a formula mandated in legislation known as the Sustainable Growth Rate (SGR). SGR establishes a spending target for physician services. CMS has announced a negative update of -21.2 percent for the 2010 Medicare Physician Fee Schedule due to the application of the SGR formula. This will result in a **CY 2010 conversion factor (CF) of \$28.3769**. This represents a decrease from the 2009 CF of \$36.0666. Negative updates have been expected every year since 2002, although Congressional action has averted payment reductions since 2003. Congressional action will be needed again in order to avoid a payment reduction in 2010.

Physician Administered Drugs and the SGR Formula

» **Physician administered drugs will be removed from the SGR formula.**

CMS will remove physician administered drugs from the calculation of allowed and actual expenditures. While this proposal would not change the update for 2010 it will reduce the past discrepancy between actual and targeted expenditures and would reduce the number of years in which physicians are projected to experience a negative update.

Through the public comments process CMS received many comments asking the Secretary and Congress to do more to avert the scheduled reduction in physician payments for 2010 and future years. CMS stated that other options suggested in comments would require a change in statute.

Specialty Impact

Included in the rule, is a chart showing the impact of the proposed work, practice expense (PE), and malpractice (MP) relative value units (RVU) changes on the various Medicare recognized specialties. The analysis does not include the effect of any conversion factor change which is the same for all specialties. The projected impact on specialties is a function of the proposed changes to physician work, practice expense, and malpractice. An excerpt from the chart is below and the full chart is attached.

Table 49: CY 2010 Total Allowed Charge Impact for Work, Practice Expense and Malpractice (MP) Changes

Specialty	Allowed Charges (mil\$)	Impact of Work RVU Changes	Impact of PE RVU Changes		Impact of MP RVU Changes	Combined Impact	
			Full	Transition		Full	Transition
TOTAL	77,796	0%	0%	0%	0%	0%	0%
Neurology	1,414	-3%	4%	1%	0%	1%	-2%
Neurosurgery	591	-1%	2%	0%	0%	1%	-1%

Practice Expense Changes

Practice Expense Relative Value Units (RVUs) represent the resources used in furnishing supplies, office rent/lease, equipment and personnel wages (excluding malpractice expense) when providing physician services.

AMA Physician Practice Information Survey (PPIS)

» CMS will update the PE/HR data based on the new PPIS survey data over a four year period beginning January 1, 2010. Modifications and exceptions are being made for radiation oncology, oncology, clinical labs and Independent Diagnostic Testing Facilities (IDTFs).

The American Medical Association (AMA) in collaboration with numerous medical specialty societies conducted a survey titled, the Physician Practice Information Survey (PPIS) to update the specialty-specific PE per hour (PE/HR) data used to develop PE RVUs. The PPIS survey was administered in 2007 and 2008 and unlike previous surveys included nonphysician practitioners (NPP). In this final rule CMS has agreed to transition to this new data over a four year period: 2010 (75% current data/25% PPIS data); 2011 (50% current data/50% PPIS data), 2012 (25% current data/75% PPIS data), and 2013 (0% current data/100% PPIS data).

The new PPIS data is replacing data obtained from the American Medical Association's (AMA's) Socioeconomic Monitoring Surveys (SMS) from 1995-1999. For several specialties more current supplemental survey data was accepted and is being used by the Agency to calculate PE RVUs. These specialties include cardiology, dermatology, gastroenterology, radiology, cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, independent diagnostic testing facilities (IDTFs), radiation oncology, medical oncology, and urology. Because the SMS data and the supplemental survey data are from different time periods, CMS has historically inflated them by the Medical Economic Index (MEI) to help make the data comparable.

Modifications and Exceptions to the Decision to Use the PPIS Survey Data to Establish PE RVUs

Radiation Oncology Services

CMS has made several revisions to the radiation oncology PPIS data which will have a significant positive impact on radiation oncology services. In the proposed rule all PE changes would have resulted in an estimated -17% impact on radiation oncology services. In the final rule the impact is estimated to be at -3%.

Oncology, Clinical Labs, and Independent Diagnostic Testing Facilities (IDTFs)

CMS will continue to use supplemental survey data for oncology, clinical labs, and IDTFs.

CMS will continue to use supplemental survey data for medical oncology, hematology and hematology/oncology due to a provision in previous Medicare legislation requiring the use of supplemental survey data for oncology administration codes. Although the use of supplemental survey data resulted in a higher PE per hour rate than the new PPIS survey data, the practice expenses values for hematology/ oncology are being reduced because some other specialties are seeing some substantial increases. That is, since the system is budget neutralized, the adoption of the new PPIS data had an adverse impact on hematology/oncology even though the per hour data for hematology/oncology was not reduced.

Neither IDTFs nor independent labs participated in the PPIS. CMS will continue to use current PE/HR data that was developed using their supplemental survey data. Despite this policy change IDTFs are expected to experience a -29 percent impact once all of the PE changes are implemented.

Portable X-Ray Suppliers

In the proposed rule, lacking specific PE data on portable x-ray suppliers, for purposes of calculating PE RVUs, this specialty was crosswalked to radiology. Based on public comments, CMS is changing the crosswalk for portable x-ray suppliers to IDTFs.

Equipment Utilization Rate Assumption

» CMS will increase the utilization assumption from 50 percent to 90 percent for expensive diagnostic equipment priced at more than \$1 million.

This new payment policy would decrease PE RVUs mainly for MRIs and CTs. This policy would not apply to therapeutic equipment, thereby exempting radiation oncology services from this policy. Similar to the transition to the new PPIS data, this change will be phased in over a four year period.

CMS has based this decision on data from the Medicare Payment and Advisory Commission (MedPAC) on MRI and CT use. In allocating equipment costs for calculating PE RVUs, CMS assumes equipment is in use 25 hours per week or 50 percent of the time a facility/office is open (a 50 hour week is assumed). A 2006 survey sponsored by MedPAC on CT and MRI machines indicates that the current usage rate is understated. According to the data from the survey MRI scanners are used an average of 52 hours per week and CT machines are operated an average of 42 hours per week. The result of this policy would be a decrease in the equipment costs allocated to these services and reduction in PE RVUs for CT, MRI and other services associated with equipment priced at \$1 million or above. CMS has stated in the rule they do not believe this new policy would affect access to care in rural areas.

CMS stated that they are open to receiving more comprehensive data on this topic and will evaluate any data submitted for consideration in future rulemaking.

Malpractice (MP) Relative Value Units (RVUs)

Revision of Resource-Based Malpractice RVUs

» CMS updates data used to establish MP RVUs.

Initial implementation of resource-based malpractice (MP) RVUs occurred in 2000. CMS is required to review these RVUs no less than every five years. The first review of malpractice RVUs were addressed in the CY 2005 final rule.

For the CY 2010 fee schedule CMS will revise the MP RVUs using specialty specific malpractice premium data. The Agency sought to collect premium data representing at least 50 percent of physician malpractice premiums paid in each state as identified by the State Departments of Insurance and by the National Association of Insurance Commissioners (NAIC).

Malpractice RVUs for TC Portion of Certain Services

» **CMS establishes MP RVUs for the technical portion of the services based on a resource based methodology for the first time.**

Currently, the MP RVUs for TC services and the TC portion of global services are based on historical allowed charges and have not been made resource based due to a lack of available malpractice premium data. CMS will use the medical physician premium data collected by their contractor as a proxy for the malpractice premium paid by all entities providing TC services. This will primarily impact IDTFs.

Miscellaneous MP RVU Issues

The final rule also addressed other miscellaneous MP RVU issues.

- In determining MP RVUs each code is assigned to one of two risk factors: surgery or nonsurgery. In the proposed rule CMS considered revising the approach for assigning risk factors. CMS is not finalizing this proposal and will continue with its current methodology in 2010.
- In the proposed rule CMS assigned a zero payment to several codes for malpractice due to rounding. In this final rule CMS agreed with commenters that all services have some level of malpractice risk and that it would be inappropriate for services to receive zero payment for malpractice due to rounding. These services will be changed to 0.01 malpractice RVUs for CY 2010.

Geographic Practice Cost Indices (GPCIs)

1.0 Work GPCI Floor

» **The 1.0 work GPCI floor will expire on December 31, 2009.**

Geographic Practice Cost Indices (GPCIs) measure resource cost differences among localities compared to the national average for each of the three fee schedule components (work, PE, and malpractice).

A 1.0 work GPCI floor was enacted and implemented for CY 2006 and was set to expire on June 30, 2008. Section 134 of the Medicare Improvements for Patients and Providers Act (MIPPA) extended the 1.0 work GPCI floor from July 1, 2008 through December 31, 2009. As a result, 54 (out of 89) physician fee schedule localities will receive a decrease in their work GPCI. Puerto Rico receives the largest decrease (-9.6 percent), followed by South Dakota (-5.8 percent), North Dakota (-5.3 percent), rest of Missouri (-5.1 percent), and Montana (-5.0 percent).

Several commenters urged CMS to make the 1.0 work GPCI floor permanent. CMS stated that the Agency does not have the authority to extend this provision beyond December 31, 2009.

Five Year Review Refinement of Relative Value Units

CMS is required by law to review all RVUs no less than every five years. The first five year review was initiated in 1994 and refinements went into effect in 1997. The second Five-Year Review of physician work RVUs began in 1999 and refinements went into effect beginning in CY 2002. The third five-year review of the physician work RVUs began in CY 2004 with the resulting changes being effective beginning in 2007. After the last five year review CMS immediately began working with the AMA RVS Update Committee (RUC) to review potentially misvalued codes on an ongoing basis as opposed to waiting for the next five year review.

Fourth Five-Year Review of Work RVUs

» **CMS initiates the fourth five year review of work RVUs with the resulting changes being effective beginning in 2012.**

In this final rule CMS announced the its initiation of the fourth five-year review of work RVUs. The Agency is soliciting comments on services for which the currently assigned work RVUs may be inappropriate. CMS will accept comments until December 29, 2009.

As part of this process CMS will also identify codes for review by the AMA RUC as well. In identifying codes for review CMS will consider two factors: 1) codes that were originally valued as being performed in the inpatient environment but are now being performed in the outpatient environment and 2) codes that have not previously been reviewed by the RUC. The existence of a possible rank order anomaly (i.e. code A that is more physician work is valued less than code B) will not be the primary basis for undertaking the review of a code as it has been in previous five-year review. However, rank order anomalies will continue to be used as a way to screen for potential problem areas. Codes that have been reviewed/revised under the potentially misvalued code initiative may also be considered for review under the five-year review of work RVUs.

CMS will review all comments received and forward codes to the AMA RUC. In order to maintain relativity, CMS may decide to submit the entire family of codes (including the base code) for review. The AMA RUC will use its standard survey process to review work RVU values. CMS has noted that to gain a better understanding of the distribution of data from surveys and other data sources submitted in support of work RVU refinements, CMS will require that the minimum/maximum values, the 5th, 25th, 50th (median), 75th, and 95th percentiles be reported and the geometric mean. This list is similar but slightly expanded to what is typically reported in the RUC survey process.

The AMA will forward its recommendations to the Agency. The Agency will respond to the recommendations and announce any changes in valuations through the notice and rulemaking process. CMS intends to publish this notice in the spring of 2011. The changes would be effective January 1, 2012.

The AMA RUC has established standards that must be met in order to request a change in valuation. These standards are referred to as compelling evidence standards. CMS listed these standards in the final rule for informational purposes.

AMA Standards of Compelling Evidence

- Documentation in the peer reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following Technique.
 - Knowledge and technology.
 - Patient population.
 - Site-of-service.
 - Length of hospital stay.
 - Physician time.
- An anomalous relationship between the code being proposed for review and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower.
- Evidence that technology has changed physician work, that is, diffusion of technology.
- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.
- Evidence that incorrect assumptions were made in the previous valuation of the service

Five-Year Review of PE RVUs

» CMS solicits comments for five-year review of PE RVUs.

The next five-year review of PE RVUs will be addressed in CY 2014 and CMS is soliciting comments on approaches to take for this next five-year review of PE RVUs. However, to the extent that there are changes in physician time or in the number or level of post procedure visits as a result of the fourth five-year review of work, there will be a potential impact on the practice expense inputs, and CMS will revise the inputs accordingly.

CPT Code Changes

Consultation Services

» CMS will budget neutrally eliminate the use of all consultation codes. CMS will establish three G-codes to describe initial inpatient consultations approved for telehealth to preserve the ability of providers to bill for initial inpatient consultations delivered via telehealth.

A consultation service is an evaluation and management (E/M) service furnished by a physician or qualified NPP at the request of another physician or appropriate source. The payment for a consultation has been set higher than for an initial visit because a written report must be made to the requesting professional. CMS stated in the proposed rule and reiterated in the final rule that they believe the rationale for differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services.

This policy change will entail the following:

- CMS will budget neutrally eliminate the use of all consultation codes, except for telehealth consultation services.
- Providers are instructed to bill an initial or if appropriate established visit code (office, hospital, or nursing facility) in lieu of a consultation code.
- In order to maintain budget neutrality, CMS will increase the work RVUs for the new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE and malpractice RVU calculations.
- Because major surgery codes (10-day or 90-day) include bundled payment for related post-operative visits, CMS will increase payments for these services in order to account for the increase in the value of the visits that are incorporated into these bundles.
- In order to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth, CMS has created three G codes (G0425, G0426, and G0427) specific to the telehealth delivery of initial inpatient consultations.
- CMS will create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. This modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care.

Payment for Initial Preventive Physical Examination (IPPE)

» CMS will increase the work RVUs for the IPPE.

The IPPE is reported with code G0402 and is valued at 1.34 work RVUs in 2009. For CY 2010 CMS will increase the work RVUs for this service to 2.30 work RVUs. This value was crosswalked from code 99204, Evaluation and management new patient, office or other outpatient visit. Based on analysis of the work and intensity, CMS concluded the IPPE is most similar to code 99204.

Potentially Misvalued Services Under the Physician Fee Schedule

» **CMS accepts AMA RUC recommendation on 113 codes that were identified as potentially misvalued.**

The AMA RVS Update Committee (RUC) reviewed a number of potentially misvalued codes through their Five Year Review Workgroup at the February and April 2009 meetings. CMS accepted the recommendations submitted by the RUC and has established interim values for these codes with the exception of one speech language code that was impacted by a provision in recent Medicare legislation.

CMS also noted that they will continue to consider other issues related to the potential misvaluation of services under the physician fee schedule that was raised in the proposed rule. These issues include:

- Updating prices for high cost supplies.
- Nonsurgical CPT codes that are often billed together.
- Creation of a group of experts separate from the AMA RUC to help the Agency improve the review of relative values.

Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services

Section 135 of MIPPA requires advanced diagnostic imaging service suppliers to be accredited by an accreditation organization (AO) by January 1, 2012. Payment for the technical component (TC) of the service is contingent upon the supplier being accredited by an accreditation organization designated by the Secretary. For the purposes of this policy, advanced diagnostic imaging services include: diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography.

» **This rule sets forth the criteria for designating organizations to accredit suppliers. CMS separately published a notice to solicit applications from entities interested in becoming an accredited organization (AO).**

In this final rule CMS is finalizing the accreditation provisions:

- Clarifying that the—
 - Medical directors and supervising physicians are equivalent positions;
 - Equipment used by the supplier must performance specifications;
 - AOs may maintain or adopt standards that are more stringent than those of Medicare;
 - The AOs are required to notify Medicare of the accreditation decision of those suppliers billing Medicare
 - Accreditation requirement does not apply to hospitals; and AO only needs to notify CMS for significant changes from what was approved on the AO's initial approved application.
- Including a requirement that a supplier must assist the beneficiary in obtaining his/her medical records if he/she requests.
- Including a requirement that the supplier must notify the AO of any subsequent changes to the modalities being offered since the accreditation decision was made.
- Clarifying that AOs must respond to complaints from any source with respect to an accredited supplier.
- Changing the regulations text to require that an AO notify CMS of any supplier deficiency putting Medicare beneficiaries in immediate jeopardy within 2 business days (previously 2 calendar days).

- Confirming that when a designated accrediting organization has its deeming authority withdrawn, CMS and the remaining AOs will work together in a collaborative effort to distribute suppliers affected by such withdrawal amongst other accreditations organizations within a reasonable time period.

Physician Self-Referral

The physician self-referral law prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a direct or indirect financial relationship. The statute establishes a number of exceptions. Determining if this direct or indirect relationship is critical to determining when this law applies.

Stands in the Shoes Provision

» CMS clarifies an aspect of the "stands in the shoes" provisions of the Stark self-referral regulations

The physician self-referral law prohibits a physician from making referral for certain designated health services (DHS) payable to Medicare to an entity with which he or she (or an immediate family member) has a direct or indirect financial relationship, unless an exception applies. The statute establishes a number of exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that pose no risk of program or patient abuse.

Phase III of Stark, which was published on September 5, 2007, stated that all referring physicians will be treated as standing in the shoes of their physician organizations for purposes of applying the rules that describe direct and indirect compensation arrangements. CMS designed this definition because of concerns that some were construing the definition of indirect compensation too narrowly.

In this final rule CMS is clarifying an application of certain exceptions to arrangements in which a physician stands in the shoes of his or her physician organization. To stand in the shoes the physician would be considered to have the same compensation arrangements as the physician organization in whose shoes the referring physician stands. A physician who has ownership or investment interest in a physician organization is deemed (or required) by Medicare to stand in the shoes of his or her physician organization. Physicians with only a titular ownership interest (that is, physicians without the ability or right to receive the financial benefits if ownership or investment, including but not limited to, the distribution of profits, dividends, proceeds of sale, or similar return in investments) are not deemed to stand in the shoes of their physician organizations.

Physician Quality Reporting Initiative (PQRI)

The Physician Quality Reporting Initiative (PQRI) was authorized by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007. In 2009 participating professionals were eligible for a bonus of 2.0 percent of the estimated total allowed charges for all covered professional services furnished during the reporting period. Providers report either individual measures or a measure group through a variety of reporting mechanisms. In 2010 the Secretary is once again authorized to provide an incentive payment equal to 2.0 percent of the estimated total allowed charges for all covered professional services during the reporting period.

» Changes for the PQRI Program in 2010

CMS announced a number of changes to the 2010 PQRI program.

- Group practice – For the first time group practices will be able participate in the PQRI program. A group practice is defined as at least 200 or more individual eligible professionals. Group practices would be required to report for a 12 month period and will be required to submit

information on their measures using a data collection tool based on the data collection tool used in CMS' Medicare Care Management Performance (MCMP) demonstration and the Physician Group Practice (PGP) demonstration. Group practices would be required to report on a common set of 26 NQF-endorsed quality measures that are based on measures currently used in the MCMP and/or PGP demonstration. Similar to previous demonstration projects, the group practice will be required to report on beneficiaries assigned by Medicare to the group practice.

- Electronic Health Record Reporting - For 2010 CMS will add a third reporting mechanism, electronic health record (EHR) for a limited subset of measures. This proposal is contingent upon the successful completion of the 2009 EHR data submission testing process.
- Alternative Reporting Period Established for Claims-Based Reporting – The standard reporting period is 12 months. In previous years an alternative 6-month reporting was established for registry-based reporting and participants who report measure groups. In 2010 for the first time the alternative 6-month reporting period will be available to individuals reporting via the claims-based method.
- Quarterly Error Report – CMS will publish an aggregate level error report on a quarterly basis as a means of providing more timely feedback to providers.

» Reporting methods, criteria for successful reporting, measures and other details of the 2010

PQRI Program

For the 2010 program, participants have three reporting methods available to them: claims-based reporting, registry reporting, and electronic health record (EHR)-based reporting. Table 7 in the final rule summarizes the criteria for successful reporting and the reporting periods for the different reporting mechanisms. In addition to reporting individual measures, participants can also report a preselected group of measures. The specific groups have been identified by CMS. Table 8 in the final rule summarizes the methods of reporting, criteria for successful reporting and the different reporting periods for reporting measure groups.

The 2010 PQRI program will include 175 individual measures. This includes 30 new measures for 2010 program. Four measures from the 2009 program have been retired.

2009 Measures Retired

- Measure #11 - Stroke and Stroke Rehabilitation: Carotid Imaging Reporting
- Measure #34 - Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (tPA) Considered
- Measure #95 - Otitis Media with Effusion (OME): Hearing Testing
- Measure #152 - Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD

Twenty-six measures have been identified as registry-only reporting measures. This means that participants who report measures through claims will not be able to report these measures. CMS does not guarantee that there will be a registry available to participants to report these measures. Measures are typically identified as registry-only measures due to some level of complexity in the measure. Ten measures have been selected as available for EHR-based reporting.

CMS has also identified thirteen measure groups for the 2010 program. Seven of the groups are being retained from last year and six new measure groups have been finalized for 2010.

2010 Measure Groups

- Diabetes Mellitus
- CKD
- Preventive Care

- CABG;
- Rheumatoid Arthritis
- Perioperative Care
- Back Pain
- Coronary Artery Disease (CAD)*
- Heart Failure*
- Ischemic Vascular Disease (IVD)*
- Hepatitis C – new for 2010
- Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)*
- Community Acquired Pneumonia (CAP)*

* New measure group for 2010

Neurology Measures for the 2010 PQRI Program

The following neurology-related measures have been approved for the 2010 PQRI program.

Measure Number	Measure Title
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy
33 (registry reporting only)	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia
36	Stroke and Stroke Rehabilitation: Consideration for Rehabilitation Services
NA (new for 2010)	Stenosis Measurement in Carotid Imaging Studies

In addition to the neurology-specific measures, CMS is retaining the 2009 HIT measure # 24: Adoption/Use of Electronic Health Records (EHR).

The 2010 measure specifications document, which provides guidance on the appropriate definition and reporting of the measures, will be posted on the CMS website no later than December 31, 2009.

E-Prescribing Incentive Program

2010 will be the second year of the MIPPA authorized E-prescribing incentive program. The program uses a mix of carrots and sticks to encourage participation. Successful participants will be eligible for the following bonus payments: 2% in 2010; 1% in 2011; 1% in 2012; and, 0.5% in 2013. In order to be eligible for the program, the e-prescribing quality measure must apply to at least 10 percent of the professional’s total Part B allowed charges. Eligible participants who are not successful or do not participate will face the following reductions to their Medicare payments: -1% in 2012; -1.5% in 2013; and -2.0% in 2014 and each subsequent year. CMS will report publicly the names of eligible professionals who are successful electronic prescribers. The Recovery Act specifies that an individual provider or group providers is not eligible to receive the incentive if, for the EHR reporting period, the eligible professional earns an incentive payment under the new Health Information Technology (HIT) incentive program authorized under the Recovery Act.

» CMS announces changes for the 2010 E-prescribing program.

- CMS will expand the scope of the program to include professional services outside of the professional office and outpatient setting. The expanded codes include skilled nursing facilities and in the home care setting.
- CMS will also expand the program creating a group practice option. However, in order for a group practice to participate one of the requirements is that the group practice must be one that is

selected to participate in the PQRI group practice reporting option. The group practice will be required to report the 2010 electronic prescribing measure at least 2,500 times during the reporting period to be considered successful.

- To be considered a successful prescriber, eligible professionals need only to report 25 separate electronic prescribing events during the reporting period. In 2009 participants were required to report measure at least 50% of the time to be considered successful
- For 2010, in addition to the current claims-based reporting mechanism, electronic prescribers will be allowed to report the e-prescribing measure through qualified registries or through a qualified EHR product. Only registries and EHR products that qualify for the 2010 PQRI and have the capability to report the e-prescribing measure will be qualified for submitting data on the e-prescribing measure for 2010.
- Participants will be required to submit one G-code: GXXX, At least 1 prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system. This is a reduction from the 2009 program that included 3 G-codes.

CMS did note that if they can at some point rely on Part D data, they anticipate no longer needing eligible professionals to submit data on their electronic prescribing activities.

Physician Resource Use Measurement and Reporting Program

As required by MIPPA, in 2009 CMS established and implemented a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback to physicians that measure resources involved in furnishing care to Medicare beneficiaries. CMS is implementing this program in a phased-in approach. Phase I which consisted of the dissemination of an approximately 50-page report on resource use related to specific conditions to a select number of physicians was completed earlier this year.

» CMS announces changes to the Physician Resource Use Measurement and Reporting Program.

In the proposed rule CMS solicited comments on the program. Based on feedback received CMS is finalizing the following changes:

- Selected conditions for Phase I were: congestive heart failure, chronic obstructive pulmonary disease, prostate cancer, cholecystitis, coronary artery disease with acute myocardial infarction, hip fracture, community acquired pneumonia, and urinary tract infection. CMS will add diabetes to the list of conditions for the 2010 program.
- Phase I of the program disseminated reports to individual physicians. In 2010, CMS will add reporting to a group of physicians. Group reporting will be defined as more than one physician practicing medicine together. In addition to organized group practices, groups could include physicians who practice within the same practice, facility, or geographic area.

Physician Value Based Purchasing (PVBP) Program

Currently, Medicare health professional payments are based on the quantity of services or procedures provided, without recognition of quality or efficiency. MIPPA requires the Secretary to develop a value-based purchasing (VBP) program for Medicare payment for professional services paid under the physician fee schedule. By May 1, 2010 the Secretary shall submit a report to Congress containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

While the Agency did not finalize any proposals in this rule, they did provide an update on their activities in this area and responded to public comments. The Agency has created an internal cross-component team, the PVBP Steering Committee to lead development of the PVBP plan. Four subgroups were established to address the major sections of the plan: measures; incentives; data strategy and infrastructure; and public reporting. The steering committee has identified its goal as one to improve

Medicare beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services.

The steering committee has begun to develop potential recommendations for inclusion in the Report to Congress. Consideration will be given to approaches that:

- Overlay the current physician fee schedule, such as differential fee schedule payments based on measure performance
- Address multiple levels of accountability, including individual health professional, as well as larger care teams or organizations made up of a variety of health professionals and facilities
- Promote more integrated care through shared savings models and bundled payment arrangements

Two issues the steering committee is considering for the PVBP plan is 1) whether to reward eligible professionals for performance, and not merely participation and 2) whether to recommend paying incentives for attainment, improvement, or both.

Other Miscellaneous Issues

Part B Drugs

» CMS adopts standard for MIPPA requirement of publically transparent evaluation process and conflict of interest process for statutorily named compendia.

Medicare has designated compendia that are authoritative sources for use in the determination of "medically-accepted indication" of drugs and biologicals used off-label in an anticancer chemotherapeutic regimen. MIPPA requires that on or after January 1, 2010 no compendia may be included on the list of compendia unless it has a publically transparent process for evaluating therapies and for identifying potential conflicts of interest.

In this final rule CMS revises the definition of compendium to add a requirement that a compendium have a publicly transparent process for evaluating therapies and for identifying conflicts of interests. The Agency has also defined a publicly transparent process for evaluating therapies and for identifying conflicts of interests.

Publicly Transparent Evaluation Process

Publicly transparent process for evaluating therapies means that the process provides that the following information from an internal or external request for inclusion of a therapy in a compendium are available to the public for a period of not less than 5 years, which includes availability on the compendium's web site for a period of not less than 3 years, coincident with the compendium's publication of the related recommendation:

- The internal or external request for listing of a therapy recommendation including criteria used to evaluate the request.
- A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the request.
- A listing of all individuals who have substantively participated in the review or disposition of the request.
- Minutes and voting records of meetings for the review and disposition of the request.

Publicly Transparent Conflict of Interests Process

Publicly transparent process for identifying potential conflicts of interests means that the process provides that the following information is identified and made timely available in response to a public request for a period of not less than 5 years, coincident with the compendium's publication of the related recommendation:

- Direct or indirect financial relationships that exist between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium.
- Ownership or investment interests between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium.

Miscellaneous Part B Drug Issues

The rule also reviewed details regarding some technical issues related to the widely available market price (WAMP) and average manufacturer price (AMP).

Telehealth Services

» CMS has made additions and revisions to its list of approved telehealth services.

For CY 2010 CMS has finalized the following additions to the list of approved Medicare telehealth services:

- Individual health and behavior assessment codes 96150-96152.
- Revision to G-codes for follow-up inpatient telehealth consultations, codes G0406-G0408 to include follow-up telehealth consultations furnished to beneficiaries in hospitals and skilled nursing facilities (SNFs).

Outpatient Mental Health Treatment

» CMS outlines plan to begin implementation of MIPPA provision to phase out the difference in coinsurance between mental health services and most other services.

Under current law, Medicare imposes a coinsurance rate of 50 percent for outpatient mental health services, as compared to 20 percent for most other services. A provision in MIPPA phases down Medicare's coinsurance for outpatient mental health services to the 20 percent rate over a five year period, beginning in 2010. When this policy is fully implemented in 2014, Medicare will pay for outpatient mental health services at the same level as other Part B services.

These impacts are prior to the application of the CY 2010 negative PFS CF update under the current statute.

- Combined impact of all of the estimated CY 2010 RVU changes under the 4-year transition (Tran) adopted in this final rule with comment period for the PE changes. These are the estimated CY 2010 impacts, prior to the application of the CY 2010 negative PFS CF update under the current statute.

TABLE 49: CY 2010 Total Allowed Charge Impact for Work, Practice Expense, and Malpractice Changes*

	(A) Specialty	(B) Allowed Charges (mil \$)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes**		(E) Impact of MP RVU Changes	(F) Combined Impact	
				Full	Tran		Full	Tran
1	TOTAL	77,796	0%	0%	0%	0%	0%	0%
2	ALLERGY/IMMUNOLOGY	173	0%	-1%	0%	0%	-2%	0%
3	ANESTHESIOLOGY	1,744	0%	4%	1%	0%	3%	0%
4	CARDIAC SURGERY	373	-1%	-1%	0%	2%	1%	1%
5	CARDIOLOGY	7,158	-1%	-10%	-5%	-1%	-13%	-8%
6	COLON AND RECTAL SURGERY	130	-1%	4%	1%	1%	4%	1%
7	CRITICAL CARE	223	-1%	2%	1%	1%	3%	1%
8	DERMATOLOGY	2,520	1%	1%	1%	1%	3%	3%
9	EMERGENCY MEDICINE	2,416	0%	2%	1%	0%	3%	1%
10	ENDOCRINOLOGY	374	-1%	3%	0%	0%	2%	0%
11	FAMILY PRACTICE	5,094	2%	5%	2%	1%	7%	4%
12	GASTROENTEROLOGY	1,792	-2%	0%	0%	1%	0%	-1%
13	GENERAL PRACTICE	727	1%	4%	1%	0%	6%	3%
14	GENERAL SURGERY	2,227	-1%	3%	1%	1%	4%	1%
15	GERIATRICS	170	1%	6%	2%	1%	8%	3%
16	HAND SURGERY	89	-1%	3%	1%	-1%	2%	-1%
17	HEMATOLOGY/ONCOLOGY	1,897	0%	-5%	-1%	0%	-6%	-1%
18	INFECTIOUS DISEASE	554	-1%	3%	0%	1%	3%	0%
19	INTERNAL MEDICINE	10,133	1%	4%	1%	1%	5%	2%
20	INTERVENTIONAL PAIN MANAGE	356	-2%	3%	-1%	0%	0%	-3%
21	INTERVENTIONAL RADIOLOGY	225	-1%	-9%	-2%	0%	-10%	-3%
22	NEPHROLOGY	1,803	-1%	2%	0%	1%	2%	1%
23	NEUROLOGY	1,414	-3%	4%	1%	0%	1%	-2%
24	NEUROSURGERY	591	-1%	2%	0%	0%	1%	-1%
25	NUCLEAR MEDICINE	74	-5%	-15%	-10%	-2%	-23%	-18%
26	OBSTETRICS/GYNECOLOGY	624	0%	0%	-1%	0%	0%	-1%
27	OPHTHALMOLOGY	4,758	0%	11%	3%	2%	13%	5%
28	ORTHOPEDIC SURGERY	3,261	0%	3%	1%	-1%	2%	0%
29	OTOLARNGOLOGY	933	-1%	1%	-1%	0%	0%	-2%
30	PATHOLOGY	994	0%	-1%	1%	-1%	-3%	-1%
31	PEDIATRICS	65	1%	3%	1%	0%	4%	2%
32	PHYSICAL MEDICINE	824	-1%	6%	2%	0%	5%	1%

	(A)	(B)	(C)	(D)		(E)	(F)	(G)		(H)
	Specialty	Allowed Charges (mil \$)	Impact of Work RVU Changes	Impact of PE RVU Changes**		Tran	Impact of MP RVU Changes	Combined Impact		
				Full	Tran			Full	Tran	
33	PLASTIC SURGERY	284	0%	4%	1%		1%	5%	2%	
34	PSYCHIATRY	1,095	0%	2%	1%		1%	3%	2%	
35	PULMONARY DISEASE	1,765	-1%	2%	0%		1%	2%	0%	
36	RADIATION ONCOLOGY	1,809	0%	-3%	0%		-2%	-5%	-1%	
37	RADIOLOGY	5,056	0%	-14%	-3%		-2%	-16%	-5%	
38	RHEUMATOLOGY	493	0%	-1%	0%		0%	-2%	-1%	
39	THORACIC SURGERY	389	-1%	0%	0%		2%	1%	1%	
40	UROLOGY	1,993	-1%	-8%	-3%		0%	-10%	-4%	
41	VASCULAR SURGERY	656	-1%	-3%	-2%		0%	-3%	-2%	
42	AUDIOLOGIST	36	-1%	-16%	-9%		-7%	-23%	-17%	
43	CHIROPRACTOR	713	0%	3%	1%		1%	4%	2%	
44	CLINICAL PSYCHOLOGIST	544	0%	-8%	-2%		0%	-8%	-2%	
45	CLINICAL SOCIAL WORKER	362	0%	-7%	-1%		0%	-7%	-1%	
46	NURSE ANESTHETIST	681	0%	4%	1%		0%	4%	1%	
47	NURSE PRACTITIONER	1,018	1%	5%	1%		1%	6%	3%	
48	OPTOMETRY	848	1%	10%	3%		1%	12%	5%	
49	ORAL/MAXILLOFACIAL SURGERY	36	-1%	4%	1%		0%	3%	0%	
50	PHYSICAL/OCCUPATIONAL THERAPY	1,883	0%	9%	3%		-1%	8%	2%	
51	PHYSICIAN ASSISTANT	757	0%	4%	1%		0%	5%	2%	
52	PODIATRY	1,682	1%	6%	2%		-1%	6%	2%	
53	DIAGNOSTIC TESTING FACILITY	923	-1%	-29%	-7%		-4%	-34%	-12%	
54	INDEPENDENT LABORATORY	970	0%	-5%	0%		-1%	-7%	-1%	
55	PORTABLE X-RAY SUPPLIER	87	0%	8%	3%		-1%	7%	2%	

* Does not include the impact of the current statute CY 2010 negative update except as applied in the OPSS imaging cap comparison (see next footnote). Rows may not sum to total due to rounding.

** Note: The statute caps the PFS imaging payment amount at the comparable payment amount in the hospital outpatient prospective payment system (OPSS) cap. In the absence of the negative current statute CY 2010 PFS update, the proposed fully implemented PE change to the equipment utilization rate for expensive diagnostic equipment from 50 percent to 90 percent would increase expenditures by less than 1 percent due to a loss of savings from the OPSS cap.