CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 615	**Date: December 29, 2009**
	Change Request 6756

NOTE: Transmittal 615, dated December 29, 2009, rescinds and replaces Transmittal 613, dated December 23, 2009, FISS is indicated as a responsible party for Business Requirement 6756.1. All other information remains the same.

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

I. SUMMARY OF CHANGES: This Change Request (CR) provides a summary of the policies in the 2010 Medicare Physician Fee Schedule and announces the Telehealth Originating Site Facility Fee.

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and 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.

IV. ATTACHMENTS:

One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 615	Date: December 29, 2009	Change Request: 6756

NOTE: Transmittal 615, dated December 29, 2009, rescinds and replaces Transmittal 613, dated December 23, 2009, FISS is indicated as a responsible party for Business Requirement 6756.1. All other information remains the same.

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

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: The purpose of this change request is to provide a summary of the policies in the 2010 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 2010 Physician Fee Schedule that sets payments to physicians effective January 1, 2010 went on display on October 30, 2009 and was published on November 25, 2009.

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 §1842(i)(3) of the Act. The MEI increase for CY 2010 is 1.2 percent.

B. Policy: For calendar year 2010, the payment amount for HCPCS code "Q3014, Telehealth originating site facility fee" is 80 percent of the lesser of the actual charge or $24.00. The beneficiary is responsible for any unmet deductible amount or coinsurance.

See the attachment for a summary of issues discussed in CMS-1413-FC, Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010.

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	

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	
6756.1	Effective for dates of service January 1, 2010 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 $24.00.	X		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	
6756.2	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's 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

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:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Gaysha Brooks, **Gaysha.Brooks@cms.hhs.gov**, (410) 786-9649

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. ***For Fiscal Intermediaries, Regional Home Health Intermediaries (RHHI's), and/or Carriers***:

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

B. ***For Medicare Administrative Contractors (MAC)*****:**

The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

Attachment

Attachment (Informational Only)

Summary of Significant Physician Fee Schedule Issues Discussed in CMS-1413-FC, Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010

I. PHYSICIAN FEE SCHEDULE (PFS) ISSUES

Practice Expense Issues

A. Practice Expense Survey

The two primary data sources used to calculate practice expense 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 RVUs ensures that the practice expense RVUs reflect the best and most current data available.

In the 2010 PFS proposed rule, we proposed to include the data collected by the AMA's PPIS into the calculation of resource based practice expense relative value units as the best and most current data available. We did not propose a transition, nor did we propose to blend in the use of the old SMS or supplemental survey data for specialties that participated in the PPIS.

In this rule, we finalize our proposal to use the PPIS survey date to calculate PE RVUs. While we did not propose a transition, we believe 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. We will also continue using the oncology supplemental survey data for the drug administration codes.

B. Equipment Utilization Rate

In the 2010 PFS proposed rule, we 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). We stated that we believed this was a reasonable assumption given the high cost of this equipment and MedPAC is analysis of expensive imaging equipment. As we have in the past, we asked for any additional data. 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 OPPS cap).

In this rule, we finalize our proposal to increase the equipment utilization rate to 90 percent for expensive diagnostic equipment priced at more than $1 million. As requested by commenters, we are transitioning this change over a 4 year period to the practice expense RVUs. We are not finalizing our proposal to increase the utilization rate assumption for expensive therapeutic equipment.

Geographic Practice Cost Indices (GPCIs): Locality Discussion

In the CY 2010 PFS proposed rule, we noted that the legislative 1.0 work geographic practice cost index (GPCI) floor established by section 134 of the MIPPA expires December 31, 2009.

The proposed CY 2010 GPCIs did not include the 1.0 floor.

In the 2010 PFS proposed rule, we summarized the comments received on the interim locality study report, "Review of Alternative GPCI Payment Locality Structures." We did not propose to implement any of the options and noted that significant payment redistributions would occur if a nation-wide locality reconfiguration were implemented. We stated that we would consider the impact of any potential alternative locality configurations in the event we were to propose a change in the future.

In this rule, we reiterate that we are not proposing any changes in the PFS locality structure at this time but that we will continue to review the options available. A final report will be posted to the CMS Web site 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 must be budget neutral overall. In 2005, we implemented the results of the first comprehensive review of the MP RVUs. Therefore, the MP RVUs must now be updated for CY 2010. Malpractice represents approximately 3 percent of total Medicare physician fee schedule payments.

Currently, the MP RVUs for technical component (TC) services (for example diagnostic tests) and the TC portion of global services are based on historical allowed charges and have not been made resource based due to a lack of available malpractice premium data for non-physician suppliers.

In the CY 2010 PFS proposed rule, we discussed our proposed methodology and updated premium data for the second update of malpractice RVUs. We proposed to use medical physicist premium data as a proxy for the malpractice premiums paid by all entities providing TC services; primarily 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 CY 2000 and used in the CY 2005 updates.

In this rule, we finalize the updated malpractice RVUs. We state that we will use malpractice premium data for IDTFs instead of medical physicist premium data that has been verified by our contractor. We believe that using actual malpractice premium data paid for IDTFs is a more accurate source of the malpractice costs by providers of technical component services, than using medical physicist data. TC services will still experience significant reductions in the MP RVUs with the use of the IDTF data, but the reduction will not be as severe as proposed in the proposed rule. We are finalizing the other malpractice RVUs with some small technical changes based on comments received.

Specific Coding Issues related to Physician Fee Schedule

1. Consultation Services

In the 2010 PFS proposed rule, we 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. We 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.

Payments for major surgeries include bundled payment for the related post-operative visits occurring over a 10-day or 90-day global period. When payments for new and established office visits were increased after the third Five-Year Review, we also increased the bundled payments for these post-operative visits in the global period. However, given that these post-operative visits are not related to consultations, we did not propose to increase the bundled payments to reflect the increase in the visits.

In this rule, we finalize 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, we also are increasing the surgical global period RVUs to reflect the resulting increases in the RVUs for the visit codes. This increase is consistent with the "building block" approach we are recommending for the upcoming Five Year Review of work RVUs. We note that some of the specialties adversely impacted by the adoption of the PPIS data (e.g. cardiology) are also adversely impacted by the elimination of the use of the consultation codes.

2. Initial Preventive Physical Exam

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provided for coverage under Part B for the Initial Preventive Physical Exam (IPPE) or "Welcome to Medicare" visit. The Medicare Improvements for Patients and Providers Act of 2008 (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. Last year, we implemented the MIPPA revisions to the benefit, retained the existing value for the IPPE, and requested comments on whether it should be revalued. In the CY 2009 PFS proposed rule, we proposed to increase the work RVUs to the same level as a level 4 new patient office visit. The work RVU for the IPPE would increase from 1.34 to 2.30.

In this rule, we are revising the work RVUs as proposed.

3. Canalith Repositioning

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

In the 2010 PFS proposed rule, we proposed to change the indicator to I (Invalid). Physicians would continue to be paid for this service as part of an E/M service. Physical therapists would continue to use one of the more generally defined "always therapy" CPT codes.

In this rule, we finalize our proposal to make the CPT code for canalith repositioning invalid.

4. Clarification Concerning Certain Audiology Codes

In the CY 2010 PFS proposed rule, we proposed to clarify that therapeutic and/or management activities are not payable to audiologists because they do not fall under the diagnostic tests benefit category designation.

In this rule, we finalize the clarification of audiology services.

Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (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, we will pay outpatient mental health services at the same level as other Part B services. For 2010, we will pay 55 percent of the approved amount for outpatient psychiatric services. In the CY 2010 PFS proposed rule, we proposed to implement the MIPPA provision and some technical corrections to clarify exceptions to the limitation.

In this rule, we finalize Section 102 provisions as proposed.

Section 131(d): Value-based Purchasing

Section 131(d) of the MIPPA directs the Secretary to develop a plan to transition to a value-based purchasing (VBP) program for Medicare payment for physician and other professional services. The statute requires a Report to Congress (RTC) no later than May 1, 2010. In response to the MIPPA, we created an internal cross-component Physician VBP Workgroup charged with developing a VBP Plan. This Workgroup drafted an issues paper, which was presented during a public listening session on December 9, 2009. The workgroup also drafted a progress letter to Congress that was sent to the Senate Finance Committee in January of this year.

In the CY 2010 PFS proposed rule, we made no specific proposals but summarized the progress of the PVBP work to date.

In this final rule, we summarize the comments received, but not make any changes to payments.

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 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.

1. Special payment rule for teaching anesthesiologists.

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 PFS proposed rule, we proposed to 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.

In this final rule, we implement this provision as proposed.

2. Anesthesia "Handoff"

MIPPA Section 139 requires the teaching anesthesiologist to be present at the key or critical portions of an anesthesia procedure and that another teaching anesthesiologist could be available during non-critical or key portions of a 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. Anesthesiologists advised us 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 CY 2010 PFS proposed rule, we proposed to require that only one teaching anesthesiologist be present during all of the key or critical portions of a procedure with no handoff to another teaching anesthesiologist. In addition, we proposed that another teaching anesthesiologist with whom the teaching anesthesiologist has an arrangement could be immediately available to furnish services during a non-critical or non-key portion. We also acknowledged that an alternative would be to permit different anesthesiologists in the same group to be considered the teaching physician for purposes of being present during critical or key portions. We solicited comments on how the continuity of care and the quality of care are preserved during handoffs, whether there is an accepted maximum number of handoffs, any industry studies that have examined this issue, what factors contribute to handoffs, and if any anesthesia practices do not use handoffs.

In this rule, we finalize an alternative provision that will permit handoffs between members of the same anesthesia group. We permit different members of the same teaching anesthesiologist group to collectively provide the anesthesia service and to be present at the key or critical periods. We believe this is consistent with current anesthesia practice as reported by the commenters and it is less disruptive to current anesthesia practice arrangements. We may propose to standardize protocols and quality rules for handoffs for the future.

3. CRNA Teaching Payment Policy

Section 139(b) of the MIPPA instructs the 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 CY 2010 PFS proposed rule, we proposed a new payment policy for teaching CRNAs that is similar to the special payment rule for teaching anesthesiologists. We proposed to limit applicability of the rule to teaching CRNAs who are not medically directed. We also proposed to pay the teaching CRNA at the regular fee schedule rate for each of two concurrent anesthesia cases involving student nurse anesthetists. In all other arrangements involving student nurse anesthetists, we would continue with our current payment policies.

In this rule, we finalize our proposal to allow 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.