

# 2012 Medicare Physician Fee Schedule Proposed Rule

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On July 1, 2011, CMS issued the 2012 Medicare physician fee schedule (MPFS) proposed rule. Comments on the rule will be accepted until Aug. 30, 2011. The final rule will be issued on or about Nov. 1, 2011, and will take effect on Jan. 1, 2012.

## 2012 MPFS Payment Update

CMS is proposing a negative 29.5 percent payment update for services in 2012, based on the application of the sustainable growth rate (SGR) formula, which is required by statute. CMS does not have the ability to address the 29.5 percent reduction, as this requires a change in law. While the president's budget submission for fiscal year (FY) 2012 would extend current payment rates through Dec. 31, 2013, Congress must pass legislation that would address the cut. The AGA, along with the rest of the medical community, continue to work with Congressional leaders, urging them to permanently address the broken Medicare physician payment system, and replace it with a more stable and predictable update mechanism that takes into account the actual cost of providing care to Medicare beneficiaries.

## Practice Expense Payments

CMS is proposing to implement the third year of a four-year transition to new practice expense relative value units (RVUs), based on data from the Physician Practice Information Survey (PPIS) that was adopted in the MPFS calendar year (CY) 2010 final rule. Therefore, the 2012 practice expense RVUs are a 25 percent/75 percent blend of the previous practice expense RVUs based on the American Medical Association's (AMA) Socioeconomic Monitoring Survey and supplemental survey data and the new practice expense RVUs developed using the PPIS data, as described previously.

Specific to colorectal cancer, CMS notes that it recently identified a number of CPT codes which inadvertently duplicated labor and supply inputs in the practice expense database. CMS is proposing to remove the duplicate labor and supply inputs in the proposed CY 2012 database for the following CPT codes.



<b>LABOR AND SUPPLY INPUT DUPLICATION</b>		
<b>CPT Code</b>	<b>Description</b>	<b>Duplicate Supply</b>
45541	Correct rectal prolapse	lubricating jelly (K-Y) (5gm uou)
45550	Repair rectum/remove sigmoid	lubricating jelly (K-Y) (5gm uou)
46258	Remove in/ex hem grp w/fistu	anoscope (3)
46261	Remove in/ex hem grps & fiss	anoscope (3)

In addition, CMS proposes to accept, with modification, an AMA Relative Value System Update Committee (RUC) recommendation that standardizes the nonfacility (office) direct practice expense inputs that account for moderate sedation as typically furnished as part of certain services. Specifically, the RUC recommended, based on input from AGA and other specialty societies, that the direct practice expense inputs allocated for moderate sedation include additional clinical labor time, supplies and so on. The following codes are impacted by this change.

<b>INHERENT MODERATION SEDATION CODES VALUED IN THE NONFACILITY SETTING</b>			
<b>CPT Code</b>	<b>Description</b>	<b>CPT Code</b>	<b>Description</b>
43200	Esophagus endoscopy	45305	Proctosigmoidoscopy w/bx
43201	Esoph scope w/submucous inj	45307	Proctosigmoidoscopy fb
43202	Esophagus endoscopy biopsy	45308	Proctosigmoidoscopy removal
43216	Esophagus endoscopy/lesion	45309	Proctosigmoidoscopy removal
43217	Esophagus endoscopy	45315	Proctosigmoidoscopy removal
43234	Upper GI endoscopy exam	45317	Proctosigmoidoscopy bleed
43235	Upper GI endoscopy diagnosis	45320	Proctosigmoidoscopy ablate
43236	Upper GI scope w/submuc inj	45332	Sigmoidoscopy w/fb removal
43239	Upper GI endoscopy biopsy	45333	Sigmoidoscopy & polypectomy
43453	Dilate esophagus	45335	Sigmoidoscopy w/submuc inj
43456	Dilate esophagus	45338	Sigmoidoscopy w/tumor remove



43458	Dilate esophagus	45339	Sigmoidoscopy w/ablate tumor
44385	Endoscopy of bowel pouch	45340	Sig w/balloon dilation
44386	Endoscopy bowel pouch/biop	45378	Diagnostic colonoscopy
44388	Colonoscopy	45379	Colonoscopy w/fb removal
44389	Colonoscopy with biopsy	45380	Colonoscopy and biopsy
44390	Colonoscopy for foreign body	45381	Colonoscopy submucous inj
44391	Colonoscopy for bleeding	45382	Colonoscopy/control bleeding
44392	Colonoscopy & polypectomy	45383	Lesion removal colonoscopy
44394	Colonoscopy w/snare	45384	Lesion remove colonoscopy
44901	Drain app abscess percut	45385	Lesion removal colonoscopy
45303	Proctosigmoidoscopy dilate	45386	Colonoscopy dilate stricture

## Potentially Misvalued Code Initiative

For 2012, CMS is expanding the potentially misvalued code initiative, focusing on high volume and dollar codes billed by physicians to determine whether these codes are overvalued and if evaluation and management (E/M) codes are undervalued. Specifically, CMS will refer the E/M codes, along with the codes listed in the table below, to the AMA RUC for review.

SELECT LIST OF PROCEDURAL CODES REFERRED FOR AMA RUC REVIEW	
CPT Code	Description
45378	Diagnostic Colonoscopy
43235	Upper GI Endoscopy, Diagnosis

These codes were selected for review based on the fact that they have not been reviewed for at least six years and, in many cases, the last review occurred more than 10 years ago. According to CMS, they represent high Medicare expenditures under the MPFS; thus, CMS believes that a review to assess changes in physician work and update direct practice expense inputs is warranted. Furthermore, these codes are believed to have significant impact on MPFS payment on the specialty level. Therefore, CMS believes a review of the relativity of the code to ensure that the work and practice expense RVUs are appropriately relative within the specialty and across specialties is essential.



CMS also identified CPT code 88305 (Level IV – surgical pathology, gross and microscopic examination) as a code potentially requiring updates to its direct practice expense inputs. Specifically, CMS was informed that the direct practice expense inputs associated with this particular tissue examination code are atypical. As a result, CMS has asked the AMA RUC to review the direct practice expense inputs and work values for this code.

As for the potentially misvalued code initiative overall, CMS proposes to consolidate the formal five-year review of work and practice expense with the annual review of potentially misvalued codes. That is, CMS would begin meeting its statutory requirement to review work and practice expense RVUs for potentially misvalued codes at least once every five years through an annual process, rather than once every five years.

CMS will also review both physician work and practice expense for each code under its potentially misvalued codes initiative to more accurately align the review of codes. CMS proposes to no longer value physician work and practice expense separately going forward.

CMS is further proposing a process by which the public could submit codes for potential review, along with supporting documentation, on an annual basis. Specifically, CMS is proposing that stakeholders may nominate potentially misvalued codes by submitting the code with supporting documentation during the 60-day public comment period following the release of the annual physician fee schedule final rule with comment period.

## **Expanded Multiple Procedure Payment Reduction**

CMS is proposing to expand its multiple procedure payment reduction to the professional interpretation of advance imaging services to recognize the overlapping activities that go into valuing these services. Specifically, CMS proposes to expand the 50 percent multiple procedure payment reduction (MPPR) currently applied to the technical component to also apply to the professional component of the second and subsequent advanced imaging services furnished in the same session.

CMS also states that it will be aggressively looking for efficiencies in other sets of codes during the following years and will consider implementing more expansive reduction policies, such as applying the MPPR to the professional component and technical component of all imaging services and the technical component of all diagnostic tests, in CY 2013 and beyond.

## **Issues Concerning Geographic Variation**

CMS is proposing changes in how it adjusts payment for geographic variation in the cost of practice.



For physician work, CMS is not proposing to revise the physician work geographic practice cost indices (GPCI) data source for CY 2012. However, the work GPCIs will be revised to account for the expiration of the statutory work floor. CMS is proposing to revise the physician work cost share weight in line with the 2011 Medicare Economic Index (MEI) weights, which are based on more current (2006) data.

For practice expense, and as a result of the Patient Protection and Affordable Care Act (PPACA), CMS is proposing to make four revisions to the practice expense data sources and cost share weights effective Jan. 1, 2012. Specifically, CMS is proposing to:

- Revise the occupations used to calculate the employee wage component of practice expense using Bureau of Labor Statistics wage data specific to the office of physicians' industry.
- Utilize two bedroom rental data from the 2006 to 2008 American Community Survey as the proxy for physician office rent.
- Create a purchased service index that accounts for regional variation in labor input costs for contracted services from industries comprising the "all other services" category within the MEI office expense and the stand alone "other professional expenses" category of the MEI.
- Use the 2006-based MEI (most recent MEI weights finalized in the CY 2011 final rule with comment period) to determine the GPCI cost share weights.

For malpractice, CMS is proposing to revise the cost share weight for the malpractice GPCI. Specifically, CMS will increase the weight from 3.865 percent to 4.295 percent.

CMS will continue to evaluate recommendations from the Institute of Medicine on GPCI's and make additional adjustments, as required by the PPACA.

## **Quality Improvement Incentive Programs**

CMS is proposing updates to the Physician Quality Reporting System (PQRS), the e-prescribing incentive program and the electronic health records (EHR) incentive program. CMS is also proposing a maintenance of certification (MOC) program incentive as mandated by the PPACA.

### **PQRS**

CMS proposes to change the definition of "group practice" to groups with 25 or more eligible professionals. This proposed definition of group practice is different from the definition of group practice that was applicable for the 2011 PQRS, which defined a group practice as two or more eligible professionals.

CMS also proposes to consolidate the Group Practice Reporting Option (GPRO) I and II into a single GPRO. However, the agency still recognizes the need to equalize the reporting burden by establishing different reporting criteria for small versus large groups. Therefore, CMS proposes



to establish the following two criteria for the satisfactory reporting of PQRS quality measures under the 2012 GPRO, based on the size of the group practice.

- For group practices comprised of 25 to 99 eligible professionals participating in the GPRO, CMS proposes that the group practice must report on all GPRO measures included in the web interface and populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 327) for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.
- For group practices comprised of 100 or more eligible professionals, CMS proposes that the group practices must report on all PQRS GPRO quality measures and populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 616) for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries.

For 2012 and subsequent years, CMS is proposing to eliminate the six-month reporting period option for claims and registry reporting (that is, registry reporting for individual measures). It will retain the 6 month reporting option for reporting measures groups via registry.

Specific to reporting mechanisms for individuals, CMS proposes to retain the claims-based, registry-based, and EHR-based reporting mechanism for 2012 and beyond. Specific to the EHR-based reporting mechanism, eligible professionals would be required to have a PQRS *qualified* EHR product, which is different from *certified* EHR technology for the EHR Incentive Program. CMS is currently exploring ways to further align these two programs' reporting requirements for future years so that certified EHR Technology may be used to satisfy both the Medicare EHR Incentive Program and the PQRS without any additional testing.

As it pertains to PQRS payments, CMS proposes not to count measures that have a 0 percent performance rate. That is, if the recommended clinical quality action is not performed on at least one patient, CMS will not count the measure.

Regarding quality measures included in the 2012 PQRS program, CMS is proposing to retain the 2011 PQRS measures and include the following new measures and measures groups.

<b>PROPOSED PATHOLOGY MEASURES INCLUDED IN THE 2012 PQRS</b>			
<b>Type</b>	<b>PQRS Measure Number</b>	<b>Measure Title</b>	<b>Reporting Mechanism</b>



Individual Measure	TBD	Barrett's Esophagus	Claims, Registry
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<b>PROPOSED MEASURES INCLUDED IN THE PROPOSED 2012 IBD MEASURES GROUP**</b>	
<b>PQRS Number</b>	<b>Measure Title</b>
TBD	Inflammatory Bowel Disease (IBD): Assessment of Inflammatory Bowel Disease Activity and Severity
TBD	Inflammatory Bowel Disease (IBD): Preventive Care: Steroid Sparing Therapy
TBD	Inflammatory Bowel Disease (IBD): Preventive Care: Steroid Related Iatrogenic Injury – Bone Loss Assessment
TBD	Inflammatory Bowel Disease (IBD): Preventive Care: Influenza Immunization
TBD	Inflammatory Bowel Disease (IBD): Preventive Care: Pneumococcal Immunization
TBD	Inflammatory Bowel Disease (IBD): Screening for Latent TB Before Initiating Anti-TNF Therapy
TBD	Inflammatory Bowel Disease (IBD): Hepatitis B Assessment Before Initiating Anti-TNF Therapy
226	Preventative Care and Screening: Tobacco Use; Screening and Cessation Intervention
<i>** This measures group is reportable through registry-based reporting only.</i>	

The AGA Digestive Health Outcomes Registry™ is qualified for CMS quality reporting. It provides participating providers with a streamlined way to meet CMS reporting requirements for the hepatitis C measures group and potentially qualify for increased reimbursement for Medicare Part B encounters. In 2010, the AGA Registry successfully submitted data on behalf of 44 eligible professionals. CMS has shown that professionals who participate through a registry were more likely to earn incentive payments and higher incentive payments due to the lack of submission errors and missing data common in claims-based reporting. The registry additionally supports the IBD measures group, which the AGA submitted to CMS and is included in the proposed 2012 PQRS.

CMS is also proposing to provide more flexibility to entities sponsoring MOC programs to define what an eligible professional is required to do to “more frequently” for purposes of the PQRS MOC program incentive.



With regard to feedback reports, CMS proposes to provide interim feedback reports for eligible professionals reporting individual measures and measures groups through the claims-based reporting mechanism for 2012 and beyond. These reports would be a simplified version of annual feedback reports that CMS currently provides for such eligible professionals and would be based on claims for dates of service occurring on or after Jan. 1 and processed by March 31 of the respective program year. Reports would be available in summer of the program year. CMS will also retain the informal review process it implemented in the 2011 PQRS, which used the quality net help desk.

Finally, CMS announced that the reporting period for purposes of the 2015 PQRS payment adjustment (negative 1.5 percent) will be the 2013 program year. The adjustment will increase to negative 2 percent for 2016 and beyond.

### ***e-Prescribing Incentive Program***

CMS is proposing to modify the electronic prescribing measure (eRx) to allow eligible professionals to use either a qualified electronic prescribing system (based on original criteria in measure) or certified EHR technology. In addition, CMS is proposing to adopt criteria for the 2012 and 2013 incentives that parallel those for the 2011 incentive, and criteria for the 2013 and 2014 payment adjustments that parallel those for the 2012 payment adjustment.

CMS is also proposing to modify the way the electronic prescribing measure is reported for purposes of the 2013 and 2014 payment adjustment by eliminating the requirement that the measure may only be reported during an instance indicated in the denominator of the electronic prescribing measure.

CMS is also proposing, for purposes of the 2013 and 2014 payment adjustments, to provide significant hardship exemption categories for professionals who practice in a rural area with limited high speed internet access; practice in an area with limited available pharmacies for electronic prescribing; are unable to electronically prescribe due to local, state, or federal law; or, prescribe fewer than 100 prescriptions during a six-month, payment adjustment reporting period.

In addition, and for purposes of determining whether an eRx GPRO is a successful electronic prescriber for 2012 through 2014, CMS proposes to modify the definition of the "group practice" to be consistent with modifications being proposed to the definition of "group practice" for the 2012 PQRS, including changes to the definition of a "group practice" and the consolidation into one GPRO reporting mechanism.



Finally, CMS is proposing for both individual eligible professionals and group practices participating in the eRx GPRO, a six-month reporting period (between Jan. 1, 2012, and June 30, 2012) for purposes of the 2013 payment adjustment. For the 2014 payment adjustment, CMS is proposing either a 12-month reporting period (between Jan. 1, 2012, and Dec. 31, 2012) or a six-month reporting period (between Jan. 1, 2013, and June 30, 2013) for individual eligible professionals. For group practices, there would only be a six-month reporting period (between Jan. 1, 2013, and June 30, 2013) option.

### ***EHR Incentive Program***

CMS proposes that for the 2012 payment year, eligible professionals may continue to report clinical quality measure results as calculated by certified EHR technology by attestation, as for the 2011 payment year. CMS proposes to establish a pilot mechanism through which eligible professionals participating in the Medicare EHR Incentive Program may report clinical quality measure information electronically using certified EHR technology for the 2012 payment year.

In addition, CMS is proposing a PQRS-Medicare EHR incentive pilot. The pilot would allow eligible professionals to satisfy the clinical quality measure reporting requirements for both the PQRS and the EHR incentive program.

### ***Physician Compare Website***

CMS proposes to take an initial step by making public the performance rates of the quality measures that group practices submit under the 2012 PQRS GPRO. CMS would make public the measure performance for each of the measures included in the 2012 Physician Quality Reporting System GPRO. A minimum threshold of 25 patients will have to be met in order for the group practice's measure performance rate to be reported on the physician compare website. For groups reporting using GPRO information that is made public in 2013, CMS does not propose to post information with respect to the measure performance of individual physicians or eligible professionals associated with the group. However, it proposes to identify the individual eligible professionals who were associated with the group during the reporting period. Specifically, CMS will identify the eligible professionals associated with the group by posting a list of the eligible professionals on the physician compare website.

### **Value Based Modifier and Physician Feedback Reports**

CMS is proposing quality and cost measures that would be used in establishing a new value-based modifier that would reward physicians for providing higher quality and more efficient care, as required by the PPACA. Specifically, CMS is proposing to use performance on:



- The measures in the core set of the PQRS for 2012
- All measures in the GPRO of the PQRS for 2012
- The core measures, alternate core and 38 additional measures in the EHR incentive program measures for 2012.

Specifically, PQRS measures 113 (colorectal cancer screening) and 128 (body mass index screening and follow-up) are proposed quality measures for the value modifier.

CMS is proposing to use CY 2013 as the initial performance year for purposes of adjusting payments in CY 2015. However, CMS notes that the modifier would likely evolve after its initial application in 2015. All physicians will be subject to the value modifier beginning in 2017.

With respect to the physician feedback program, the agency expects to expand dissemination of feedback/resource use reports to cover 100,000 physicians nationally in 2012.

### **Non-Physician Related Issues Included in the 2012 MPFS Proposed Rule: Productivity Adjustment for ASC Payments**

In the 2012 MPFS proposed rule, CMS is proposing a productivity adjustment for ambulatory surgical center (ASC) payments as required by the PPACA. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity.

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Review the [2012 Medicare Physician Fee Schedule Proposed Rule](#). Download the CMS fact sheets:

- [CMS Proposals for Changes to Physician Payment Policies and Rates for Calendar Year 2012](#)
- [Proposed Changes for Calendar Year 2012 Physician Incentive Programs](#)
- [Proposed 2012 Policy, Payment Changes for HOPDs and ASCs](#)

