



News Flash – The Centers for Medicare & Medicaid Services (CMS) would like to remind Physician Quality Reporting Initiative (PQRI) participants that there is a “Verify Report Portlet” look-up tool available on the PQRI Portal for Eligible Professionals (EPs) to verify if a 2007 re-run and/or 2008 PQRI feedback report exists for your organization’s Tax Identification Number (TIN) or National Provider Identifier (NPI). The TIN or NPI must be the one used by the EP to submit Medicare claims and valid PQRI quality data codes. This tool is available at (<https://www.qualitynet.org/portal/server.pt>) on the internet. There are two ways to access 2007 re-run and/or 2008 PQRI feedback reports: 1) An individual EP can simply call their respective Carrier or A/B MAC provider contact center to request confidential 2007 PQRI re-run and/or 2008 PQRI feedback reports that will contain information based on their individual NPI, or 2) EPs can logon to the secure PQRI Portal on QualityNet at (<http://www.qualitynet.org/portal/server.pt>) to access their feedback report(s) based their TIN, or for a group.

MLN Matters® Number: MM6756 **Revised**

Related Change Request (CR) #: 6756

Related CR Release Date: December 29, 2009

Effective Date: January 1, 2010

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Implementation Date: January 4, 2010

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

Note: This article was revised on December 30, 2009, to reflect a revised CR 6756, which was issued on December 29, 2009. The CR release date, transmittal number (see above), and the Web address for accessing CR 6756 were changed. All other information remains the same.

Provider Types Affected

This article is for physicians, other practitioners, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries and paid under the MPFS.

Provider Action Needed

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This article is based on Change Request (CR) 6756 which provides a summary of the policies in the 2010 MPFS and announces the telehealth originating site facility fee payment amount. Be sure billing staff are aware of these Medicare changes.

Background

The Social Security Act (Section 1848(b)(1)) at http://www.ssa.gov/OP_Home/ssact/title18/1848.htm requires the Centers for Medicare & Medicaid Services (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)) 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 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 1842(i)(3) of the Social Security Act (or the ACT). The MEI increase for calendar year (CY) 2010 is 1.2 percent. **The telehealth originating site facility fee (HCPCS code Q3014) for 2010 is 80 percent of the lesser of the actual charge or \$24.00.**

Summary of Other Key Changes Discussed by CR 6756

Practice Expense (PE) Issues

The two primary data sources used to calculate practice expense (PE) relative value units (RVUs) are:

- 1) Specialty-specific survey data on indirect practice expenses; and
- 2) Procedure specific data on direct practice expenses, based primarily on American Medical Association (AMA) recommendations reviewed by 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 practice expense (PE) RVUs ensures that the practice expense RVUs reflect the best and most current data available. In the 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

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proposal to use the PPIS survey date to calculate PE RVUs. CMS believes the impact of using the new PPIS data warrants a 4 year transition for existing 2009 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.

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 payment rates (the OPFS 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. 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 (MIPPA) 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 RVUs

Section 1848(c) of the Act required the implementation of resource-based Malpractice (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

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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.

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.

For more information on revisions to consultation services please see Transmittal 1875, Change Request 6740, and dated December 14, 2009. A related MLN Matters® article, MM6740, is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf> on the CMS website.

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. MIPPA made several changes to the IPPE including

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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 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. 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

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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.

Certified Registered Nurse Anesthetist (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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Additional Information

If you have questions, please contact your Medicare MAC, carrier, or FI at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction, CR6756, issued to your Medicare MAC, carrier, or FI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R615OTN.pdf> on the CMS website.

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