



Summary of Policies in the 2010 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount – JA6756

Note: Change Request (CR) 6756 was revised and reissued on December 29, 2009. The CR release date, transmittal number, and the Web address for accessing CR6756 were changed.

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- Contractors Affected**
- Part A/B Medicare Administrative Contractors (A/B MACs)
 - Medicare Carriers
 - Fiscal Intermediaries (FIs)

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



CR6756 provides a summary of the policies in the 2010 MPFS and announces the telehealth originating site facility fee payment amount.

Telehealth Originating Site Facility Fee

- For 2010, the telehealth originating site facility fee (Healthcare Common Procedure Coding System code Q3014) is 80 percent of the lesser of the actual charge or \$24.00.

2010 MPFS

Practice Expense (PE) Issues

- The two primary data sources used to calculate PE relative value units (RVUs) are:
 - Specialty-specific survey data on indirect practice expenses; and
 - Procedure specific data on direct practice expenses, based primarily on American Medical Association (AMA) recommendations reviewed by the Centers for Medicare & Medicaid Services (CMS).
- Recently, the AMA conducted a new Physician Practice Information Survey (PPIS) and expanded it to include non-physician practitioners paid under the MPFS.
- The incorporation of the AMA's contemporaneous, consistently collected, multi-specialty PPIS data into the calculation of the resource-based PE RVUs ensures that the practice expense RVUs reflect the best and most current data available.
- In the calendar year (CY) 2010 MPFS proposed rule, CMS proposed to include the data collected by the AMA's PPIS into the calculation of resource-based practice expense RVUs.
- **In the 2010 MPFS final rule, CMS finalized its proposal to use the PPIS survey data to calculate PE RVUs.**
- CMS believes the impact of using the new PPIS data warrants a 4-year transition for existing 2009 Current Procedural Terminology (CPT) codes from the current PE RVUs to the PE RVUs developed using the new PPIS data.
- New and substantially revised CPT codes will not be subject to a transition. CMS will also continue using the oncology supplemental survey data for the drug administration codes.

Provider Needs to Know...

Equipment Utilization Rate

- In the CY 2010 MPFS proposed rule, CMS proposed to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for expensive equipment (purchase price over \$1 million).
- Many of these high cost diagnostic imaging services are currently subject to a statutory payment limit based on the Outpatient Prospective Payment System (OPPS) payment rates (the OPPS cap).
- **In the MPFS final rule, CMS finalized the proposal to increase the equipment utilization rate to 90 percent for expensive diagnostic equipment priced at more than \$1 million.**

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- This change will be transitioned over a 4-year period. CMS is not finalizing the proposal to increase the utilization rate assumption for expensive therapeutic equipment.

Geographic Practice Cost Indices (GPCIs): Locality Discussion

- In the CY 2010 MPFS proposed rule, CMS noted that the legislative 1.0 work GPCI floor established by Section 134 of the Medicare Improvements for Patients and Providers Act expires December 31, 2009. The proposed CY 2010 GPCIs did not include the 1.0 floor.
- In the MPFS final rule, CMS summarized comments received on their report on potential alternative locality configurations.
- Also in the final rule, CMS reiterated that they are not proposing any changes in the PFS locality structure but will continue to review the options available.
- A final report will be posted to the CMS website after further review of the studied alternative locality approaches.

Malpractice (MP) RVUs

- Section 1848(c) of the Social Security Act (or the Act) required the implementation of resource-based MP RVUs for services furnished beginning January 1, 2000. Section 1848(c) (2) (B) (i) of the Act requires that CMS review and if necessary, adjust RVUs no less often than every 5 years.
 - The law requires that the updates to the MP RVUs are budget neutral overall. In 2005, CMS implemented the results of the first comprehensive review of the MP RVUs. The second update must be implemented for CY 2010.
 - In the past, the MP RVUs for technical component (TC) services (for example, diagnostic tests) and the TC portion of global services were based on historical allowed charges and were not resource-based due to a lack of available malpractice premium data for non-physician suppliers.
 - In the CY 2010 PFS proposed rule, CMS discussed the proposed methodology and updated premium data for the second update of malpractice RVUs.
 - CMS proposed to use medical physicist premium data as a proxy for the malpractice premiums paid by all entities providing TC services (primarily Independent Diagnostic Testing Facility (IDTFs)).
 - Other than this TC change, the proposed rule methodology conceptually followed the same approach, with some minor refinements, used to originally develop the resource based MP RVUs.
 - In the CY 2010 MPFS final rule, CMS finalized the updated malpractice RVUs.
 - **Due to newly available data, CMS will use malpractice premium data for IDTFs instead of medical physicist premium data to determine the malpractice premiums paid by technical component suppliers.**
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Specific Coding Issues Related to Physician Fee Schedule

Consultation Services

- In the CY 2010 MPFS proposed rule, CMS proposed to eliminate the use of all consultation codes (inpatient and office/outpatient consultation codes used for various places of service) except telehealth consultation G-codes.
- CMS justified this proposal on the grounds that in light of recent reductions in the documentation requirements for consultation services, the resources involved in doing an inpatient or office consultation are not sufficiently different than the resources required for an inpatient or office visit to justify the existing differences in payment levels.
- Eliminating the consultation codes would have the effect of increasing payments for the office visit codes that are billed by most physicians and most commonly by primary care physicians.
- Although all physicians would gain from the increased payment for office visits, the net result would be a reallocation of payments from specialists (who bill consultation codes much more frequently) to primary care physicians.
- **In the CY 2010 MPFS final rule, CMS finalized the proposal to eliminate the use of all consultation codes (inpatient and office/outpatient consultation codes used for various places of service) except telehealth consultation G-codes.**
- As requested by the surgical specialties, CMS increased the surgical global period RVUs to reflect the resulting increases in the RVUs for the visit codes.

Initial Preventive Physical Exam (IPPE)

- The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provides for coverage under Part B for the IPPE, also known as the "Welcome to Medicare" visit. The Medicare Improvements for Patients and Providers Act (MIPPA) made several changes to the IPPE including expanding the benefit period to not later than 12 months after an individual's first coverage period begins under Medicare Part B.
- Last year CMS implemented the MIPPA revisions to the benefit, but retained the existing value and requested comments on whether it should be revalued.
- In the CY 2010 PFS proposed rule, CMS proposed to increase the work RVUs to the same level as a level 4 new patient office visit.
- **In the CY 2010 MPFS final rule, CMS adopted this proposal. Consequently, the work RVU for the IPPE will increase from 1.34 to 2.30.**

Canalith Repositioning

- In the CY 2009 MPFS final rule, a new CPT code 95992 for *canalith repositioning procedure(s)* was bundled with Evaluation and Management (E/M) codes.
- After the final rule was published, CMS recognized that physical therapists that had previously been performing this service now had no way to bill for it since they cannot bill for E/M services.

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- In the 2010 MPFS proposed rule, CMS proposed to change the indicator to I (Invalid).
 - In the CY 2010 MPFS final rule, CMS finalized the proposal to make the CPT code for canalith repositioning invalid.
 - Physicians will continue to be paid for this service as part of an E/M service.
 - Physical therapists will continue to use one of the more generally defined “always therapy” CPT codes.

Clarification Concerning Certain Audiology Codes

- In the CY 2010 MPFS final rule, CMS is clarifying that therapeutic and/or management activities are not payable to audiologists because they do not fall under the diagnostic tests benefit category designation.

MIPPA Provisions

Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

- By statute, Medicare pays 50 percent of the approved amount for outpatient mental health treatment services, while paying 80 percent of the approved amount for outpatient physical health services.
- Section 102 of the MIPPA gradually phases out the limitation by 2014.
- When the provision is fully implemented, CMS will pay outpatient mental health services at the same level as other Part B services.
- For 2010, CMS will pay 55 percent of the approved amount for outpatient psychiatric services.

Section 139: Improvements for Medicare Anesthesia Teaching Programs

- Section 139 of MIPPA establishes a special payment rule for teaching anesthesiologists and provides a directive to the Secretary of Health and Human Services (HHS), regarding payments for the services of teaching certified registered nurse anesthetists (CRNAs).
- It also specifies the periods when the teaching anesthesiologist must be present during the procedure in order to receive payment for the case at 100 percent of the fee schedule amount.
- These provisions are effective for services furnished on or after January 1, 2010, as follows:
 - The special payment rule for teaching anesthesiologists allows payment to be made at the regular fee schedule rate for the teaching anesthesiologist's involvement in the training of residents in either a single case or in two concurrent anesthesia cases. In the CY 2010 MPFS final rule, CMS will apply the special payment rule to teaching anesthesiologists in the following three cases:
 - The teaching anesthesiologist is involved in one resident case (which is not concurrent to any other anesthesia case); or
 - The teaching anesthesiologist is involved in each of two concurrent resident

cases (which are not concurrent to any other anesthesia case); or

- The teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under medical direction payment rules.

Anesthesia Handoff

- MIPPA Section 139 requires the teaching anesthesiologist to be present at the key or critical portions of an anesthesia procedure.
- It also specifies that the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure.
- However, in the proposed rule CMS proposed that the teaching anesthesiologist must be present during key or critical portions of a procedure.
- Anesthesiologists advised CMS that it may be common practice for different members of a teaching anesthesia group to provide a service instead of a single teaching anesthesiologist. This practice is referred to as an anesthesia handoff.
- In the 2010 MPFS final rule, CMS finalized an alternative option that permits handoffs between members of the same anesthesia group for key or critical portions of a procedure.
- This option is consistent with current anesthesia practice and it is less disruptive to current anesthesia practice arrangements. CMS may propose to standardize protocols and quality rules for handoffs in the future.

CRNA Teaching Payment Policy

- Section 139(b) of the MIPPA instructs the HHS Secretary to make appropriate adjustments to Medicare teaching CRNA payment policy so that it is consistent with the adjustments made by the special payment rule for teaching anesthesiologists under Section 139(a) of the MIPPA.
 - In the 2010 MPFS final rule, CMS allows the teaching CRNA, who is not medically directed, to be paid the full fee for his/her involvement in two concurrent cases with student nurse anesthetists. Other payment policies would remain unchanged.
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Background

- The Social Security Act (Section 1848(b)(1)) 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, 2010.
 - The Social Security Act (Section 1834(m)) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 21, 2002, at \$20.
 - For telehealth services provided on or after January 1 of each subsequent calendar year, 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 Section
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1842(i)(3) of the Social Security Act.

- The MEI increase for CY 2010 is 1.2 percent.
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Operational Impact	N/A
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Reference Materials	<p>The related MLN Matters® article can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6756.pdf on the CMS website.</p> <p>The official instruction (CR6756) regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R6150TN.pdf on the CMS website.</p> <p>Transmittal 1875, CR6740, dated December 14, 2009, provides more information on revisions to consultation services. A related MLN Matters® article, MM6740, is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf on the CMS website.</p>
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