

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**News Flash** – Per Section 5501(a) of the Affordable Care Act, the Primary Care Incentive Payment (PCIP) program authorizes an incentive payment of 10 percent of Medicare’s program payments to be paid to qualifying primary care physicians and non-physician practitioners for services rendered from Sunday, January 1, 2011, to Thursday, December 31, 2015. CMS has published 22 Frequently Asked Question (FAQ) items related to the PCIP program. These new FAQs can be found [here](#). Alternatively, these FAQ items can be found by visiting <http://questions.cms.gov/> and searching for “PCIP” or “Primary Care Incentive Payment.”

MLN Matters® Number: MM7671 **Revised**

Related Change Request (CR) #: 7671

Related CR Release Date: January 18, 2012

Effective Date: January 1, 2012

Related CR Transmittal #: R2379CP

Implementation Date: January 3, 2012

## Summary of Policies in the Calendar Year (CY) 2012 Medicare Physician Fee Schedule (MPFS) Final Rule and the Telehealth Originating Site Facility Fee Payment Amount

**Note:** This article was updated on August 2, 2012, to reflect current Web addresses. Previously, it was revised on February 2, 2012, to reflect a revised CR7671 issued on January 18, 2012. The CR was revised to amend language in the summary of the multiple procedure payment reduction and revisions to the practice expense geographic adjustment policies described below in the “Background” section of this article. In addition, the article now reflects a new transmittal number, CR release date, and a revised Web address for accessing the CR. All other information remains the same.

### Provider Types Affected

Physicians and non-physician practitioners who submit claims to Fiscal Intermediaries (FIs), carriers, and A/B Medicare Administrative Contractors (MACs) are affected by this article.

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## What You Need to Know

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This article is based on Change Request (CR) 7671, which summarizes the policies in the CY 2012 Medicare Physician Fee Schedule Final Rule and announces the Telehealth Originating Site Facility Fee payment amount for CY 2012. Please be sure that your staffs are aware of these changes.

## Background

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The purpose of this article is to inform you about the CR7671, which summarizes the policies in the CY 2012 Medicare Physician Fee Schedule (MPFS) and announces the telehealth originating site facility fee payment amount. Section 1848(b)(1) of the Social Security Act requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians' services for the subsequent year.

- The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2011, that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2012.
- The final rule (published in the "Federal Register" on November 28, 2011) addresses Medicare public comments on payment policies that were described in two separate proposed notices earlier this year:
  - The Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule (published in the "Federal Register" on June 6, 2011), and
  - The Medicare Program: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2012 (published in the "Federal Register" on July 19, 2011).
- The final rule also addresses interim final values established in the CY 2011 MPFS final rule with comment period (published in the "Federal Register" on November 29, 2010).
- Finally, the final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2012 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until January 3, 2012.

## Updated Policies

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### *Summary of Policies in the CY 2012 Medicare Physician Fee Schedule (MPFS)*

### *Misvalued Codes Under the Physician Fee Schedule*

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The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. The final rule adopts coding changes and revisions to values for about 300 services that have been identified as misvalued, reducing payments for these services by approximately \$100 million. CMS also identified additional categories of services that may be misvalued, including some of the highest expenditure codes in each specialty that have not been reviewed in the past five years.

### **Multiple Procedure Payment Reduction Policy**

Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures performed on the same patient by the same physician or group practice in the same session, based on efficiencies in the practice expense (PE) and pre- and post-surgical physician work. Beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction (MPPR) for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session. For CY 2012, CMS is applying the MPPR to the professional component (PC) of certain diagnostic imaging services. The MPPR currently applies only to the technical component (TC). The procedure with the highest PC and TC payment would be paid in full. Beginning CY 2012, the PC payment will be reduced for subsequent procedures furnished to the same patient, by the same physician, in the same session. Although the final rule also applies this policy to procedures furnished to the same patient in the same session by physicians in the same group practice, CMS is not applying the imaging MPPR to group practices for 2012 due to operational considerations..

### **Revisions to the Practice Expense Geographic Adjustment**

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice cost components of each of more than 7,000 types of physician services. The Affordable Care Act revised the methodology for calculating the PE GPCIs for CY 2010 and CY 2011 so that the employee compensation and rent components of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average while CMS studied the changes that are being undertaken in the 2012 physician fee schedule final rule.

CMS is applying several changes to the GPCIs as a result of additional analyses conducted both in accordance with section 3102 (b) of the Affordable Care Act and commitments made in the CY 2011 final rule with comment period. For CY 2012, CMS will use the Bureau of Labor Statistics Occupational Employment Statistics

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specific to the offices of physicians industry to calculate the PE employee wage index. In addition, CMS is replacing the U.S Department of Housing and Urban Development rental data as the proxy for physician office rent with rent data from the 2006-2008 American Community Survey. Lastly, CMS is creating a purchased service index to account for the labor-related industries within the “all other services” and “other professional expenses” Medicare Economic Index (MEI) categories. These changes result in very little change to the GPCIs and indicate that the data CMS has used to adjust for geographic variation is consistent and accurate. However, the expiration of statutory provisions, including a floor of 1.0 for the work GPCI and the limited recognition of cost differences for employee wage and office rent in the PE GPCI, will result in some payment reductions in the areas that benefitted from them in 2010 and 2011. Congress may choose to extend one or both of these provisions for CY 2012 subsequent to the release of this CR. In the event that Congress decides to extend either of these provisions for CY 2012, CMS will update the GPCIs for all impacted areas appropriately.

CMS is additionally basing the GPCI cost share weights on the revised and rebased 2006 MEI finalized by OACT in the CY 2011 final rule with comment period. CMS opted not to adopt the 2006-based MEI for GPCI cost share weights in the 2011 final rule in response to public comments. CMS subsequently addressed many of these commenters concerns in the CY 2012 final rule through the changes that are described above.

The Institute of Medicine (IOM) also has been evaluating the accuracy of the geographic adjustment factors used for Medicare physician payment. Their first report released in full in September includes an evaluation of the accuracy of geographic adjustment factors for the hospital wage index and the GPCIs and the methodology and data used to calculate them. CMS already is implementing many of the IOMs recommendations through the revisions to the GPCIs adopted in the CY 2012 final rule with comment period. Some IOM recommended revisions to the GPCIs will require a change in law.

### **Implementation of the 3-day Payment Window Policy in Wholly Owned or Wholly Operated Entities**

On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) was enacted. Section 102 of this Act, entitled “Clarification of 3-Day Payment Window,” clarified when certain non-diagnostic services furnished to Medicare beneficiaries in the three days (or, in the case of a hospital that is not a subsection (d) hospital, (e.g. psychiatric, inpatient rehabilitation, or long-term care) during the one day) preceding an inpatient admission should be considered “operating costs of inpatient hospital services” and therefore included in the hospital’s payment under the Hospital Inpatient Prospective Payment System (IPPS). This policy is generally known as the “3-day payment

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window," and a hospital must include on the inpatient claim for a Medicare beneficiary's inpatient stay, the technical portion of all outpatient diagnostic services and admission-related non-diagnostic services provided during the payment window. The statute makes no changes to the existing policy regarding billing of diagnostic services.

When a physician's office or clinic that is wholly owned or wholly operated by a hospital furnishes a service subject to the 3 day payment window policy, Medicare will pay the Professional Component of services with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split. Once a physician's office or practice has received confirmation of a beneficiary's inpatient admission from the admitting hospital, it should, for services furnished during the 3 day payment window, append CMS payment modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days) to all claim lines for diagnostic services and for those non-diagnostic services that have been identified as related to the inpatient stay. The new modifier will be available for use on January 1, 2012, and CMS encourages wholly owned or wholly operated physician offices and entities to begin to use the modifier when services are subject to the 3 day payment window policy. CMS will delay implementation of the policy until July 1, 2012, so that physician's offices and entities may coordinate their internal claims and payment practices. Physician non-diagnostic services that are unrelated to the hospital admission are not subject to the payment window and should be billed without the payment modifier.

### **Annual Wellness Visit Providing a Personalized Prevention Plan**

The Affordable Care Act provided for Medicare coverage for an Annual Wellness Visits (AWV) providing personalized prevention plan services. The statute required that a Health Risk Assessment (HRA) be included and taken into account in the provision of personalized prevention plan services as part of the annual wellness visit. As a result, CMS included the HRA as a part of the AWV.

The Centers for Disease Control and Prevention (CDC) published "A Framework for Patient-Centered Health Risk Assessments: Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries." This framework includes sections on:

- History of health risk assessments,
- Defining the HRA framework and rationale for its use
- Use of HRAs and follow-up interventions that evidence suggests can influence health behaviors; and
- A suggested set of HRA questions.

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As discussed in the preamble to the CY 2012 Physician Fee Schedule Final Rule, we believe it is important that health professionals have the flexibility to address additional topics as appropriate, based on patient needs, consistent with the final rule. Thus, there is not only one type of HRA that will meet the CDC guidelines.

CMS is providing payment for the AWW through the same Level II HCPCS codes as were used in CY 2011 and is adjusting the payment rate for these HCPCS codes to accommodate the additional physician office staff time that is expected to be expended in assisting a beneficiary with the completion of the HRA.

### **Molecular Pathology Procedure Codes**

Beginning January 1, 2012, there will be 101 additional molecular pathology procedure codes released by the American Medical Association (AMA). However, each of these new molecular pathology procedure codes represents a test that is currently being furnished and which may be billed to Medicare. When these types of tests are billed to Medicare, the existing CPT codes are “stacked”, or billed in combination with each other, to represent one given test. Under the new CPT coding structure for these molecular pathology services, a physician or laboratory would bill Medicare the new, single CPT procedure code that corresponds to the test represented by the “stacked” codes rather than billing each component of the test separately. CMS notes that not all of the current “stacked” molecular pathology CPT codes represent physicians’ services paid on the Physician Fee Schedule (PFS); many are only payable on the Clinical Laboratory Fee Schedule (CLFS).

For payment purposes under the PFS and CLFS, these 101 new molecular pathology procedure codes will be assigned a MPFS procedure status indicator of “B” (Bundled Code). Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (for example, a telephone call from a hospital nurse regarding care of a patient)). While these services would traditionally be assigned a procedure status indicator of “I” (Not Valid for Medicare purposes Medicare uses another code for the reporting of, and the payment for these services.), assigning these CPT codes a procedure status of B will allow CMS to gather claims information important to evaluating eventual pricing of these new molecular pathology CPT codes.

To that end, as of January 1, 2012, Medicare requests that Medicare claims for molecular pathology procedures reflect both the existing “stacked” CPT codes that are required for payment and the new single CPT code that would be used for payment purposes if the new CPT codes were active. While the allowed charge amount will be \$0.00 for the new molecular pathology procedure codes that carry the procedure status indicator of B, Medicare requests that Medicare claims also reflect a

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charge for the non-payable service. Please note that these CPT codes are listed in the CY 2012 PFS final rule as having a procedure status indicator of I--the CY 2012 final rule text and accompanying files will be corrected to reflect the procedure status indicator of B for these 101 molecular pathology CPT codes.

### Telehealth Services

CMS is adding smoking and tobacco cessation counseling to the list of Medicare telehealth services. These services are similar to other services, such as Kidney Disease Education (KDE) counseling services and Medical Nutrition Therapy (MNT) services, already on the telehealth list. In addition, CMS is changing the criteria for adding codes to the List of Medicare Telehealth services under the "category 2" methodology ("category 1" are services that are similar to services already on the telehealth list). Currently, CMS requires evidence of similar diagnostic findings or therapeutic interventions of a requested service via telehealth to an in-person service prior to adding it to the telehealth list under category 2. In the 2012 final rule with comment period, CMS eases the standard by no longer requiring telehealth services to demonstrate equivalence to the same service provided face-to-face and instead requires that the service demonstrate clinical benefit when furnished through telehealth. The refined category 2 review criteria are effective for services requested to be added to the telehealth benefit beginning in CY 2013.

### *Telehealth Originating Site Facility Fee Payment Amount*

Section 1834(m) of the Social Security Act 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 \$20.00. 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 Act. The MEI increase for CY 2012 is 0.6 percent.

For CY 2012, the **payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or \$24.24.** The beneficiary is responsible for any unmet deductible amount or coinsurance.

## Additional Information

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For more information and access to the CY 2012 Final Rule, go to the "Physician Fee Schedule" available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html> on the CMS website. The official instruction, CR7671, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2379CP.pdf> on the CMS website.

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

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