



Provider Inquiry Assistance

Summary of Policies in the 2009 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount – JA6349

Related CR Release Date: December 19, 2008

Date Job Aid Revised: January 20, 2009

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Key Words	MM6349, CR6349, R419OTN, MPFS, 2009, Physician, Fee, Telehealth
Contractors Affected	<ul style="list-style-type: none"> • Medicare Carriers • Fiscal Intermediaries (FIs) • Part A/B Medicare Administrative Contractors (A/B MACs)
Provider Types Affected	Physicians, other practitioners, providers, and suppliers submitting claims to Medicare Carriers, FIs, and/or A/B MACs for services provided to Medicare beneficiaries and paid under the MPFS



Change Request (CR) 6349 provides a summary of the policies in the 2009 MPFS and announces the telehealth originating site facility fee payment amount.

The following summarizes the key points in CR6349.

MPFS ISSUES

Provider Needs to Know...	<ul style="list-style-type: none"> • Payment for Preadministration-Related Services for Intravenous Infusion of Immune Globulin (IVIG) Payment is no longer made under the physician fee schedule for G0332, for preadministration related services for IVIG infusion, effective January 1, 2009. This code has been deleted from the MPFS database and is no longer recognized for services furnished after December 31, 2008.
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- **Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging**
 - The Centers for Medicare & Medicaid Services (CMS) added several additional procedures to the MPPR list.
 - Six procedures represent codes newly created since the MPPR list was established.
 - Four additional procedures were identified as similar to procedures currently subject to the MPPR.
 - CMS also removed Current Procedural Terminology (CPT) code 76778 (a deleted code) from the list.
 - **Proposed Healthcare Common Procedure Coding System (HCPCS) code for Prostate Saturation Biopsies**
 - Prostate Saturation Biopsy is a technique that was previously described by Category III CPT code 0137T (*Biopsy, prostate, needle, saturation sampling for prostate mapping*).
 - Typically, this service entails 40-80 core samples taken from the prostate under general anesthesia. Currently, the biopsies are reviewed by a pathologist and this service is captured under CPT code 88305, *Surgical pathology, gross and microscopic examination*, which is separately billed by the physician for each core sample taken.
 - CPT Code 88305 has a physician work value of 0.75 and a total non-facility payment rate of \$102.83. CMS added four G-codes to more accurately represent the pathologic evaluation, interpretation, and report for this service.
 - In the final rule with comment period, CMS finalized its proposal, but provided assigned values to the four new G-codes based upon assumption of the number of cancerous cells.
 - **New and Revised Codes**
 - CMS received work relative value unit recommendations for 128 new and revised CPT codes from the American Medical Association (AMA) Relative Update Committee (RUC) this year. Of the recommendations received, CMS accepted 114 and disagreed with 14.
 - The CPT Editorial Panel created 20 CPT codes to replace the G-codes for monthly and per diem end-stage renal disease (ESRD) services. CMS accepted the AMA RUC recommendations for these services. The new CPT codes are listed in the table that starts on page 3 of MLN Matters article MM6349.
 - **Renumbered CPT Codes**

Effective for calendar year (CY) 2009, the CPT codes in the table that starts on page 4 of MM6349 have been renumbered.
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- **Medicare Telehealth Services**
 - CMS has added HCPCS codes specific to follow-up inpatient consultation delivered via telehealth and clarified that the criteria for these services will be consistent with Medicare policy for consultation services.
 - For 2009, Medicare contractors will pay for the Medicare telehealth originating site facility fee as described by HCPCS code Q3014 at 80 percent of the lesser of the actual charge or \$23.72.
 - The beneficiary is responsible for any unmet deductible amount or coinsurance.
 - **Part B Drug Issues**
 - In the 2009 MPFS final rule, CMS announces it will adopt three regulatory changes affecting payment of Part B Drugs under the Average Sales Price (ASP) methodology:
 - CMS will update its regulations to comport with the new volume-weighting ASP calculation methodology established in Section 112(a) of the Medicare and Medicaid State Children's Health Insurance Program Extension Act of 2008.
 - CMS will make conforming changes to its regulations to address the special payment rule for certain single source drugs or biologicals that are treated as multiple source drugs because of the application of the grandfathering provisions of Section 1847A of the Act.
 - Section 1847A(d)(1) of the Act allows the Secretary to disregard the ASP for a Part B drug or biological that exceeds the widely available market price or the average manufacturer price for such drug by an applicable threshold percentage. For CY 2009, CMS will maintain the threshold at 5 percent, absent of data that suggests a change is appropriate.
 - **Application of Health Professional Shortage Area (HPSA) Bonus Payment**
 - CMS makes minor policy revisions to clarify that physicians who furnish services in areas that are designated as geographic HPSAs as of December 31 of the prior year but not included on the list of ZIP codes for automated HPSA bonus payments should use the AQ modifier to receive the HPSA bonus payment.
 - **Independent Diagnostics Testing Facilities (IDTFs)**
 - CMS is requiring all mobile units providing diagnostic testing services to Medicare beneficiaries to enroll in the Medicare program.
 - In addition, all mobile units furnishing diagnostic testing services will be required to bill for services unless the service is furnished under arrangement with a hospital.
 - When services are furnished under arrangement, the hospital will continue to bill for the diagnostic testing services.
 - **Physician and Non-physician Enrollment Safeguards**

The following is a summary of the enrollment provisions in the MPFS final rule for 2009:

 1. Limit retrospective payments to physicians and non-physician practitioners and
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physician and non-physician practitioner organizations.

- CMS has established that the effective date of billing for physicians and non-physician practitioners and physician or non-physician practitioner organizations as the later of:
 - The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or
 - The date an enrolled physician or non-physician practitioner first started rendering services at a new practice location.
 - This provision permits physicians and non-physician practitioners to retrospectively bill for services furnished up to 30 days prior to the effective date of enrollment if the physician or non-physician practitioner meets all program requirements, even if the initial enrollment application is rejected or denied as long as the application is ultimately approved.
 - In addition, physicians and non-physician practitioners will be permitted to retrospectively bill for services furnished up to 90 days prior to the effective date if the physician or non-physician practitioner meets all program requirements. In addition, there is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 United States Code §§5121-5206 (Stafford Act).
2. Prohibit physicians and non-physician practitioners (as well as owners, authorized officials, and delegated officials of a physician or non-physician practitioner organization) from obtaining additional billing privileges if their current billing privileges are suspended or an overpayment is pending.
 3. Require all providers and suppliers, including individual practitioners, to maintain ordering and referring documentation for 7 years from the date of service.
 4. Require physician and non-physician organizations, physicians and nonphysician practitioners, and IDTFs to submit all outstanding claims within 60 days of the revocation date.
 5. Require physicians and non-physician practitioners and physician and non-physician practitioner organizations to notify their Medicare contractor of a change of ownership, final adverse action, or change of location that impacts a payment amount within 30 days. Failure to notify the designated contractor of these changes may result in an overpayment from the date of the reportable change.
- **Educational Requirements for Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNS)**
 - In the 2009 MPFS final rule, CMS finalizes its proposal to recognize the doctor of nursing practice (DNP) degree.
 - It also states that it will continue to study the evolution of the DNP degree to ensure that it continues to be consistent with our program requirements.
 - In addition, CMS finalized a proposed technical correction to the NP regulatory qualifications that will clarify that the requirement for a master's degree in nursing is

the minimum educational level for newly enrolled NPs and CNSs independently treating Medicare beneficiaries.

Provisions from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

Section 101: Improvements to Coverage of Preventive Services

- Payment for the Initial Preventive Physical Examination (IPPE)
 - The MMA provided for one IPPE per beneficiary per lifetime.
 - A beneficiary is eligible when first enrolling in Medicare Part B on or after January 1, 2005, and receives the IPPE benefit within the first 6 months of the effective date of the initial Part B coverage period.
 - If the physician or qualified NPP is not able to perform both the examination and the screening electrocardiogram (EKG), an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate existing HCPCS G-code(s).
 - MIPPA made several changes to the IPPE, including expanding the IPPE benefit period to not later than 12 months after an individual's first coverage period begins under Medicare Part B. Other changes to this benefit were included in segment 1 of the rule.
- Summary of Other IPPE Payment Changes in Section 101 of the MIPPA
 - The Deductible Change with MIPPA
 - The Medicare deductible does not apply to the IPPE if performed on or after January 1, 2009, within the beneficiary's 12-month initial enrollment period of Medicare Part B.
 - The waived deductible is applicable to the IPPE service only. Medicare will pay for one IPPE per beneficiary per lifetime.
 - The Medicare deductible for the IPPE performed before January 1, 2009 (G0344) applies.
 - Coinsurance applies irrespective of codes or date of the IPPE.
 - The waived deductible for the IPPE, effective January 1, 2009, does not apply to the screening EKG.
 - New G-Codes Needed with MIPPA Implementation
 - CMS revised the G-codes for the IPPE and EKG to reflect the changes in the legislation. The EKG codes will reflect a once-in-a lifetime screening with a referral from an IPPE.

Section 132: Incentives for Electronic Prescribing

- Eligible professionals who are successful electronic prescribers will be paid 2 percent incentive of estimated allowable charges submitted not later than 2 months after the end of the reporting period for 2009 successful electronic prescribing.

- A “successful electronic prescriber” is defined under Section 1848(m)(3)(B)(ii) of the Social Security Act as an eligible professional who reports the e-prescribing measure in at least 50 percent of the cases in which the measure is reportable by the professional.
- Although the Secretary is given authority to assess successful electronic prescribing using either data reported by eligible professionals using electronic prescribing quality measures or using Part D prescription data, CMS will use the former for 2009.
- CMS will set forth the statutory criteria for successful electronic prescriber as reporting the measure in 50 percent of applicable cases.
- There is also a limitation of the applicability of the e-prescribing incentive.
- For CY 2009, in order to be considered an eligible professional for purposes of the e-prescribing incentive, the e-prescribing measure denominator codes must apply to at least 10 percent of the total of allowed charges for all such covered services furnished by the eligible professional.

Section 149: Adding Certain Entities as Originating Sites for Payment of Telehealth

- Currently, telehealth may substitute for a face-to-face, “hands on” encounter for professional consultations, office visits, office psychiatry services, and a limited number of other PFS services that CMS has determined to be appropriate for telehealth.
 - Medicare will make a fixed payment to the originating site as well as a PFS payment to the physician.
 - The originating site must be located in a non-metropolitan statistical area county or rural HPSA.
 - To date, originating sites have been limited to:
 - The office of a physician or practitioner;
 - A hospital;
 - A critical access hospital (CAH);
 - A rural health clinic; and
 - A federally qualified health center.
 - The MIPPA recognizes the following additional originating sites, effective for services furnished on or after January 1, 2009:
 - A hospital-based or CAH-based renal dialysis center (including satellites);
 - A skilled nursing facility; and
 - A community mental health center.
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Background

- The Social Security Act (Section 1848(b)(1) at http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) requires CMS to provide (by regulation before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year.
- CMS published a document that will affect payments to physicians effective January 1, 2009.
- The Social Security Act (Section 1834(m) at http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20.
- For telehealth services provided on or after January 1 of each subsequent CY, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) as defined in §1842(i)(3) of the Social Security Act.
- The MEI increase for CY 2009 is 1.6 percent. The telehealth originating site facility fee for 2009 is 80 percent of the lesser of the actual charge or \$23.72.

Operational
Impact

N/A

Reference
Materials

The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6349.pdf> on the CMS website.

The official instruction (CR6349) issued regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R4190TN.pdf> on the CMS website. A complete summary of significant issues discussed in CMS-1403-FC, *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)* is attached to CR6349.