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# 2010 Proposed Physician Fee Schedule

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Association of
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# 2010 Proposed Physician Fee Schedule

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# Agenda

Physician payment

- SGR
- GPCI
- RVU Changes
  - Consultation Codes, Practice Expense, Malpractice
- Teaching Anesthesiologists

Quality Reporting and Resource Use

- PQRI, RUR, E-Prescribing

Other

- Physician Signature

# Fee Schedule Payment

Components:

1. Work Relative Value Units (RVUs)
2. Practice Expense RVUs
3. Resource-based Malpractice RVUs

- Each component adjusted by geographic practice cost index (GPCI)
- Conversion Factor (CF) yields dollar amount
- All RVU adjustments are budget neutral



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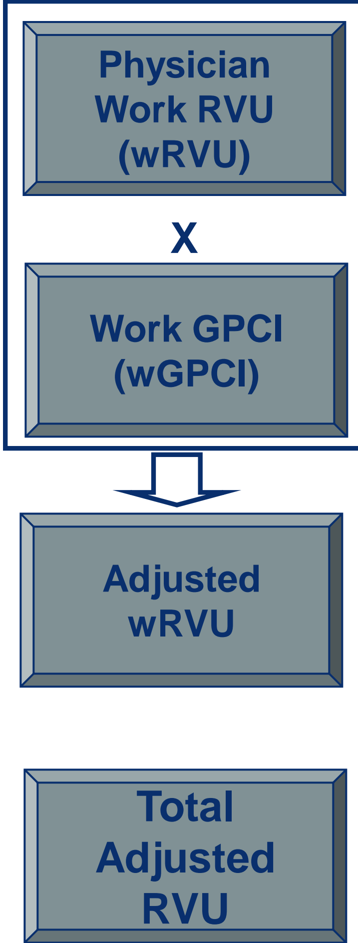
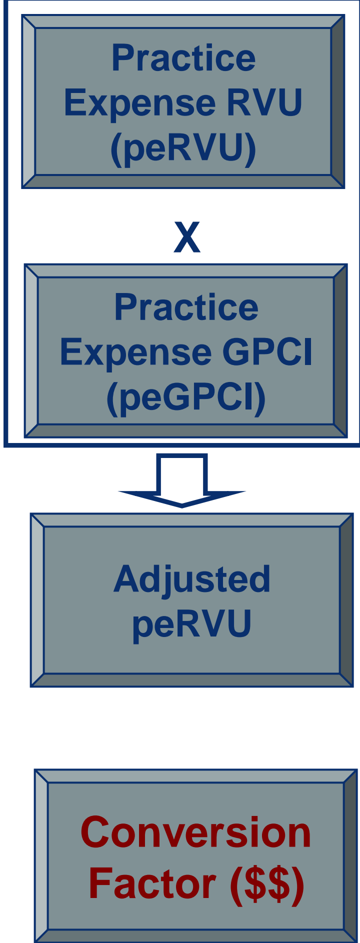
# Calculating Physician Payments

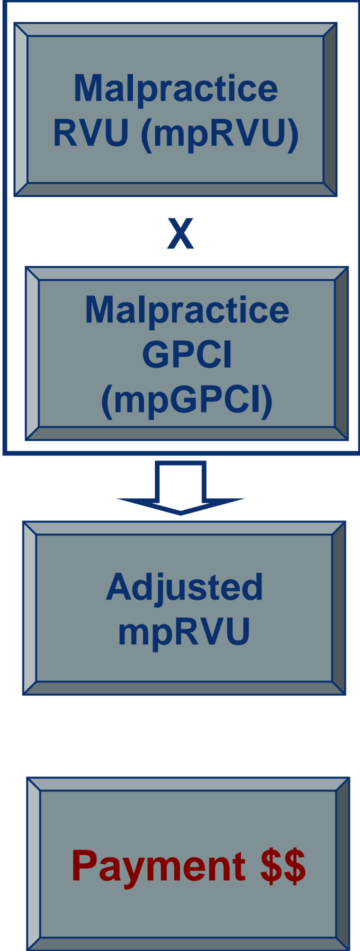
Each service has three Relative Value Units (RVUs)

Each RVU adjusted by Geographic Practice Cost Indices (GPCI)

Adjusted weights are summed and multiplied by Conversion Factor to reach the final dollar amount

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Total Adjusted RVU X Conversion Factor ($$) = Payment $$

# SGR

- If no Congressional action, a -21.5% reduction in fee schedule

- Removal of drugs from SGR calculation
  - CMS use administrative authority to delete “physician-administered drugs” from definition of “physician services” for SGR calculation
  - Does not change negative update, but reduces number of years in which physicians are expected to get negative update
  - $45 Billion from 2010-2014



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# Geographic Practice Cost Indices (GPCI)

- To measure resource cost differences amount localities compared to national average for each fee schedule component
- No changes proposed
- Current floor of 1.0 for work RVU set to expire; Congress expected to extend

# Consultation Codes

Eliminate use of all consultation codes except for telehealth consultation G-codes

Increase work RVUs for:

- new and established office visits
- Initial hospital and nursing facility visits

Incorporate increased use of these visits into Practice Expense (PE) and malpractice RVU calculations



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# For Hospital and Nursing Facilities

Modifier to identify admitting physician of record who is overseeing patient's care

Subsequent visits to be reported as subsequent hospital care codes and subsequent nursing facility care codes



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# Budget Neutrality

Elimination of consultation codes will increase work RVUs

- By approximately 6% for new and established office visits
- By approximately 2% for initial hospital and facility visits



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# What is included in PE-RVUs?

Practice expense is ~45% of payment

Comprised of direct and indirect expenses

- Direct expenses include medical equipment, supplies, clinical staff time
- Indirect expenses include administrative staff and office supplies



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# 2010 Practice Expense Proposal

- Final year transitioning to new PE methodology
- Use updated COST surveys
- Change utilization assumptions for expensive equipment

RESULT:

- Major shifts in payments for certain specialties



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# New cost data

- AMA Physician Practice Information Survey (PPIS)
  - Multispecialty cost survey collected in 2007/2008
  - Replaces previous cost surveys
  - Adjusts PE/HR cost for many specialties



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# Utilization Rate

- Increase the utilization rate assumption for equipment >$1 million from 50% to 90%
  - Increase utilization rate = decrease PE RVUs

- Adjustment based on MedPAC study of CT/MRI use in 6 markets

- Negative impact on radiation oncology, independent diagnostic testing facilities (IDTF)



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# Malpractice Expense Changes

- CMS required to review all RVUs every 5 years – 2010 is the 5yr review for malpractice RVUs

- Proposed Changes
  - Use updated premium information (2006/2007)
  - Use premium data for non-physician practitioners conducting the Technical Component of diagnostic services
  - Use data for dominant specialty for “low-volume” services


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# Overall Impact of Proposals

- CMS impact analysis excludes negative projected update
- 6-8% increase for primary care services
- Large shifts due to change in practice expense RVUs

# Impact by Specialty

## Specialties most negatively affected

| | Impact of work RVU changes (%) | Impact of PE RVU changes (%) | Impact of MP RVU changes (%) | Combined Impact (%) |
|---|---|---|---|---|
| DIAGNOSTIC TESTING FACILITY | 0 | -19 | -5 | -24 |
| RADIATION ONCOLOGY | 0 | -17 | -1 | -19 |
| NUCLEAR MEDICINE | 0 | -12 | -2 | -13 |
| CARDIOLOGY | 0 | -10 | -1 | -11 |
| RADIOLOGY | 0 | -10 | -1 | -11 |
| PORTABLE X-RAY SUPPLIER | 0 | -8 | -2 | -11 |
| INTERVENTIONAL RADIOLOGY | 0 | -10 | 0 | -10 |
| AUDIOLOGIST | 0 | -4 | -7 | -10 |

**Source: CMS Regulatory Impact Analysis, Table 39,FR 33661**
**Does not include impact of negative update**



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# Impact by Specialty

## Primary care specialties*

| | Impact of work RVU changes (%) | Impact of PE RVU changes (%) | Impact of MP RVU changes (%) | Combined Impact (%) |
|---|---|---|---|---|
| FAMILY PRACTICE | 2 | 5 | 1 | 8 |
| GERIATRICS | 1 | 6 | 1 | 8 |
| GENERAL PRACTICE | 1 | 5 | 0 | 6 |
| INTERNAL MEDICINE | 1 | 4 | 1 | 6 |

*Primary care specialties as defined by CMS in rule, FR 33662
**Source: CMS Regulatory Impact Analysis, Table 39,FR 33661**
**Does not include impact of negative update**



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# Impact by Specialty

## Other specialties positively affected

| | Impact of work RVU changes (%) | Impact of PE RVU changes (%) | Impact of MP RVU changes (%) | Combined Impact (%) |
|---|---|---|---|---|
| OPTOMETRY | 1 | 11 | 0 | 12 |
| OPHTHALMOLOGY | 0 | 11 | 0 | 11 |
| PHYSICAL/OCCUPATIONAL THERAPY | 0 | 10 | 0 | 10 |
| NURSE PRACTITIONER | 1 | 5 | 1 | 7 |
| PHYSICAL MEDICINE | 0 | 7 | 0 | 7 |
| ANESTHESIOLOGY | 0 | 5 | 1 | 6 |
| INTERVENTIONAL PAIN | -1 | 7 | 0 | 6 |
| PODIATRY | 1 | 7 | -1 | 6 |

**Source: CMS Regulatory Impact Analysis, Table 39,FR 33661**
**Does not include impact of negative update**



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# Teaching Anesthesiologists

MIPAA: “special payment rule for teaching anesthesiologists” (TA)

- (A) Is present during all critical or key portions of the anesthesia service or procedure involved; and
- (B) TA (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure

Parity with teaching surgeons



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# 3 Scenarios

TA is involved in one resident case not concurrent with any other case

TA involved in two concurrent resident cases not concurrent with any other case

TA involved in one resident case current with a case paid under medical direction



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# The Proposal

To receive 100% fee schedule amount for 2 concurrent cases:

- One individual TA must be present during all key or critical portions of the procedure
- Another TA could be immediately available to furnish services during a non-critical or non-key portion



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# Teaching CRNAs

Rule for teaching CRNAs who are not medically directed

Teaching CRNA to be paid at regular fee schedule rate for each of 2 concurrent student nurse anesthetist cases

- Must be present for pre and post anesthesia services included in anesthesia base unit
- During concurrent cases may not perform services for other patients



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# Teaching CRNAs ‘cont.

Medical direction policy applies if both anesthesiologist and CRNA involved in a student nurse anesthetist case



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# QUESTIONS

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# Physician Quality Reporting Initiative (PQRI)



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# PQRI Overview

- Established by the Tax Relief and Health Care Act of 2006
- Pay-for-REPORTING program
  - Incentives for reporting on quality metrics; not performance
  - Performance on quality metrics not publicly reported
- Eligible professionals select the measures and method to report
- Number of measures and reporting options change each year



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# PQRI Overview

- Reporting measured at the individual professional level (NPI)
- Lump-sum payment after the reporting period completed to Tax ID
- No appeals process
- Incentives based on total Medicare Part B allowed charges for reporting period
  - 2007 incentive: 1.5% subject to a cap
  - 2008 incentive: 1.5% (cap removed)
  - 2009 & 2010 incentive: 2.0%

# PQRI and E-Rx Timeline

**TRHCA 12/20/06** | **MMSEA 12/29/07** | **MIPPA 7/15/08** | **ARRA 2/17/09**

2007 → 2008 → 2009

**TRHCA 12/20/06 (2007)**
- 1 option for satisfactory reporting
- July-Dec 2007
- 74 measures
- Claims-based
- 1.5% incentive, subject to cap

**MMSEA 12/29/07**
- Jan-Dec 2008
- 119 measures (incl EHR and E-RX)
- Claims-based
- 1.5% incentive – no cap

**MIPPA 7/15/08**

**2007 results**

NEW OPTIONS ADDED
- 4 measures groups
- Registry reporting
- Alternative reporting period for new options (Jul-Dec 2008)

**ARRA 2/17/09**
- 9 options to qualify
- Jan-Dec 2009 or Jul-Dec 2009
- 153 measures OR 7 measures groups (remove E-RX)
- Claims OR Registry
- 2% incentive

NEW E-RX Program
- 1 measure, claims
- Jan –Dec 2009
- Separate 2% incentive

**2008 results**

NEW 2010 Process for group practice reporting; Possible EHR reporting

# PQRI Vocabulary 101

- **Criteria for satisfactorily reporting=**

  Ways in which an **eligible professional** can qualify for the reporting incentive

- **Eligible Professional =**

Physicians

Physical and occupational therapists

Qualified speech-language pathologists

Nurse practitioners

Physician assistants

Clinical nurse specialists

Certified registered nurse anesthetists

Certified nurse midwives

Clinical social workers

Clinical psychologists

Registered dietitians

Nutrition professionals

Qualified audiologists

# PQRI Vocabulary 101

- **Individual measures**
  - Single quality metric, results reported as ratios
  - Each measure has detailed specs to identify:
    - Denominator
    - Numerator
  - Measures are nationally endorsed or adopted
- **Measures groups**
  - Sets of at least 4 individual measures that apply to the same patient population
    - Usually grouped by conditions (ex. Diabetic patients, low-back pain, etc.)
  - All measures in "group" have the same denominator



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# PQRI Vocabulary 101

- **Quality Data Codes (QDCs)**
  - Special codes that convey the quality information
  - Numerator of the metric

- **Reporting Period**
  - 6- or 12-month period that represents the time quality data are and the period eligible for the incentive



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# PQRI Vocabulary 101

- **Reporting Mechanism, or** How data is submitted
  - **Claims**
    - Professional reports QDCs to CMS on Part B claims
  - **Registry**
    - Registry (clinical data repository) submits data to CMS
  - **Electronic Health Record**
    - Professionals submit data using qualified EHR (testing, proposed for 2010)



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# 2010 PQRI

- 2% incentive on total Medicare Part B allowed charges

- Proposed changes
  - Add new individual measures, measures groups
  - Add minimum reporting requirement
  - Simplify measures group reporting
  - Add data submission through EHRs
  - Option for group reporting



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# Measures for 2010

## Individual Measures

- 30 new individual measures
  - 22 of 30 can only be reported through registries
- 9 measures can no longer be reported through claims (only reported through registries)
- 1 measure moved from registry only reporting to registry/claims reporting
- Retired 7 measures

Total 176 individual measures

## Measures Groups

- 6 new measures groups
  - Coronary artery disease
  - Heart Failure
  - Ischemic Vascular Disease
  - Hepatitis C
  - HIV/AIDS
  - Community-acquired pneumonia

Total 13 measure groups



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# Successful Reporting - 2010 Proposals

## Individual Measures

80% of applicable patients for at least 3 measures (or 1 or 2 measures if less than 3 measures are applicable to the professional's practice)

*AND*

*Report on a minimum of 15 patients for at least 1 measure for 12-month reporting period; min of 8 patients for 6-month period*

## Measures Groups

- 30 ~~consecutive~~ patients

  OR
- 80% of applicable patients *with a minimum of 15 patients for 12-month reporting period; min of 8 patients for 6-month period*

2010 proposals are highlighted in red and italicized.

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# Reporting Mechanism

## Claims

- Professional submits QDCs when submitting Medicare Part B claims
- Cannot resubmit a claim only to correct a QDC
- *9 measures move from claims/registry to registry only*

## Registry

- Registries submit data after reporting period
  - Ability to catch and correct reporting errors

## *EHR*

- *Proposed for 2010 for limited measures*
  - *Contingent on successful testing*
- *Professional submits data to clinical warehouse using qualified EHR.*

***CMS proposes transitioning away from claims reporting after 2010.***

2010 proposals are highlighted in red and italicized.

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# Qualified Registries

- Registries must self-nominate to become "qualified" to submit data to PQRI
    - 2008 and 2009 registries that successfully submit data do not need to reapply
- New requirements for 2010 registries
    - Have at least 25 participants
    - Provide at least 1 feedback report per year
    - Not be owned/managed by individual locally-owned single specialty practice (1 location or 1 practitioner)
    - Participate in monthly calls with CMS
    - Provide a flow of measure calculation
    - Use PQRI measures

# Qualified EHRs

- EHR data submission contingent on successful completion of 2009 testing
- If EHR reporting is finalized, qualified vendors are those that complete data submission testing in 2009
  - Vendors to be posted by end of 2009
- Other EHR vendors can self-nominate in 2010 for 2011 reporting



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# 2010 Proposed PQRI Options (Individuals)

| Reporting Measure | Successful Reporting Criteria | Claims Reporting | | Registry Reporting | | EHR |
|---|---|---|---|---|---|---|
| | | Jan-Dec 2010 | Jul-Dec 2010 | Jan-Dec 2010 | Jul-Dec 2010 | Jan-Dec 2010 |
| Individual measures—1 or 2[a] | For each measure, report on ≥ 80% of applicable Medicare Part B FFS patients of each eligible professional[b] | X | | | | |
| Individual measures—3 or more | For at least 3 measures, report on ≥ 80% of applicable Medicare Part B FFS patients of each eligible professional[b] | X | | X | X | X |
| Measures groups | Report on 30 patients[c] | X | | X | | |
| | Report on 80% of the applicable Medicare Part B FFS patients of each eligible professional[b] | X | X | X | X | |

[a] This option is available only if fewer than 3 measures are applicable to the practice.
[b] Must report on a minimum of 15 patients for at least 1 measure for 12 month period; min of 8 patients for 6month reporting period
[c] For claims-based reporting, patients must be covered under Medicare Part B FFS. For registry reporting, patients may include, but may not be exclusively, non-Medicare Part B FFS patients.



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# Group Reporting

- Required by Medicare Improvement for Patients and Providers Act (MIPPA) - new for 2010
- 2% incentive on total allowed charges for all NPIs in “group”
  - Individuals cannot received separate incentives if the group receives an incentive
- Based on Physician Group Practice (PGP) and Medicare Care Management Performance (MCMP) demos



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# Group Reporting (Cont.)

- Group requirements
  - Defined by tax ID number (TIN)
  - Must have >= 200 professionals
  - Have an active Individuals Access to CMS Systems (IACS) account
  - Provide NPI and names of professionals to CMS
  - Agree to publicly report PERFORMANCE DATA

# Group Reporting (Cont.)

- Measures
  - 26 NQF-endorsed measures
  - 4 disease modules:
    - Diabetes
    - Heart failure
    - Coronary artery disease
    - Preventive care services



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# Group Reporting (Cont.)

- Reporting Mechanism
  - Data submitted through special pre-populated database
  - For each module, CMS assigns random sample of beneficiaries based on plurality of E/M services provided (1/1/2010 – 10/29/2010)
    - Patients with only 1 visit are excluded
  - Practice fills in numerator information for patients
  - Report on the first 411 assigned patients for each disease module

No process to review or appeal the patients assigned to the group.



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# Resource Use Reports/ Value-based Purchasing

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# Resource Use Reports

- Background
  - Mandated by MIPPA
  - Limited pilot started in 2009
  - Confidential Reports measure per capita and episode resource use
- Proposals to expand project
  - Add diabetes care
  - Expand number of geographic areas (to be listed in the final rule)
  - Add in quality measures
  - Measure resource use for groups



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# Value-based Purchasing

- "… increase the value of care by rewarding providers for higher quality and more efficient services…."
- CMS required to submit plan on transitioning to VBP to Congress by May 2010
- RUR, quality reporting, shared savings demos are "building blocks" of VBP program.



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# E-Prescribing Incentive Program

Separate from, and in addition to, 2% PQRI incentive

- 2010: 2%
- 2011 and 2012: 1%
- 2013: 0.5%

Disincentives:

- 2012: 1%
- 2013: 1.5%
- 2014: 2%

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# ARRA Disincentives

If not a meaningful user by 2015, then 1% reduction in fee schedule payments.

**BUT** if received a 2% e-prescribing disincentive in 2014, then your meaningful use disincentive in 2015 is 2%

# New 2010 Proposals

- Simplify e-prescribing - only report when e-prescribing has occurred
- E-prescribe at least 25 times
- Allow registry and EHR reporting
- Add skilled nursing facilities and home care setting to the applicable billing codes that make up the denominator
- Add Group Reporting option



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# Registries/EHRs

Registries and EHRs qualified to submit for PQRI are eligible to submit e-prescribing information



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# Successful E-Prescriber: #1

At least 25 times during 2010:

Must report that at least 1 prescription for a Medicare Part B FFS patient created during an encounter (defined by the denominator of the e-prescribing measure) was electronically prescribed

Must be submitted using a qualified e-prescribing system



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# Successful E-Prescriber: #2

Medicare Part B allowed charges for services to which e-prescribing measure applies are at least 10 percent of the total part B allowed charges for all covered professional services

- Based on claims submitted at the TIN/NPI level

# Group Practice E-Rx Option

Only group practices selected to participate in the PQRI group practice reporting option

Must participate in both PQRI and e-prescribing group practice reporting options

When self-nominate for PQRI would also indicate the E-Rx reporting mechanism the group will use

Same reporting options as for PQRI—claims-based, registry-based, EHR-based (if finalized)

# Success E-Rx for a Group: #1

At least 1 prescription during an encounter was generated using a qualified e-prescribing system at least 2500 times during the reporting period

- Based on assumption: 200 eligible professionals; half would have opportunity to report the e-prescribing measure
- (100 professionals x 25 electronic prescriptions)

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# Success for a Group: #2

Must meet threshold that 10% of group's charges come from the encounter codes in denominator

- Determined first quarter 2011
- Group practice's total 2010 allowed charges for professional services submitted for the measure's HCPCS codes divided by group's total Part B allowed charges for all covered professional services



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# Public Reporting

Names of successful EPs and group practices will be available publicly available in 2011.

An EP can be listed as satisfactorily submitting data in both PQRI and e-prescribing programs



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# Questions

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# Physician Signatures

Physician signature not required on requisition for clinical diagnostic lab tests, but must be evident that the physician ordered the services

Written order for diagnostic tests must be signed by the ordering physician or NPP

- Order=communication from treating physician/practitioner requesting performance of diagnostic test
- Requisition=actual paperwork that identifies test(s) to be performed



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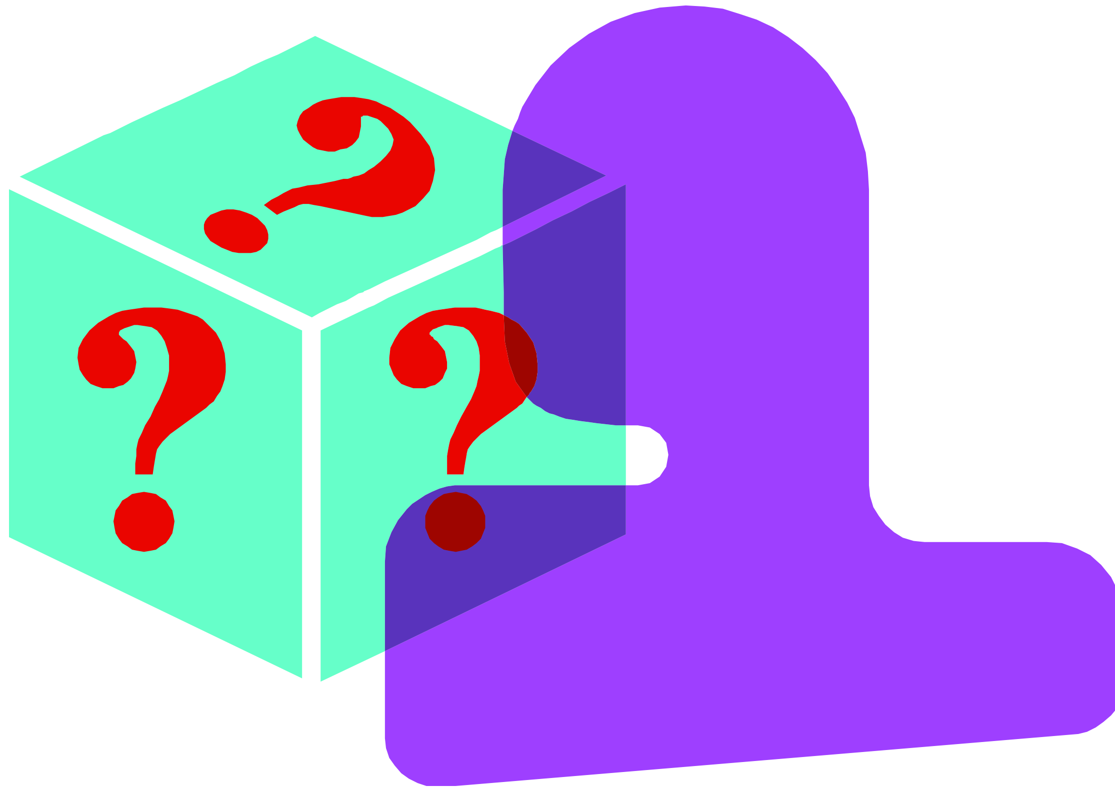
# Questions





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# Additional Resources

Physician Fee Schedule Rule plus supporting documents

http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?itemID=CMS1223902

AAMC Health IT page

http://www.aamc.org/members/gir/hit/start.htm



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