



**MEDICARE PHYSICIAN FEE SCHEDULE FINAL RULE
HIGHLIGHTS FOR CALENDAR YEAR 2010**

The American Medical Group Association (AMGA) submitted comments to the Centers for Medicare and Medicaid Services (CMS) on selected provisions of the proposed Medicare Physician Fee Schedule rule on August 31, 2009. On Friday, October 30, 2009, the final rule with payment and policy updates for calendar year 2010 was put on display at the Office of the Federal Register. While in previous years Congress has taken action to block payment cuts to physicians and other providers paid under the fee schedule, in 2010 payments will decrease by 21.2 percent if Congress does not act to avert this reduction.

A summary of AMGA comments and the CMS responses to them follows in the paragraphs below. The final rule will be published in the Federal Register on November 25, 2009. In the meantime, to link to the final rule, visit the [Office of the Federal Register website](#).

Equipment Usage Rate Assumption

Issue: CMS proposed to change the usage rate assumption in its practice expense relative value unit computations (PE/RVUs) for equipment priced over \$1 million, based on a Medicare Payment Advisory Council (MedPAC) review of data from six markets around the country. The change would increase the usage rate assumption from 50 percent to 90 percent.

Recommendation: AMGA comments strongly urged CMS to withdraw this change in the usage rate assumption until it could obtain, study, and apply more statistically valid data, since the MedPAC study was based on only six markets. We argued that the payment consequences of such a change could result in limiting access to patients for these services.

Outcome: CMS finalized its proposal to increase the utilization rate assumption for magnetic resonance imaging (MRI) and for computed tomography (CT), with a four year transition to the new PE RVU's, citing MedPAC's comment letter which states that the decrease in PE RVUs for expensive diagnostic imaging services should not affect access to care in rural areas, and their belief that physicians and suppliers would not typically make such significant capital investments in equipment that would only be utilized about half the time.

Elimination of Consultation Codes

Issue: CMS proposed to eliminate consultation codes, except for those used in the delivery of telehealth consultations, due to longstanding confusion about proper documentation of these codes. Differences between Medicare guidelines and American Medical Association Current Procedural Terminology (AMA

CPT) guidelines have been a source of confusion for many years. The proposal would increase the work RVUs for new and established office visits by approximately 6 percent and the work RVUs for initial hospital and facility visits by approximately 2 percent to reflect the elimination of the consultation codes for these settings.

Recommendation: AMGA recommended that CMS keep consultation codes as written, and, instead, make its documentation requirements consistent with those of CPT, and concurrently increase education and outreach to the physician community. We cited the impact of the policy changes for 2010 on the various specialties, and that redistribution, although putatively budget neutral in its outcome, would not be fairly distributed among specialties, with some taking larger reductions in payment for these services.

Outcome: CMS has chosen to finalize its proposals to eliminate the consultation codes.

EHR Reporting Option for the Physician Quality Reporting Initiative (PQRI) Program

Issue: CMS proposed to finalize the EHR-based reporting mechanism for the 2010 PQRI program in order to begin to accept data from qualified EHR systems on a subset of measures for common chronic illnesses and preventive services. Qualified EHR's are those that successfully completed the 2009 EHR Testing Program. CMS also stated that they will begin a transition away from claims-based reporting in the PQRI program in the future.

Recommendation: AMGA strongly supported the CMS proposal to finalize the EHR-based reporting option for the PQRI program, given the difficulty of submitting data through claims-based reporting methods. AMGA also expressed support for the PQRI program requirements to progress to electronic means of reporting rather than to rely on claims-based reporting.

Outcome: CMS finalized its proposal to accept EHR-based reporting from a qualified EHR system on a subset of measures for common chronic illnesses and preventive services and reiterated their plan to gradually transition the PQRI program toward electronic reporting either through qualified EHR systems or registries.

PQRI Group Practice Reporting Option

Issue: As required by the Medicare Improvements for Patients and Providers of 2008 (MIPPA), CMS issued proposals for the implementation of the new group practice-specific Physician Quality Reporting Initiative (PQRI). It based the methodology for the program on the Physician Group Practice Demonstration (PGP Demo). Use of the PGP Demo methodology will limit the number of group practice participants because of the requirement for the group to have 200 eligible professionals, in addition to other operational difficulties presented by this methodology.

Recommendation: AMGA provided a substantial number of comments to CMS on its proposal to utilize the PGP Demo methodology for the new PQRI group reporting option. Among the issues is the requirement for group practice participants to have 200 eligible professionals to qualify, the use of a retrospective attribution methodology for the patient sample, and the number of measures that groups

would have to report on the very first year. AMGA recommended that CMS reconsider the requirement for medical groups to have 200 or more eligible professionals, given that this was not justified by the statutory language establishing the program and would serve only to limit participation. We also suggested that prospective attribution of the patient populations be used, but that if CMS opted to maintain retrospective attribution, that it be refined to ensure the accuracy by: 1) use of claims that have the CPT code for “established” patients only, 2) use of claims that show the place of service code 11 (the code for office visits), and 3) a requirements that the patients in the sample have at least two office visits during the year in order to get into the sample. Lastly, AMGA suggested a gradual phasing to reporting on the proposed 26 measures since this magnitude of reporting would be difficult if not impossible in the first year of participation.

Outcome: CMS is finalizing its proposal to use the PGP Demo methodology, without the suggested refinements, for the 2010 PQRI group reporting option. CMS cited its desire to purposely limit the number of participants in the program to allow it to gain experience before expanding participation. Language in the final rule states, however, that CMS will assign patients to a group practice only if they receive the plurality of their office or other outpatient evaluation and management (E/M) services from the practice and have had at least two E/M services from the practice in the 10-month period evaluated by CMS for assignment to the sample. CMS will use 2010, the initial implementation year, to further develop and refine aspects of the group practice reporting option, and anticipates adapting and expanding this option to group practices with fewer than 200 eligible professionals in the future.

MedPAC Recommendation to Establish a Separate Panel of Experts to Review Relative Value Units

Issue: The Medicare Payment Advisory Commission (MedPAC) reported to Congress a number of recommendations to CMS to improve the review of the relative values for physician fee schedule services. In response, CMS proposed to establish a panel of experts, separate from the AMA RUC, to help improve the review of relative values.

Recommendation: AMGA took the position that since the current partnership between CMS and the AMA RUC has been successful and that steps being taken to address the identification of misvalued codes are already underway, no separate panel need be established.

Outcome: Based on the comments received from AMGA and others, is holding action in abeyance as it continues to evaluate comments and explore this issue.

Resource Based Practice Expense (PE) Relative Value Units (RVUs) Physician Practice Information Survey (PPIS)

Issue: CMS proposed to update the practice expense (PE) per hour data in its PE/RVU methodology and to rely on data from the Physician Practice Information Survey (PPIS), rather than the previously used information from the AMA Socioeconomic Monitoring System (SMS) and supplemental survey data provided by some specialty societies.

Recommendation: AMGA supported the CMS proposal to move forward with using PPIS data. SMS and supplemental survey data previously used was outmoded. MedPAC, and many others, have called for use of the most currently available practice expense data. Since the PPIS followed SMS formulations, included almost all medical specialty information, and was current, AMGA supported the use of PPIS survey data by CMS.

Outcome: CMS agreed and will use PPIS data.

Miscellaneous Provisions

--CMS finalized its proposal to remove drugs from the sustainable growth rate calculation, retrospectively to the 1996/1997 base year, which will provide \$122 billion to funding for physician services over ten years.

--CMS finalized its proposal to require reporting of one e-prescribing measure rather than 3 for 2010. The e-prescribing measure can be submitted through one of these three methods: claims, a qualified registry, or a qualified EHR product. The list of denominator codes for 2010 has also been expanded to include: 99324 through 99328, 99334 through 99337 and 99346. CMS will issue the final specifications, including qualified registries, by December 31, 2009 on their website at:
<http://www.cms.hhs.gov/ERXIncentive>.

--CMS finalized its proposal to increase the relative value for the "Welcome to Medicare" visit. The work value for this service will increase from 1.34 to 2.30.