



## 2012 Medicare Physician Fee Schedule Final Rule Summary

On Nov. 1, 2011, CMS issued the 2012 Medicare Physician Fee Schedule (MPFS) final rule, which addresses changes to the physician fee schedule and other Medicare Part B payment policies. The final rule is effective beginning Jan. 1, 2012. The rule will be published in the *Federal Register* on Nov. 28, 2011.

### Payment Update

CMS announced a reduction to payment rates for physicians' services in calendar year (CY) 2012 under the sustainable growth rate (SGR) formula. These payment rates are currently scheduled to be reduced under the SGR system on Jan. 1, 2012. The total reduction in MPFS rates between CY 2011 and CY 2012 under the SGR system will be 27.4 percent. CMS calculates the CY 2012 MPFS conversion factor to be \$24.6712. [Review how the payment reductions affect GI codes.](#)

By law, CMS is required to make these reductions, which can only be averted by an act of Congress. While Congress has provided temporary relief from these reductions every year since 2003, a long-term solution is critical. CMS stated they will continue to work with Congress to fix this untenable situation so doctors and beneficiaries no longer have to worry about the stability and adequacy of their payments from Medicare under the physician fee schedule. 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.

The overall effect of the changes in this final rule on gastroenterology is 0 percent, according to the CMS impact analysis. This impact does not include the effects of the January 2012 conversion factor change under current law.

### Practice Expense Changes

CMS is implementing 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 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 along with the new practice expense RVUs developed using the PPIS data.

CMS recently identified a number of CPT codes that inadvertently duplicated labor and supply inputs in the practice expense database. Specific to GI, CMS will remove the duplicate labor and supply inputs in the 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 prolapsed	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)

CMS is finalizing the proposal 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 MODERATE 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
44393	Colonoscopy lesion removal	45384	Lesion remove colonoscopy
44394	Colonoscopy w/snare	45385	Lesion removal colonoscopy
44901	Drain app abscess percut	45386	Colonoscopy dilate stricture
45303	Proctosigmoidoscopy dilate		

### **Potentially Misvalued Services**

The Patient Protection and Affordable Care Act (PPACA) specifies the establishment of a formal process to validate RVUs under the MPFS. CMS solicited public comments on possible approaches and methodologies to consider for a validation process. CMS will discuss the validation process in more detail in a future MPFS rule once it has considered the matter further, in conjunction with the public comments received on the CY 2011 and 2012 MPFS final rules. Any proposals CMS would make on the formal validation process would be subject to public comment, and would be considered before policies were finalized.

CMS will consolidate the formal five-year review of work and PE RVUs, and potentially misvalued codes, into one annual process. CMS will also preserve the public's ability to nominate potentially misvalued codes for review, along with supporting documentation, on an annual basis. The historical practice of publishing the AMA RUC relative value recommendations for non-covered services will continue, but CMS will not accept for review either inactive or non-covered codes (for which the RVUs will have no financial impact on the MPFS) through the public nomination process. CMS will assess, identify and publish in the following year's proposed rule the list of nominated codes and codes selected for review.

CMS proposed to expand the potentially misvalued code initiative by 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. Given the significant concerns expressed by the majority of commenters, CMS is not finalizing the proposal to review the list of 91 E/M codes at this time. Instead, CMS believes allowing time for consideration of the findings in several ongoing initiatives and demonstrations will provide improved information for the valuation of these services.

CMS finalized the proposal to evaluate its list of high expenditure and high volume codes. These codes were selected for review because 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. Of interest to gastroenterologists, CMS will refer codes 45378 *diagnostic colonoscopy* and 43235 *upper GI endoscopy, diagnosis*, to the AMA RUC for review.

### **Geographic Practice Cost Indices (GPCIs)**

As required under current law, CMS adjusts payments under the MPFS to reflect local differences in practice costs by assigning separate geographic practice cost indices (GPCIs) to the work, practice expenses and malpractice cost components of physician services. In this rule, CMS finalized changes in how it adjusts payment for geographic variation in the cost of practice. CMS finalized the revisions to the sixth GPCI update using the most current data, with some modifications. Although not available at the time of this rule, CMS plans to review the complete findings and recommendations from the Institute of Medicine's studies on geographic

adjustment factors for physician payment and the Medicare economic index technical advisory panel, once available.

For CY 2012, CMS will use the Bureau of Labor Statistics occupational employment statistics specific to the offices of physicians to calculate the practice expense employee GPCI. 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.<sup>1</sup> 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 categories. CMS finalized the following GPCI cost share weights for CY 2012.

<b>COST SHARE WEIGHTS FOR CY 2012 GPCIs</b>		
<b>Expense Category</b>	<b>Current CY 2011 Cost Share Weights %</b>	<b>CY 2012 Cost Share Weights %</b>
Physician Work	52.466	48.266
Practice Expense	43.669	47.439
Employee Compensation	18.654	19.153
Office Rent	12.209	10.223 <sup>1</sup>
Purchased Services	N/A	8.095 <sup>2</sup>
Equipment, Supplies, and Other	12.806	9.968
Malpractice Insurance	3.865	4.295

<sup>1</sup> American community survey (ACS) rental data is a measurement of gross rent that includes utilities. In order to accurately capture the utility measurement present in the ACS two bedroom gross rent data, the cost share weight for utilities is combined with the fixed capital portion to form the office rent index. The cost share weight for purchased services contains both an adjusted and non-adjusted portion (5.011 percentage points geographically adjusted purchased services + 3.084 percentage points non-adjusted purchased services).

### **Expanding the Multiple Procedure Payment Reduction Policy**

CMS believes that some level of duplication exists in the professional component service for second and subsequent advanced imaging services. Based on further analysis and in response to comments, CMS finds that a 25 percent reduction would more appropriately capture the range of physician work efficiencies for second and subsequent imaging services furnished by the same physician (including physicians in the same group practice) to the same patient, in the same session, on the same day. In cases in which the physician demonstrates the medical necessity of furnishing interpretations in separate sessions, use of the 59 modifier (*distinct procedural service*) would be appropriate. The MPFS budget neutrality provision is applicable to the new multiple procedure payment reduction for the professional component of advanced imaging services. Therefore, the estimated reduced expenditures for imaging services have been redistributed to increase payment for other MPFS services.

### **Clinical Laboratory Fee Schedule: Signature on Requisition**

CMS is finalizing its proposal to retract the policy that was finalized in the CY 2011 MPFS final rule, which required a physician's or non-physician practitioner's signature on a requisition for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule (CLFS). CMS is reinstating its prior policy that the signature of the physician or non-physician practitioner is not required on a requisition for a clinical diagnostic laboratory test paid under the CLFS for Medicare purposes.

### **Quality Reporting Initiatives**

CMS finalized updates to the Physician Quality Reporting System (PQRS), e-prescribing (e-Rx) incentive program and the electronic health records (EHR) incentive program.

**Physician Quality Reporting System (PQRS).** Eligible professionals who satisfactorily report 2012 PQRS measures can qualify for an incentive equal to 0.5 percent of the total estimated part B allowed charges for all covered professional services furnished by the eligible professional [or, in the case of a group practice participating in the group practice reporting option (GPRO), the group practice] during the applicable reporting period.

CMS finalized the proposal to change the definition of "group practice" to include groups with 25 or more eligible professionals. This 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 is working to develop the GPRO so that it may be a viable reporting option for group practices smaller than 25 eligible professionals in future program years.

For 2012 and beyond, CMS is finalizing the proposal to specify a 12-month reporting period (Jan. 1 through Dec. 31 of the respective program year) for the satisfactory reporting of PQRS quality measures for claims, registry and EHR-based reporting. In addition to the 12-month reporting period available for all reporting methods, CMS is also finalizing a six-month reporting period (July 1 through Dec. 31 of the respective program year) for reporting measures groups via registry.

Specific to reporting mechanisms for individuals, CMS finalized the claims-based, registry-based and EHR-based reporting mechanism under PQRS for 2012 and beyond. CMS will not combine data submitted via multiple reporting mechanisms to determine incentive eligibility.

In an effort to better align PQRS measures with those under the EHR incentive program, for 2012, CMS included all 44 clinical quality measures in the Medicare EHR Incentive Program available for EHR-based reporting under the 2012 PQRS. Included in the measures are preventive care and screening: colorectal cancer screening (measure 112) and colorectal cancer screening (measure 114).

CMS finalized the 2012 PQRS core measure set (seven measures, one of which is available for EHR-reporting only) aimed at promoting the prevention of cardiovascular conditions. CMS also finalized 211 individual measures and 23 measures groups for claims and/or registry-based reporting in the 2012 PQRS, which included the following new measure and measures groups:

PATHOLOGY MEASURES INCLUDED IN THE 2012 PQRS			
Type	PQRS Measure Number	Measure Title	Reporting Mechanism
Individual Measure	TBD	Barrett’s Esophagus	Claims, Registry

MEASURES INCLUDED IN THE 2012 IBD MEASURES GROUP**	
PQRS Number	Measure Title
TBD	Inflammatory Bowel Disease: Type, Anatomic Location and Activity All Documented
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	Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

*\*\* This measures group is reportable through registry-based reporting only.*

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.** Note, CMS will post the detailed specifications and specific instructions for reporting measures groups on the PQRS section of the CMS website at <http://www.cms.hhs.gov/PQRS> by no later than Dec. 31, 2011.

CMS provides an additional 0.5 percent maintenance of certification (MOC) program incentive payment for 2011 through 2014 for those who qualify. CMS is providing more flexibility to entities sponsoring MOC programs to define what an eligible professional is required to do “more frequently” for purposes of the PQRS MOC program incentive.

CMS will 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 will be a simplified version of annual feedback reports that CMS currently provides for such eligible professionals and will be based on claims for dates of service occurring on or after Jan. 1 and processed by March 31 of the respective program year. CMS expects that it would be able to make these interim feedback reports available to eligible professionals in the summer of the respective program year (e.g., summer 2012 for the 2012 program year). CMS also finalized the PQRS informal review process. Eligible professionals who would like to submit a request for an informal review are required to do so via a web-based tool, the communication support page. Information on the communication support page, including the link to the page, will be available at <http://www.cms.gov/PQRS/>.

CMS finalized the proposal to establish CY 2013 (Jan. 1, 2013, through Dec. 31, 2013) as the reporting period for the 2015 payment adjustment (negative 1.5 percent). CMS will continue to explore options for potentially using a reporting period closer to the time in which the payment adjustment is applied for future years of the payment adjustment. CMS will address the remaining requirements for the 2015 payment adjustment in future rulemaking.

**e-Prescribing (eRx) Incentive Program.** The eRx incentive program provides incentive payments to eligible professionals and group practices that successfully e-prescribe. Successful participants are eligible for a 1 percent incentive payment in 2012 and 0.5 percent in 2013. The reporting period for the 2012 and 2013 incentive will be the 12-month period of the respective year (Jan. 1 through Dec. 31).

Those who do not participate will encounter the following reductions to their Medicare payments: -1 percent in 2012, -1.5 percent in 2013 and -2 percent in 2014. The reporting periods to avoid the penalty are slightly different than the reporting period to earn an incentive. In addition to the 12-month reporting period finalized in the 2011 MPFS final rule, CMS finalized an additional 6-month reporting period (Jan. 1, 2012, through June 30, 2012) for purposes of the 2013 payment adjustment. For the 2014 payment adjustment, CMS will offer both a six-month reporting period and 12-month reporting period for eligible professionals and group practices participating in the eRx GPRO. This will afford providers and group practices additional options for reporting to avoid the payment adjustments.

CMS is finalizing the claims, registry and EHR reporting mechanisms for the 12-month reporting periods for the 2012 and 2013 incentives, and the 2014 payment adjustment. Due to system limitations, CMS will allow only the claims-based reporting mechanism for purposes of the six-month 2013 and 2014 payment adjustment reporting periods.

CMS also modified the way the e-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 e-prescribing measure.

For purposes of determining whether an eRx GPRO is a successful electronic prescriber for 2012 through 2014, CMS modified the definition of "group practice" to be consistent with modifications being proposed to the definition of "group practice" for the 2012 PQRS.

CMS finalized the following significant hardship exemption categories for the 2013 and 2014 payment adjustments 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. Eligible professionals and group practices may report a significant hardship by reporting Medicare G-codes (*G9642 eligible professional or group practice practices in a rural area with limited high speed internet access* or *G8643 eligible professional or group practice practices in an area with limited available pharmacies for electronic prescribing*) on claims for services rendered during the respective 2013 and 2014 six-month reporting periods. Eligible professionals may also submit requests via a web-based tool.

**EHR Incentive Program.** 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 also established a pilot program through which eligible professionals can report clinical quality measures for the EHR incentive program through the *PQRS-Medicare EHR Incentive Pilot* for the 2012 payment year. The pilot will allow eligible professionals to satisfy the clinical quality measure reporting requirements for both the PQRS and EHR incentive programs.

### **Physician Compare Website**

CMS is finalizing its proposal to publicly report in 2013, the performance rates of the quality measures that group practices submit under the 2012 PQRS GPRO. CMS will use a minimum sample size of 25 patients for reporting and displaying measure performance on the physician compare website. CMS intends to identify those eligible professionals who have assigned their Medicare Part B billing rights to the group practice's tax identification number, however performance rates will not be displayed on the individual eligible professionals' profile on physician compare in 2013. Group practices participating in 2012 PQRS GPRO must agree in advance to have their reporting performance results publicly reported as part of their self-nomination to participate. CMS is also finalizing its proposal to modify the GPRO web interface for 2012 to calculate the numerator, denominator and measure performance rate for each measure from the data that the group practices use to populate the web interface. This modification will allow the group practice the opportunity to preview their measure performance results before they are made public in 2013.

In addition, as discussed in the Medicare Shared Savings Program (MSSP) final rule, because accountable care organizations (ACO) will be considered to be group practices under the PQRS GPRO under the shared savings program, CMS believes ACO performance on the quality measures reported using the GPRO web interface should be reported on physician compare in

the same way that CMS is reporting on the performance of other group practices that participate in the PQRS GPRO. Therefore, performance data on quality measures reported by ACOs on behalf of its eligible professionals in group practices using the GPRO web interface will also be reported on the physician compare website in the same way as for the group practices that report under the PQRS.

### **Value-Based Modifier**

CMS is establishing quality and cost measures, as well as the initial performance period that will be used in establishing a new value-based modifier as required by the PPACA. CMS is building the foundation for the modifier and recognizes additional stakeholder input is needed. The agency plans to convene public events in the next year to gather stakeholder input on the value-based modifier.

CMS finalized a proposal to include the measures in the core set of the PQRS for 2012 and the core measures, alternate core and additional measures in the EHR incentive program for 2012. For physicians practicing in groups, the measures CMS is finalizing for the value modifier include all measures in the GPRO PQRS for 2012 and the rates of potentially preventable hospital admissions for two ambulatory care sensitive conditions at the group practice level (heart failure and chronic obstructive pulmonary disease). Included in the quality measures for the value modifier are PQRS measures 113 (colorectal cancer screening) and 128 (body mass index screening and follow-up). CMS also finalized the proposal to use total per capita cost measures and per capita cost measures for beneficiaries with four specific chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease and diabetes) in the value modifier.

CMS is still seeking other ways to close the gap between the performance period (CY 2013) and the payment adjustment period (CY 2015). In the interim, however, CMS is finalizing a proposal that CY 2013 be the initial performance period for payment adjustments in 2015, because it aligns with the PQRS and EHR incentive program. CMS recognizes the alternatives are more onerous to physicians and beneficiaries than its original proposal and will reexamine the initial performance period in future rulemakings.

### **Physician Feedback Reports**

CMS plans to continue using the quality of care measures reported in PQRS with the physician feedback reports. CMS is implementing phase III of the physician feedback program by providing reports on both resource use and quality measures to physician groups that participated in GPRO-1 in 2010 and to physicians practicing in the following states — Iowa, Kansas, Missouri and Nebraska. CMS is taking steps this year to address many of the issues raised in the recent Government Accountability Office report, “Medicare Physician Feedback program: CMS Faces Challenges with Methodology and Distribution of Physician Reports,” that described the challenges involved with developing and disseminating physician feedback reports. CMS also plans to include episode-based costs in future feedback reports.