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Date: July 8, 2011

CMS Issues Proposed 2012 Physician Fee Schedule

By Jeanne Vance*

On July 1, 2011, the Centers for Medicare & Medicaid Services (CMS) issued [proposed payment rate and policy changes](#) for the Medicare physician fee schedule that would go into effect for calendar year (CY) 2012. The proposed rule will be published in the July 19, 2011, *Federal Register*. Highlights of the proposed changes are discussed below. Note that the proposed rule does not address CMS' projected reduction of 29.5% to the conversion factor for CY 2012 that is based on the application of the sustainable growth rate (SGR). The reason is that this reduction can only be averted through a change in law. The President's budget submission for fiscal year (FY) 2012 would extend current payment rates through Dec. 31, 2013.

Expansion of Potentially Misvalued Codes Initiative

Medicare pays for physician services under Section 1848 of the Social Security Act, which bases payment on a formula comprised in part of national uniform "relative value units" (RVUs) that measure the relative resources used in furnishing a service. National RVUs are established for physician work, practice expense, and malpractice expense. In addition, payments are adjusted based on a geographic practice cost index (GPCI) that accounts for regional differences in the cost of delivering services.

Under the proposed rule, CMS will consolidate its required five-year review of work RVUs and practice expense with its annual review of potentially misvalued codes. CMS proposes a process by which the public can submit codes for potential CMS review as potentially misvalued codes on an annual basis. For CY 2012, CMS is focusing its misvalued code initiative on the highest volume and dollar codes billed by physicians to determine whether they are undervalued in the RVU system, and whether

evaluation and management codes are undervalued.

Changes in Data Sources for Geographic Practice Cost Indices

The Affordable Care Act (ACA) requires CMS to analyze the current methodology and data sources used to calculate certain GPCI components. Under the proposed rule, CMS would change some of the sources that it takes into account in calculating cost differences among localities compared to the national average for each of the physician work, practice expense and malpractice components to the physician fee schedule. For example, CMS would use data from the American Community Survey (ACS) in place of U.S. Department of Housing and Urban Development rental data and other data currently used for nonphysician employee compensation.

Expansion of Multiple Procedure Payment Reduction Policy

Medicare reduces payment by 50% for the second and subsequent surgical procedures and for the second and subsequent technical component of advanced imaging procedures furnished to the same patient by the same physician on the same day. This payment limitation, according to CMS, is in place to account for efficiencies in the practice expense and physician work that occur in this instance. CMS proposes to expand its multiple procedure payment reduction to the professional interpretation of advanced imaging services. The professional component payment limitations would match the payment limitations already in place for the technical component of the same service. CMS also invites public comments regarding the expansion of multiple procedure payment reduction policies.

Payment for Telehealth Services

CMS proposes to expand telehealth services that are eligible for Medicare payment to include services that assist patients to stop smoking. In addition, CMS would change the way additional telehealth services become eligible for reimbursement by inclusion on the approved telehealth list commencing in 2013. Under the proposed rule, CMS would consider a service to be eligible for payment as a telehealth benefit if it has demonstrated clinical benefit when the service is delivered via telehealth.

Extension of Payment for Technical Component of Certain Physician Pathology Services

CMS proposes that independent laboratories may not bill the Medicare program for the technical component of physician pathology services furnished to hospital patients commencing January 1, 2012.

Coverage and Payment of the Annual Wellness Visit

The ACA created Medicare Part B coverage for annual wellness visits

providing personalized prevention plan services commencing January 1, 2011. In connection with the annual wellness visit, CMS proposes criteria for a health risk assessment (HRA) designed to assist in developing the personalized prevention plan. CMS believes that use of the HRA will increase physician efficiency during the wellness visit.

Quality Reporting Incentives

Under the proposed rule, CMS would update physician incentive programs, including the Physician Quality Reporting System, ePrescribing Incentive Program, and Electronic Health Records Incentive Program. CMS announced plans to roll out quality comparison data on its Physician Compare website commencing in 2013, consistent with the requirements of ACA.

Establishment of Value-Based Modifier

CMS would establish a new value-based modifier that would reward physicians or groups of physicians for providing higher quality and efficient healthcare. The modifier would be established using proposed quality and cost measures. As required in ACA, CMS would adjust payments to physicians using the modifier on a phased-in basis commencing January 1, 2015. CY 2013 quality and cost data would be used for payment adjustments in 2015. The value-based modifier would be implemented in a budget-neutral fashion, meaning that payments for some physicians would go up and others would go down based on use of this proposed modifier.

Modification of Three-Day Payment Window Policy as it Applies to Physician Services

CMS would modify payment for physician services that are subject to the so-called "Three-Day Payment Window." This rule provides that certain services furnished to Medicare beneficiaries in the three days preceding an inpatient admission are included in the hospital's Hospital Inpatient Prospective Payment System payment, instead of being paid for separately as Part B services. Under the rule, hospitals must include on the claim form for a Medicare beneficiary's inpatient stay the technical component of outpatient diagnostic services and admission-related nondiagnostic services if they are delivered within the three-day period. Under the proposed rule, physician practices that are wholly owned or operated by a hospital and that occur during the patient's stay would be reimbursed at a lower rate as though the services had been delivered in a hospital setting.

Comments to the proposed rule are due on August 30, 2011.

**We would like to thank Jeanne L. Vance, Esquire (Salem & Green, Sacramento, CA), for authoring this email alert.*

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