CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2129	**Date: DECEMBER 29, 2010**
	Change Request 7264

SUBJECT: Summary of Policies in the CY 2011 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount

I. SUMMARY OF CHANGES: This change request provides a summary of the policies in the CY 2011 Medicare Physician Fee Schedule Final Rule and announces the Telehealth Originating Site Facility Fee payment amount for CY 2011. The attached Recurring Update Notification applies to Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 190.6 and Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 270.5.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Unless otherwise specified, the effective date is the date of service.

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2129	Date: December 29, 2010	Change Request: 7264

SUBJECT: Summary of Policies in the CY 2011 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount

Effective Date: January 1, 2011
Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background:

The purpose of this change request is to provide a summary of the policies in the CY 2011 MPFS and to announce the telehealth originating site facility fee payment amount. Section 1848(b)(1) of the Social Security Act (the 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 2011 Physician Fee Schedule that sets payments to physicians effective January 1, 2011, went on display on November 2, 2010, and was published in the Federal Register on November 29, 2010.

B. Policy:

Telehealth Originating Site Facility Fee Payment Amount

Section 1834(m) of the 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. 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 2011 is 0.4 percent.

For calendar year 2011, the payment amount for HCPCS code "Q3014, Telehealth originating site facility fee" is 80 percent of the lesser of the actual charge or $24.10. The beneficiary is responsible for any unmet deductible amount or coinsurance.

Summary of Policies in the CY 2011 Medicare Physician Fee Schedule (MPFS)

Affordable Care Act Provisions

***Elimination of Deductible and Coinsurance for Most Preventive Services*:** Effective January 1, 2011, the Affordable Care Act waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services. Specifically, the provision waives both the deductible and coinsurance for Medicare-covered preventive services that have been recommended with a grade of A ("strongly recommends") or B ("recommends") by the U.S. Preventive Services Task Force (USPSTF), as well as the initial preventive physical examination and the new annual wellness visit. The Affordable Care Act also waives the Part B deductible for tests that begin as colorectal cancer screening tests but, based on findings during the test, become diagnostic or therapeutic services.

***Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan*:** The Affordable Care Act extends the preventive focus of Medicare coverage to provide coverage for annual wellness visits in which beneficiaries will receive personalized prevention plan services (PPPS). The law states that the annual wellness visit may include at least the following six elements, as determined by the Secretary of Health and Human Services:

- Establish or update the individual's medical and family history.
- List the individual's current medical providers and suppliers and all prescribed medications.
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements.
- Detect any cognitive impairment.
- Establish or update a screening schedule for the next 5 to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient's risk factors.
- Furnish personalized health advice and appropriate referrals to health education or preventive services.

CMS has developed two separate Level II HCPCS codes for the first annual wellness visit (G0438 - Annual wellness visit, including personalized prevention plan services, first visit), to be paid at the rate of a level 4 office visit for a new patient (similar to the initial preventive physical examination), and for subsequent annual wellness visits (G0439 - Annual wellness visit, including personalized prevention plan services, subsequent visit), to be paid at the rate of a level 4 office visit for an established patient.

***Incentive Payments to Primary Care Practitioners for Primary Care Services*:** The Affordable Care Act provides for incentive payments equal to 10 percent of a primary care practitioner's allowed charges for primary care services under Part B, furnished on or after January 1, 2011 and before January 1, 2016. Under the final policy, primary care practitioners are: (1) physicians who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner's MPFS allowed charges for a prior period as determined by the Secretary of Health and Human Services. The law also defines primary care services as limited to new and established patient office or other outpatient visits (CPT codes 99201 through 99215); nursing facility care visits, and domiciliary, rest home, or home care plan oversight services (CPT codes 99304 through 99340); and patient home visits (CPT codes 99341 through 99350).

In the final rule with comment period, CMS excluded consideration of allowed charges for hospital inpatient care and emergency department visits in determining whether the 60 percent primary care threshold is met. These exclusions will make it easier for practitioners of eligible specialties to become eligible for the payment incentive program. The incentive payments will be made quarterly based on the primary care services furnished in CY 2011 by the primary care practitioner, in addition to any physician bonus payments for services furnished in Health Professional Shortage Areas (HPSAs).

CMS will determine a practitioner's eligibility for incentive payments in CY 2011 using claims data and the provider's specialty designation from CY 2009 for practitioners enrolled in CY 2009. For newly enrolled practitioners, CMS will use claims data from CY 2010 to make an eligibility determination regarding CY 2011 incentive payments. For subsequent years, CMS will revise the list of primary care practitioners on a yearly basis, based on updated data regarding an individual's specialty designation and percentage of allowed charges for primary care services.

***Incentive Payments for Major Surgical Procedures in Health Professional Shortage Areas*:** The Affordable Care Act also calls for a payment incentive program to improve access to major surgical procedures – defined as those with a 10-day or 90-day global period under the Medicare Physician Fee Schedule (MPFS) – that are

furnished by physicians in Health Professional Shortage Areas (HPSAs) on or after January 1, 2011 and before January 1, 2016. To be eligible for the incentive payment, the physician must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the MPFS payment for the surgical services furnished by the general surgeon. The incentive payments will be made quarterly to the general surgeon when the major surgical procedure is furnished in a ZIP code that is located in a HPSA. CMS will use the same list of HPSAs that it has used under the existing HPSA bonus program.

***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 insurance cost components of each of more than 7,000 types of physicians' services. The final rule with comment period discusses CMS' analysis of PE GPCI data and methods, and incorporates new data as part of the sixth GPCI update, while maintaining the current GPCI cost share weights pending the results of further CMS and Institute of Medicine studies.

The Affordable Care Act establishes a permanent 1.0 floor for the PE GPCI for frontier states (currently, Montana, Wyoming, Nevada, North Dakota, and South Dakota). The Affordable Care Act limits recognition of local differences in employee wages and office rents in the PE GPCIs for CYs 2011 and 2012 as compared to the national average. Localities are held harmless for any decrease in CYs 2011 and 2012 in their PE GPCIs that would result from the limited recognition of cost differences. CMS will continue to review the GPCIs in CY 2011, in accordance with the Affordable Care Act provision that requires the Secretary of Health and Human Services to analyze current methods of establishing PE GPCIs in order to make adjustments that fairly and reliably distinguish the costs of operating a medical practice in the different fee schedule areas.

Payment for Bone Density Tests: The Affordable Care Act increases the payment for two dual-energy x-ray absorptiometry (DXA) CPT codes (77080 and 77082) for measuring bone density for CYs 2010 and 2011. This provision requires payments for these preventive services to be based on 70 percent of their CY 2006 RVUs and the CY 2006 conversion factor, and the current year geographic adjustment.

Improved Access to Certified Nurse-Midwife Services: The Affordable Care Act increases the Medicare payment for certified nurse-midwife services from 65 percent of the PFS amount for the same service furnished by a physician to 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less). The increased payment amount is effective for services furnished on or after January 1, 2011.

***Misvalued Codes under the Physician Fee Schedule*:** 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 with comment period identifies additional categories of services that may be misvalued, including codes with low work RVUs commonly billed in multiple units per single encounter and codes with high volume and low work RVUs. The final rule also includes CMS' response to recommendations from the American Medical Association (AMA) Relative Value Update Committee (RUC) for CY 2011 regarding the work or direct practice expense inputs for 325 CPT codes.

Multiple Procedure Payment Reduction Policy for Therapy Services: The Affordable Care Act requires CMS to identify and make adjustments to the relative values for multiple services that are frequently billed together when a comprehensive service is furnished. CMS is adopting a multiple procedure payment reduction (MPPR) policy for therapy services in order to more appropriately recognize the efficiencies when combinations of therapy services are furnished together. The policy, as described in the CY 2011 MPFS final rule with comment period, states that the MPPR for "always" therapy services will reduce by 25 percent the payment for the practice expense component of the second and subsequent therapy services furnished by a single provider to a

beneficiary on a single date of service. This policy will apply to all outpatient therapy services paid under Part B, including those furnished in office and facility settings.

Since publication of the CY 2011 MPFS final rule with comment period, this policy has been modified by the Physician Payment and Therapy Relief Act of 2010. Per this Act, CMS will apply the CY 2011 MPFS final rule policy of a 25 percent MPPR to therapy services furnished in the hospital outpatient department and other facility settings that are paid under section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 of the Act.

***Modification of Equipment Utilization Factor and Modification of Multiple Procedure Payment Policy for Advanced Imaging Services*:** The Affordable Care Act adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction 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.

Medicare Economic Index

***Medicare Economic Index (MEI)*:** The MEI is an inflation index for physician practice costs that is used as part of the formula to calculate annual updates to MPFS rates. For CY 2011, CMS is rebasing and revising the MEI to use a 2006 base year in place of a 2000 base year. Prior to the rebasing for CY 2011, CMS rebased the MEI in CY 2004. In addition, the final rule with comment period announces CMS' plans to convene a technical advisory panel to review all aspects of the MEI, including inputs, input weights, price-measurement proxies, and productivity adjustment; and indicates that CMS will consider the panel's analysis and recommendations in future rulemaking.

New and Revised CPT Code Issues

Establishment of Interim Final RVUs for CY 2011: On an annual basis, the AMA RUC provides CMS with recommendations regarding physician work values for new, revised, and potentially misvalued codes. Typically, the relevant specialty society surveys physicians to gather information regarding current medical practice that is then used by the AMA RUC in developing recommendations for physician work values. CMS reviews the AMA RUC-recommended work RVUs on a code-by-code basis. CMS then decides either to accept the AMA RUC-recommended work RVUs if CMS believes the valuation is accurate, or determine an alternative value that better reflects our estimate of the physician work for the service. CMS publishes these work RVUs in the PFS final rule as interim final values, subject to public comment.

Comprehensive Codes for a Bundle of Existing Component Services: A subset of AMA RUC work RVU recommendations addressed valuing new CY 2011 CPT codes resulting from the bundling of two or more existing component services performed together 95 percent or more of the time. CMS expects this bundling of component services to continue over the next several years as the AMA RUC further recognizes the work efficiencies for services commonly furnished together. Stakeholders should expect that increased bundling of services into fewer codes will generally result in reduced PFS payment for a comprehensive service by explicitly considering the efficiencies in work and/or PE that may occur when component services are furnished together. For CY 2011, the AMA RUC provided CMS with recommendations for several categories of new comprehensive services that historically have been reported under multiple component codes. For CY 2011 the creation of comprehensive codes for a bundle of existing component services fall into three major clinical categories: endovascular revascularization, computed tomography (CT), and diagnostic cardiac catheterization.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7264.1	Effective for dates of service January 1, 2011 and after, Medicare contractors shall 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 $24.10.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7264.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space:
N/A

V. CONTACTS

Pre-Implementation Contact(s): Sara Vitolo, sara.vitolo@cms.hhs.gov, (410) 786-5714

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.