

## **AGA Summary - 2010 Physician Fee Schedule Final Rule**

On Oct. 30, 2009, CMS posted a final rule that establishes new policies and payment rates for physicians and other providers who are paid under the Medicare physician fee schedule for 2010. The rule will be published in the Federal Register on Nov. 25, 2009. The rule and associated files may be accessed at: [http://federalregister.gov/OFRUpload/OFRData/2009-26502\\_PI.pdf](http://federalregister.gov/OFRUpload/OFRData/2009-26502_PI.pdf)

### **Medicare Payment Update**

CMS has indicated the overall impact of the 2010 update to the physician fee schedule at -21.2 percent, absent Congressional intervention. This negative update is required under the sustainable growth rate (SGR) formula and includes the cumulative impact of the Tax Relief and Health Care Act of 2006 (TRHCA).

The AGA is pleased that CMS has finalized its intentions to change the definition of physician services under the SGR to exclude physician-administered drugs. The drug costs will be removed retroactive to the 1996/97 base year of the SGR formula, which will greatly lessen the forecast SGR cuts in years after 2010. This action will substantially reduce the legislative cost of congressional proposals aimed at reforming physician payments and makes a permanent solution to the SGR formula much more feasible.

The combined impact of all fee schedule changes for gastroenterology payments (work, practice expense transition, and medical liability) is -1 percent for 2010. The fee schedule changes impact specialties differently due to budget neutrality so overall, GI would be impacted a total of -22.2% for 2010 if the SGR is not addressed.

### **Physician Practice Information Survey (PPIS)**

During 2007 through 2008, the AMA conducted a new Physician Practice Information Survey (PPIS), which was designed to update the specialty-specific practice expense per hour (PE/HR) data used to develop practice expense (PE) relative value units (PE RVUs) in the physician fee schedule. The PPIS was a multi-specialty, nationally representative, survey of both physician and non-physician practitioners (NPP) that utilized a survey instrument and methods highly consistent with those used for the 1999 Socioeconomic Monitoring System (SMS) and the supplemental surveys. The PPIS gathered information from 3,656 respondents across 51 physician specialty and health care professional groups. The AGA, ASGE, ACG and AASLD participated in this survey process.

Earlier this summer, CMS proposed to utilize the PE/HR data, developed using PPIS data for all Medicare recognized specialties that participated in the PPIS, for payments effective Jan. 1, 2010. Using this new PPIS data, the gastroenterology PE/HR would drop from its 2009 level of \$101.30 per hour to \$96.78 per hour. The AGA expressed concern about the impact of the PPIS data on infusion services, and recommended that CMS not implement the PPIS data with regards to complex drug administration services. In order to mitigate the impact of the PPIS

data, we recommended a four-year phase-in of the new survey data for codes that would otherwise be impacted by a  $\pm 10\%$  change in reimbursement.

In the final rule, CMS stated that because of large negative impacts for several specialties, such as cardiology, the agency decided to phase-in the PPIS data over four years and will use this data for all specialties except medical oncology, whose supplemental practice expense data will continue to be used because of existing law. CMS estimates that there will be no impact on gastroenterology practice expense payments during both the transition and full implementation of the new PPIS data. We are also pleased that CMS's decision helps transition the large expected cuts in drug administration services.

The next Five-Year Review of PE RVUs will be addressed in CY 2014. In the interim, CMS will continue with their efforts to develop a process to ensure that prices for certain high cost supplies that are used to determine PE RVUs are accurate and reflect current information. The AGA will be responding to CMS's solicitation of comments on approaches to take for this next Five-Year Review of PE RVUs.

### **Consultation Codes**

In the proposed rule, CMS proposed to eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes). Along with this, CMS proposed to increase the work RVUs for new and established office visits, increase the work RVUs for initial hospital and initial nursing facility visits, and incorporate the increased use of these visits into their PE and malpractice RVU calculations.

CMS believed the rationale for a differential payment for a consultation service was no longer supported because documentation requirements are now similar across all E/M services. CMS stated it would make this change budget neutral by increasing the work RVUs for new and established office visits by approximately six percent and the work RVUs for initial hospital and facility visits by approximately two percent.

The GI societies strongly opposed this proposal, along with most non-primary care specialties. We were extremely concerned about the impact of eliminating consultation services, and recommended that CMS withdraw this proposal and continue to work with the AMA to further clarify its consultation policy guidelines.

In the final rule, CMS decided to stop making payments for consultation services starting in Jan. 2010, feeling that in most cases there is no substantial difference in work between consultations and visits. The AGA is very disappointed that CMS moved forward with this proposal despite substantial objection. CMS also decided to adjust the payment for the surgical global period to reflect the higher value of the office visits furnished during the global period. The AGA notes that this action applies only to Medicare, and that private payers may continue to recognize consultation codes.

## **Imaging Issues**

In the proposed rule, CMS expressed concern about the rapid utilization and cost of advanced imaging services. While the current payment rates assumed that a physician who owns this type of equipment will use it about 50 percent of the time, recent data from the Medicare Payment Advisory Commission (MedPAC) suggested this expensive equipment is being used more frequently. As the use of this type of equipment increases, the per-treatment costs for purchasing, maintaining and operating the expensive equipment declines.

CMS proposed to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over \$1 million. As part of the Alliance for Specialty Medicine, the AGA expressed concern that CMS not make this arbitrary usage change without further evaluation.

Despite opposition by many medical specialties, CMS decided to move forward with increasing the utilization assumption for expensive equipment priced over one million dollars, but will phase this change in over a four-year time period. CMS will not apply this change to expensive therapeutic equipment. This change will have a redistributive effect in the fee schedule as dollars from expensive imaging services are redistributed, which will have a positive effect on GI procedures.

CMS finalized its proposal to implement a requirement in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MIPPA) that suppliers of the technical component of advanced imaging services be accredited beginning Jan. 1, 2012. The accreditation requirement will apply to mobile units, physicians' offices, and independent diagnostic testing facilities that create the images, but will not apply to the physician who interprets them. CMS announced that CMS will address suppliers' accountability and physician and technician training through additional guidance.

## **Physician Quality Reporting Initiative (PQRI)**

The PQRI is a voluntary reporting program that provides an incentive payment to eligible professionals who satisfactorily report data on quality measures for covered professional services during a specified reporting period.

For 2010, participants in the PQRI program are eligible for an incentive payment equal to two percent of the estimated total allowed charges. While the PQRI program is only authorized through 2010, additional funding is being addressed in the health reform legislation currently being debated in Congress.

For gastroenterology, CMS selected the first GI specific measure group which is related to hepatitis C care. The hepatitis C measures group will be reportable through either claims-based reporting or registry-based reporting. Interestingly, despite opposition from GI societies, CMS

has decided to hold its position and designate measure # 83, Hepatitis C: Testing for Chronic Hepatitis C-Confirmation of Hepatitis C Viremia, as a registry-only measure.

CMS is targeting to finalize and publish all 2010 PQRI measure specifications on the CMS Web site by Nov. 15, but no later than Dec. 31, 2009. Measures related to gastroenterological care in the 2009 PQRI will remain for 2010, including Colonoscopy Interval for Patients with a History of Adenomatous Polyps (measure #185) and Body Mass Index Screening and Follow-up (measure #128).

The PQRI reporting period for 2010 is Jan. 1, 2010 to Dec. 31, 2010 for claims-based reporting. We are pleased that CMS decided to add the ability for a six-month reporting period for claims-based measures beginning in 2010. CMS will continue to allow half-year reporting for measures groups, registries and electronic health records.

CMS will post an initial list of registries qualified for the 2010 PQRI by Dec. 31, 2009 and a second list in the summer of 2010 when additional registries have been vetted. Data reported through registries for 2010 PQRI would not be due to CMS until Feb. 28, 2011. The AGA continues to move forward with its registry development efforts. The AGA Digestive Health Outcomes Registry will launch the first of a series of registries addressing a broad range of conditions and procedures in spring 2010.

Beginning with the 2010 PQRI, group practices will be eligible to participate in PQRI. Despite comments on the proposal to include smaller groups in its definition of group practices, CMS has decided that for 2010, group practices will be those with 200 or more eligible professionals. Such group practice reporting will require reporting on a common set of 26 NQF-endorsed quality measures that target high-cost chronic conditions and preventive care, as finalized by CMS.

CMS has added an EHR-based reporting mechanism for the 2010 PQRI in order to promote the adoption and use of EHRs and to provide both eligible professionals and CMS experience on EHR-based quality reporting. CMS will accept data from qualifying EHRs on 10 individual PQRI measures, one of which is Measure 113 (Colorectal Cancer Screening). Eligible providers who satisfactorily report data on at least three of the ten proposed EHR-based individual PQRI measures would be eligible for an incentive payment. In previous years, EHR-based measure submission has not counted toward eligibility for an incentive payment. There will not be an option to report measures groups through EHR-based reporting on services furnished during 2010.

CMS will retain claims-based reporting for specific structural measures, such as Measure 124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR), and circumstances where claims-based reporting is the only available mechanism available for a specific measure.

Title IV of the American Recovery and Reinvestment Act of 2009 (Recovery Act) authorizes CMS to make incentive payments through the Medicare and Medicaid programs to eligible professionals and hospitals who become “meaningful users” of certified electronic health records (EHRs). This issue will be addressed later this year in separate rulemaking.

As required by MIPPA, following the distribution of 2010 incentive payments, CMS will post on its website the names of electronic prescribers and group practices who satisfactorily report quality measures.

### **Electronic Prescribing**

Eligible professionals or group practices that meet the Electronic Prescribing Incentive Program requirements for 2010 will be eligible for an incentive payment of two percent. CMS has simplified the reporting requirements for the electronic prescribing measure and to provide eligible professionals with more reporting options. CMS finalized a new process for group practices to be considered successful electronic prescribers. Electronic prescribers will need to report the e-prescribing code at least 25 times during the reporting period to be considered a successful electronic prescriber.

MIPPA established a five-year program of incentive payments to electronic prescribers who are successful electronic prescribers. Beginning in 2012, the program will impose penalties on physicians who are not successful e-prescribers.

Incentive payments for electronic prescribers will be:

- 1.0 percent for 2011
- 1.0 percent for 2012
- 0.5 percent for 2013

Penalties will be incurred for non successful electronic prescribers starting in 2012. The **reductions** in fee schedule payments will be:

- 1.0 percent for 2012
- 1.5 percent for 2013
- 2.0 percent for 2014

### **Physician Resource Use Measurement and Reporting Program**

CMS was required under MIPPA to establish and implement by Jan. 1, 2009 a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries.

CMS solicited initial comments on this feedback program in the 2009 final physician rule. Commenters were overwhelmingly in favor of including E/M services, imaging services, laboratory services, outpatient services, procedures, and post-acute services, and using three years of data in both per capita and per episode measurement methodologies.

In the final rule, CMS finalized the feedback conditions for 2010 to include: (1) congestive heart failure; (2) chronic obstructive pulmonary disease; (3) prostate cancer; (4) cholecystitis; (5) coronary artery disease with acute myocardial infarction; (6) hip fracture; (7) community-acquired pneumonia; (8) urinary tract infection; and (9) diabetes.

Based on the high cost and high volume conditions, CMS included gastroenterology in phase I of the Physician Resource Use Measurement and Reporting Program. For phase II of the Program, CMS will expand it in ways that will make the information more meaningful and actionable for physicians. CMS will be adding reporting to groups of physicians recognizing that physicians practice in various arrangements. CMS is also proposing to add quality measurement information as context for interpreting comparative resource use.

The GI societies are supportive of CMS's future plans to provide a confidential combined report that includes both resource use and reporting of PQRI and/or electronic prescribing measures. We continue to advocate to CMS that physicians have the opportunity to correct their data and correct attributions if the methodology is incorrect or if the results contain invalid results.

CMS indicated that it received many suggestions to improve the reporting program and will be taking these suggestions under consideration as the program evolves.

### **Physician Value-Based Purchasing**

CMS continues to develop its Physician Value-Based Purchasing Program (PVBP). Therefore, CMS solicited public comments on the appropriateness of resource use measurement and reporting for different types of groups of physicians.

CMS has adopted the following goal to improve Medicare beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services. In pursuit of this goal, the PVBP Steering Committee has defined the following objectives:

- Promote evidence-based medicine through measurement, payment incentives, and transparency;
- Reduce fragmentation and duplication through accountability across settings, alignment of measures and incentives across settings, better care coordination for smoother transitions, and attention to episodes of care;
- Encourage effective management of chronic disease by improving early detection and prevention, focusing on preventable hospital readmissions, and emphasizing the importance of advanced care planning and appropriate end-of-life care;
- Accelerate the adoption of effective, interoperable HIT, including clinical registries, e-prescribing, and electronic health records; and
- Empower consumers to make value-based health care choices and encourage health professionals to improve the value of care by disseminating actionable performance information.

The goal and objectives of PVBP were captured in a CMS Issues Paper. AGA provided formal comments to CMS on this paper and will continue to provide public input on this process. CMS is required to submit a report to the Congress by May 2010 on PVBP.

The GI societies recommended that CMS widely disseminate the findings of the demonstration projects on PVBP to allow comment on specific programs. We also encouraged CMS to remember that value-based purchasing is not just about cutting costs, but also about providing Medicare beneficiaries access to high quality, cost-effective health care.

CMS is considering a variety of program activities under PVBP, including confidential feedback reports, public reporting and incentive payments. The PVBP Steering Committee will be considering the feedback it received during the public comment period.

### **MedPAC**

In the past, the Medicare Payment Advisory Commission (MedPAC) has recommended the establishment of a panel of experts separate from the AMA/Specialty Society Relative Value Update Committee (RUC) to review relative value units (RVUs). In the proposed rule, CMS solicited comments on how an outside group separate from the RUC process would be implemented.

The GI societies and many other physician specialty societies opposed the creation of a separate body to the RUC and instead suggested improvements to the current RUC process. We indicated to CMS that a better approach would be to add additional seats to the RUC to ensure that internal medicine subspecialties, such as gastroenterology, are adequately represented.

After receiving numerous comments, CMS continues to explore this issue and announced no decision on establishment of a separate panel in the final rule. CMS will also evaluate comments raised concerning the existing refinement panel process. Any revisions to this process will be discussed in future rulemaking.

### **Competitive Acquisition Program**

In the final rule, CMS finalized a number of changes to the Competitive Acquisition Program (CAP) to make the program more flexible and workable for physicians and suppliers to encourage participation in program.

The CAP resulted from the Medicare Modernization Act of 2003 (MMA) as an alternative to the average sale price methodology of obtaining certain Part B drugs used incident to physicians' services. Physicians who choose to participate in the CAP obtain drugs from vendors selected through a competitive bidding process and approved by CMS. Under the CAP, participating physicians agree to obtain all of the approximately 180 drugs on the CAP drug list from an approved CAP vendor. The approved CAP vendor retains title to the drug until it is administered, bills Medicare for the drug, and bills the beneficiary for cost sharing amounts

once the drug has been administered. The participating CAP physician bills Medicare only for administering the drug to the beneficiary. For gastroenterologists, drugs included under the CAP program include Remicade, Tysabri and Photofrin.

The 2009 CAP was postponed due to contractual issues with the vendors. As a result, CAP physician election for participation in the CAP in 2009 was put on hold, and CAP drugs have not been available from an approved CAP vendor for dates of service after Dec. 31, 2008.

In the final rule, CMS finalized many changes to the CAP program for 2010 including: reporting of timely quarterly data; improving the CAP list of available drugs; addressing the emergency restocking option; easing the restriction on physicians transporting CAP drugs to other settings than the physician's office; and addressing the dispute resolution process for the CAP for both vendors and physicians. The AGA is supportive of these changes, will continue to monitor this program, and will inform members if a successful vendor is announced for 2010.

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

As required under MIPPA, beginning on Jan. 1, 2010, the 1,000 work GPCI floor will be removed except for the 1,500 work GPCI floor for Alaska which will remain in place. In the 2009 proposed physician rule, comments were accepted on an Interim Locality Study Report to address potential GPCI changes and reconfiguration of states, specifically in California. After numerous comments, CMS did not make any changes in the GPCI for 2010. CMS intends to review the suggestions made by the commenters and consider the impact of each of the potential alternative locality configurations. A final report will be posted to the CMS website after further review of the studied alternative locality approaches.

CMS did not propose any changes in the physician fee schedule locality structure. In the event CMS decides to make a specific proposal for changing the locality configuration, CMS will provide extensive opportunities for public input.

### **Malpractice Relative Value Units (RVUs)**

CMS is required to review its resource-based malpractice RVU methodology at least every five years and recently awarded a contract to Acumen, LLC to provide this review. The methodology presented in the proposed rule conceptually followed the specialty-weighted approach used in the CY 2000 and CY 2005 PFS final rules. CMS revised the current specialty-weighted approach to accommodate additional data gathered during the malpractice premium data collection. The specialty-weighted approach bases the malpractice RVUs upon a weighted average of the risk factors of all specialties furnishing a given service. This approach ensures that all specialties furnishing a given service are accounted for in the calculation of the final malpractice RVUs. CMS will implement this proposed methodology with suggested improvements received during the comment period.

### **Initial Preventive Physical Exam (IPPE)**

CMS finalized increasing the payment rates for the Initial Preventive Physical Exam (IPPE), also called the “Welcome to Medicare” visit, to be more in line with payment rates for higher complexity services. The IPPE benefit was mandated by MIPPA to pay for an initial assessment of key elements of a beneficiary’s health status within six months of the beneficiary’s enrollment in Medicare Part B. Subsequently, Congress has extended the time period for the IPPE benefit to within one year of the beneficiary’s enrollment in Part B. The GI societies supported the payment increase to the IPPE as it provides the opportunity to discuss colorectal cancer screening with Medicare beneficiaries. However, this benefit does not include payment for the office visit prior to a screening colonoscopy.

#### **Fourth Five-Year Review of Work RVUs**

In this final rule, CMS outlined the process for its review of work values that is conducted every five years. CMS is currently initiating the fourth Five-Year Review of work RVUs with the resulting changes being effective beginning in the 2012 fee schedule. CMS is now soliciting comments only on services for which the currently assigned work RVUs may be inappropriate. CMS will review the public comments and in Feb. 2010 will forward codes identified in those comments, as well as codes that the agency has identified as potentially misvalued, to the AMA/Specialty Society Relative Value Update Committee (RUC). Specialty societies will then have the opportunity to survey its members to determine appropriate physician work values. The AGA is an active participant in the five-year review process to maintain appropriate work values for GI procedures.

#### **Other Issues**

In 2009, CMS assigned CPT code 46930, destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency), a global period assignment of 90-days which is used for major surgical procedures. In our proposed rule comments, the GI societies recommended that this code be changed to a 10-day global period used for minor procedures. In the final rule, CMS decided to maintain the 90-day global period at this time, but indicated it plans to review new technology for this procedure.

#### **Conclusion**

The new payment rates and policies apply to services furnished to Medicare beneficiaries on or after Jan. 1, 2010. AGA will continue to advocate for repeal of the SGR methodology and continue to oppose the 21.2 cut absent Congressional action.