



MEDICARE PHYSICIAN FEE SCHEDULE FINAL RULE HIGHLIGHTS FOR CALENDAR YEAR 2009

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 29, 2008. On Friday, October 31, 2008, CMS put on display its final rule with payment and policy updates for calendar year 2009. Payments to physicians in 2009 will increase by 1.1 percent, however, due to the complex formula used to determine payments in Medicare, it is possible that this increase may not be uniformly evident in reimbursements (see related document on payment variables).

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 19, 2008. CMS will accept comments on the provisions of this final rule until December 29, 2008. To link to the final rule, and information on comment submission, visit the [CMS website](#).

Independent Diagnostic Testing Facility (IDTF) Issues

Issue: The IDTF provisions in the proposed rule would have applied the operating standards for IDTFs to physician organizations, with some minor exceptions. CMS' rationale was founded on the assumption that physician groups are enrolling as participants in Medicare as group practices to circumvent the performance standards for IDTFs. In addition, CMS has concerns about the quality of testing being performed in physician offices.

Recommendation: AMGA comments stated that there was no basis for CMS' assumptions regarding imaging in doctors' offices. In the proposed rule, CMS goes so far as to exempt physician group practices from several of the standards because they meet or exceed them in several areas. AMGA also recommended that CMS focus on the impending implementation of the requirement found in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) that calls for all facilities providing advanced diagnostic imaging services to become accredited, beginning in January of 2012.

Outcome: CMS concurred with AMGA's recommendation and is deferring the implementation of this proposal due to the enactment of the MIPPA provision and CMS plans continued review of public comments with respect to IDTF standards.

Physician Self-Referral and Anti-Markup Issues

Issue: CMS proposed two alternatives to refine the current anti-markup provisions (AMPs). In the first proposal, a physician practice would be subject to the AMP if the diagnostic test is purchased, or if the professional component or supervision of the technical component is not

done by a physician who “shares a practice,” i.e. works solely for one practice. The second alternative requires that substantially the full range of services be provided in the same building of the ordering physician, which could be difficult for medical groups that have several buildings on a single campus, with a separate building devoted to radiology.

Recommendation: AMGA recommended that CMS reword the second alternative to accommodate practices that have campuses, i.e. several buildings on the same grounds. AMGA also recommended that CMS provide an exemption, based on merit, which would carve-out large, multi-specialty medical groups, and other organized systems of care, from both the AMP alternatives and IDTF provisions in the proposed rule. We argued that the risk for inappropriate actions by our members is outweighed by the desirable attributes of multi-specialty medical groups and the growing body of evidence that suggests AMGA member groups distinguish themselves in the provision of high-quality and efficient patient care, including the results of the CMS Physician Group Practice Demonstration project. We enumerated the guiding principles and criteria for entities that would qualify for such merit exemptions.

Outcome: CMS is not establishing a separate exception to the AMPs for multi-specialty medical groups based on merit. CMS notes that since they are adopting a modification to the AMPs whereby the AMP will not apply to the technical and professional components of services supervised or performed by a physician who performs “substantially all,” defined as at least 75 percent of his or her professional services within that practice, that no additional exceptions will be made. CMS also retained the second alternative whereby substantially the full range of services be provided in the same building of the ordering physician. “Same building” is defined in regulation as “a structure with, or combination of structures that share a single street address as assigned by the U.S. Postal Service, excluding all exterior spaces and interior loading docks or parking garages.” CMS states that both alternatives provide viable options for multi-specialty medical groups.

Physician Quality Reporting Initiative (PQRI)

Issue: In the proposed rule, CMS stated that it was considering electronic health record (EHR)-based submission on a subset of quality measures for 2009, and expansion of the number of measures groups.

Recommendation: AMGA expressed strong support for the possibility of EHR-based submission of a subset of quality measures for 2009. We also expressed our support for the expansion of measures groups that focus on high-cost, high-volume disease states. We explained that claims-based reporting of quality measures has always presented a barrier to participation in the PQRI program for many medical groups in many cases, due to existing EHR systems that are sophisticated and often proprietary. Given that multi-specialty medical groups function as a single entity, measurement should be conducted as a single entity.

Outcome: Although CMS anticipated being able to complete the testing process and begin accepting EHR data submission in 2009, the testing process is presently incomplete and they will not begin EHR submission as part of the PQRI in 2009.

CMS did expand the number of measures groups that can be reported from three to seven. The following measures groups have been finalized for 2009: diabetes mellitus, chronic kidney disease, preventive care, coronary artery bypass graft, rheumatoid arthritis, perioperative care , and back pain.

For more information on the PQRI participation options for 2009, including the final list of single measures and the various reporting options, visit: www.cms.hhs.gov/pqri. Per MIPPA, the incentive payment for successful reporting in the PQRI program was raised from 1.5 percent to 2.0 percent for 2009.

Reporting of Measure #125 for Electronic Prescribing (eRx)

Issue: In the proposed rule, CMS stated that they had removed measure #125, the structural measure for eRx, from the PQRI program, due to the new eRx incentive program created by MIPPA.

Recommendation: Since measure #125 is a structural measure, AMGA recommended that CMS allow an attestation mechanism for reporting of this measure. We stated that it is not optimal to report structural measures on a per-encounter basis. Since the attestation process has well-established precedent in the Medicare program, we suggested that it would be a more efficient process and enumerated the requirements of such a process that largely follow the current requirements for measure #125.

Outcome: CMS did not adopt our recommendation, but answered our comment by stating that professionals who utilize EHR systems should be able to auto populate their superbills with the appropriate G code for this measure.

MIPAA Provision Authorizing eRx Reporting Through Part D Claims

Issue: MIPAA provided the authority for CMS to utilize Part D claims data to determine if physicians are prescribing a sufficient number of prescriptions electronically.

Recommendation: AMGA urged CMS to move forward with implementation of a system that would utilize Part D data to determine sufficient levels of eRx activity because it would allow CMS to gather and extract the necessary data without requiring per-encounter coding.

Outcome: Although CMS acknowledged that they have the statutory authority to utilize Part D data to determine sufficient eRx activity, they are requiring eligible professionals to report on the existing eRx measure (#125), due to technical constraints. Future consideration of a Part D data reporting mechanism will depend on completion of necessary technical changes and would be addressed in future rulemaking with a notice and comment period.

Computer Generated Fax Transmissions

Issue: The proposed rule extended the computer generated fax exemption for the electronic prescription of refill requests and in instances of transmission failure, and requested stakeholder input on other eRx transactions that may be adversely affected by the elimination of the exemption.

Recommendation: AMGA was laudatory of CMS' decision to retain the computer generated fax exemption in certain instances, but recommended that the exemption should also be made available in cases when the receiving pharmacy doesn't have a fully operational eRx system.

Outcome: CMS accepted the comment of AMGA, and numerous other stakeholders, by reinstating the fax exemption for *all* eRx transactions, beginning in January 2009, and ending in January of 2012.

Miscellaneous Provisions

--The final rule makes revisions to the initial preventive physical examination by adding the measurement of an individual's body mass index, adding end-of-life planning, and removing the electrocardiogram from the list of mandated services. "End-of-life planning" is defined as verbal or written information regarding an individual's ability to prepare an advance directive in the case than an injury or illness causes the individual to be unable to make health care decisions, and whether or not the physician is willing to follow the individual's wishes.

--CMS is analyzing options to reconfigure localities for the purposes of the geographic practice cost indices (GPCIs) to reflect different resource costs in certain areas compared to the national average. On August 21st, CMS posted an interim report on the results of this research and invited public comment. The report can be found on the [CMS website](#). CMS plans to continue analyzing the issue and may propose revisions to the fee schedule areas used to calculate GPCIs and adjust payments in future rulemaking.

--The final rule incorporates the MIPAA requirement that for services after January 1, 2009, three new facility types be added to the list of authorized telehealth originating sites: hospital-based or critical access hospital-based renal dialysis center, a skilled nursing facility and community mental health center. The final rule also adopts the proposal to add new HCPCS codes specific to the telehealth delivery of follow-up inpatient consultations.

--The final rule revises the reporting time-frame for physicians and non-physician practitioners for reportable event. In cases of reportable events, the Medicare contractor must be notified within 30 days. Reportable events include federal exclusion from the Medicare program, a felony conviction, suspension of state licensure, or if a practice location is determined non-operational by CMS or its contractor.

--The final rule changes the requirements for beneficiary signatures for non-emergency ambulance transport claims. In cases where no other individual is available and authorized to sign a non-emergency ambulance transport claim on behalf of a beneficiary who is physically or mentally incapable or signing, the ambulance provider or supplier will be permitted to submit the claim without the beneficiary's signature, if specified documentation requirements are met.

--Per the MIPAA legislation, CMS is updating the wage data to complete the four-year transition to a wage index based on core-based statistical areas for End Stage Renal Disease (ESRD) facility payment, effective January 1, 2009.

--The proposed rule included a targeted exception to the physician self-referral law that would have permitted certain types of incentive payments or shared savings programs. After reviewing comments, CMS has determined that it needs additional information to finalize an exception that would allow the full array of beneficial, non-abusive incentive payment and shared savings programs. CMS is re-opening the comment period to request further input from stakeholders on this issue for 90 days following the publication of the final rule in the *Federal Register*, scheduled for November 19, 2008.