



Medicare Physician Fee Schedule, Notice of Proposed Rulemaking (NPRM), 2010 Update

(Federal Register pdf available at this [link](#))

Issues for Comment

Comments due August 31, 2009

Please note that the NPRM estimates that the conversion factor based on the statutory formula used to determine the physician payment update for 2010 is \$28.3208, which would provide a -21.5 percent decrease in payments. As in past years, legislative proposals are currently before Congress that would avert the decrease in payments, and affect some of the other policy proposals found in the NPRM. If no action is taken, however, the decrease will take effect beginning January 1, 2010.

- 1) GPCI Per MIPPA of 2008, the 1.000 work GPCI floor will expire, while the 1.500 work GPCI floor for Alaska will remain in place. Locations bearing the greatest impact are listed on page 33663 (Current proposals before Congress could modify, outcome unknown at this time).
- 2) Equipment Usage Assumption CMS is proposing to change the equipment usage assumption from a 50 percent usage rate to a 90 percent usage rate for equipment priced over \$1 million, in response to a MedPAC study showing utilization rates in six markets averaging usage of 90 percent. Using data from only six markets potentially doesn't provide a statistically significant enough sample size on which to base such a dramatic change. No change to the equipment usage assumption should be made until more data can be analyzed. CMS welcomes any comments or analysis on access issues that may flow from this change (page 33532). (Note: the current House bill, America's Affordable Health Choices Act of 2009 raises the current 50 percent usage rate to 75 percent. Outcome unknown at this time).
- 3) Consultation Codes CMS proposes, in a budget neutral manner, to eliminate the use of all consultation codes (except for telehealth consultation G-codes) by increasing the work RVUs for 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 their PE and malpractice RVU calculations. CMS believes the rationale to support a payment differential for consultation services no longer makes sense because the documentation requirements are now similar across all E/M services. The malpractice bump-up for regular E/M codes helps to mitigate the net effect, but certain specialties are more adversely affected (33553). Table 39 shows the impact of all policy changes for 2010 upon the various specialties, including elimination of consultation codes, and can be found on page 33661.

- 4) EHR Reporting for PQRI CMS proposes to retain the claims-based reporting mechanism and the registry-based reporting mechanism for 2010. They are also proposing to accept PQRI quality measures data extracted from a qualified EHR product for a limited subset of the proposed 2010 PQRI quality measures, contingent upon successful completion of the 2009 EHR data submission testing process to determine if this is feasible. The determination will be made prior to the publication of the fee schedule Final Rule. CMS notes that the EHR-based reporting mechanism has been favorable (page 33561).
- 5) Definition of "Group Practice" for purposes of PQRI Reporting CMS is defining a group practice that is eligible for participation in the group practice PQRI program as one that has 200 or more eligible professionals that report under one tax ID number; are willing to provide CMS with the NPI numbers and names of all eligible professionals associated with the tax-ID; are willing to have the group practice's PQRI quality measurement performance rates for each measure publicly reported by posting on the CMS website; and have an active Individuals Access to CMS Systems (IACS) user account. Groups will need to submit a self-nomination letter to CMS and utilize a data collection tool similar to the one used in CMS' Medicare Care Management Performance (MCMP) demonstration and the quality measure and reporting methods used in CMS' PGP demonstration. Groups would also be required to report on a set of 25 NQF-endorsed quality measures that are based on measures that target high-cost chronic conditions and preventive care. CMS will analyze claims and assign beneficiaries to each physician group practice using the same methodology used in the PGP demonstration. Also identical to the PGP demonstration, the random sample must consist of at least 411 assigned beneficiaries. The assigned beneficiaries' demographic and utilization information would be pre-populated by CMS based on claims data, with the physician group completing the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries, and then reported. Incentive payment for 2010 is 2 percent. CMS invites comments on all of these proposals (page 33570 forward). CMS assumes that since this methodology is being used for the PGP demo, that group practices may therefore be familiar with the criteria.
- 6) E-Prescribing Options for 2010 CMS proposes three reporting mechanisms for individual eligible professionals for the eRx incentive program, claims-based; registry-based; and depending on whether they finalize the proposed EHR-based reporting mechanism for PQRI, an EHR-based method. In addition, for group practices, those that have been selected for the PQRI group reporting option would be required to participate in the eRx reporting program. Group practices selected for the PQRI group reporting option must indicate which method of reporting they intend to use. For 2010, the incentive payment will be 2 percent. Eligible professionals, or group practices, that have satisfactorily reported data will be posted on the E-Prescribing Incentive Program website (page 33599).
- 7) MedPAC Recommendation to Establish a Panel of Experts Separate from AMA RUC to Review Relative Value Units (RVUs) MedPAC has recommended to CMS that they establish a group of experts, separate from the AMA RUC, to augment the work of the RUC in reviewing RVUs. The idea would be to have a panel whose members do not directly benefit from changes to

Medicare's payment rates, such as experts in medical economics and technology diffusion, and physicians who are employed by managed care organizations and academic medical centers. This idea raises several issues, and the NPRM seeks public comment on the following questions: 1) How could input from a group of experts best be incorporated into existing processes of rulemaking and agency receipt of AMA RUC recommendations? 2) What specifically would be the roles of a group of experts (for example, identify potentially misvalued services, provide recommendations on valuation of specified services, review AMA RUC recommendations selected by the Secretary, etc.) 3) How would such a group relate to the AMA RUC and existing Secretarial advisory panels such as the Practice Physician Advisory Committee? 4) What should be the composition of a group of experts? How could such a group provide expertise on services that clinician group members do not furnish? Discussion can be found on pages 33556-7.