

Summary of Centers for Medicare and Medicaid Services 2010 Medicare Physician Fee Schedule “Final Rule” on ACP Priority Issues

Comparison of CMS Decision to ACP Comment/Recommendations on Priority Issues

The Centers for Medicare and Medicaid Services (CMS) released the 2010 Medicare physician fee schedule final rule on October 30, 2009. It includes many issues important to internal medicine and its subspecialties. The table below provides a comparison for the issues with the largest impact of how the CMS decisions in its final rule compare to the positions that ACP included in its official comment letter to CMS on its proposals. The decisions on these key issues have an impact on the relative value units assigned to each individual physician service. While the impact on an individual physician depends on the mix of services he or she furnishes, CMS provides estimates of the impact on each physician specialty. CMS includes an estimate of combined impact of all of the changes for 2010 for each specialty. Because the agency decided to implement one of the high-impact changes over a four-year period (a description of this issue and an explanation of this decision is in the table below), CMS provides the estimate of the impact for 2010 had this change been fully implemented in 2010. CMS estimates that the provisions in the final rule will increase the aggregate Medicare allowed charges to general internal medicine by 2% in 2010—the gain would have been 5% without the four-year transition of the high-impact change. Some internal medicine subspecialties also gain, with a 3% increase in allowed charges to geriatrics being the largest estimated bump. CMS estimates that the allowed charges for some internal medicine subspecialties will be unchanged from 2009. Some internal medicine subspecialties see a decline in allowed charges, with the 8% estimated decrease to cardiology being the largest. The CMS impact estimates do not include the 21.2% cut to the conversion factor that is currently scheduled for 2010 as a result of the flawed Sustainable Growth Rate formula. ACP remains optimistic that Congress will avert this scheduled 2010 cut is hopeful that it will replace it with a positive 2010 update while also providing a more lasting fix to the SGR problem.

CMS PROPOSAL	ACP COMMENT; RECOMMENDATIONS	CMS FINAL DECISION
Practice Expense Data; Physician Practice Information Survey		
The CMS proposes to use practice expense per hour (PE/hr) data gathered from the recent AMA-facilitated Physician Practice Information Survey (PPIS). The PPIS	ACP supports use of the PPIS data to update the PE/hr figure for each specialty, which plays a significant role in the determination of the practice expense RVU assigned to each	CMS finalized its proposal to use the PE/hr figures from the PPIS; however, it decided to transition in the changes over a four-year period (25%, 50%, 75%, and 100%). CMS cited the support and

<p>collected practice cost data from physicians in all specialties (and from other non physician practitioners). The American Medical Association (AMA), with the assistance of a contractor, used the data from each specialty to calculate a PE/hr figure for each specialty. CMS showed confidence in the PPIS process by purchasing the data and proposing to use the PE/hr figures that resulted from it. The PE/hr figures help determine the pool of practice expense dollars available to be spread across the services that physicians of that specialty furnish. Thus, the PE/hr figures that CMS proposes to use ultimately manifest in the form of changes to the practice expense relative value units (RVU) assigned to individual physician services.</p> <p>CMS estimates a significant shift in aggregate Medicare payments for many specialties, including general internal medicine and internal medicine subspecialties, as a result of the practice expense RVU changes to individual physician services. Aggregate general internal medicine revenues would increase about 4% (other changes in the proposed rule would increase the average gain for general internal medicine by another 2 percent, or 6 percent total). Most internal medicine subspecialties would also gain, with examples being: geriatrics, 6%, infectious disease, 4%; endocrinology, 3%; and pulmonary, 3%. Aggregate payments for a few internal medicine subspecialties</p>	<p>individual physician service, beginning in 2010.</p> <p>As CMS updates the practice expense RVUs based on the PPIS survey data, ACP urges the agency to:</p> <ul style="list-style-type: none"> • Be open to comments that individual specialties have about the application of the PPIS to their specialty; • Provide additional information, in a transparent and collaborative manner, to address such concerns; and • Consider appropriate refinements in the practice expense RVUs that are derived from the PPIS, when justified based on further review of such comments from individual specialties. <p>CMS should provide a more robust discussion in the final rule of the agency’s decision making regarding use of the PPIS survey data to enable all stakeholders to have a more complete understanding and confidence in the accuracy of the updated practice expense RVUs.</p>	<p>rationale from numerous specialties, including internal medicine. In responding to comments from those in opposition that there was a lack of transparency, the agency again cited the AMA, the Lewin Group (a contractor), and CMS analytical work. In addition, the agency stated that AMA continues to conduct further analysis as requested by specialty organizations and that additional CMS analysis is available on the agency’s website. CMS concludes that it has found nothing to dissuade it from using the PPIS. The rationale for its transition decision is that there is precedent for phasing-in practice expense methodology changes and that the significant impact on individual physician services and, thus, specialties, warrants it.</p> <p>CMS agreed with a comment from American Society for Clinical Oncology (ASCO) that the a law enacted in 2003 requires CMS to use the supplemental survey data from hematology/oncology.</p> <p>CMS does not explicitly establish a process by which it will address issues raised by specialty organizations about the data that pertain to their specialty. The four-year transition, however, inherently provides opportunity to urge CMS to make changes.</p>
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would decline significantly—cardiology, -10% and hematology/oncology, -5%.		
Equipment Utilization Rate		
CMS proposes to increase the rate that it assumes that equipment involved in furnishing services or tests that costs over \$1 million from the current 50% to 90%.	<p>ACP supports an increase in the assumed utilization rate for equipment priced over \$1 million, while noting that the College has no way to independently assess the precision of the CMS-proposed 90% utilization rate.</p> <p>ACP encourages CMS to create mutually exclusive categories of equipment with different utilization rates as it continues its stated plan to explore data sources pertaining to the use of equipment priced at less than \$1 million. CMS should address whether use varies by geographic area for this less expensive equipment.</p>	CMS finalized its proposal to increase the assumed rate of utilization of equipment that costs more than a \$1 million from 50% to 90%.
Sustainable Growth Rate		
CMS proposes to remove physician administered drugs from the definition of “physicians’ services” for purposes of computing the SGR and levels of allowed expenditures and actual expenditures retrospective to the base year of 1996/1997 and for all future years. While removing physician-administered drugs from allowed and actual expenditures for all prior years does not change the -21.5% payment update proposed for 2010, it does reduce the amount and number of years that the formula would produce negative updates in the future.	<p>ACP supports the proposed modification of the SGR formula that, beginning in 2010, removes drugs from the calculation of allowed and actual expenditures retrospectively to the 1996/1997 base year.</p> <p>ACP encourages CMS to continue to work with the Congress to realize an enduring fix to this dire SGR problem.</p>	<p>CMS finalized its proposal to remove the cost of physician-administered drugs from the SGR formula in past and future years.</p> <p>CMS now calculates the 2010 SGR-induced cut to the conversion factor as -21.2%. The slight change is the result of the agency’s use of more recent data.</p>

<p>CMS proposes a -21.5% payment update for 2010, moving the fee schedule’s conversion factor down to \$28.3208. CMS has no discretion in implementing this update amount as it is determined by the SGR formula mandated by current law.</p>		
<p>Consultation Services</p>		
<p>CMS proposes to no longer recognize the Current Procedural Terminology (CPT) codes describing office/outpatient and inpatient consultation services for payment purposes beginning in 2010. CMS proposes that physicians bill office consultations using the CPT office visit codes, 99201-99215, and inpatient consultations using the CPT initial hospital care codes, 99221-99223. The money that CMS spent in 2009 to pay the CPT consultation service codes would be used to increase payment for office and initial hospital visit services—the component of payment attributed to physician work would increase by 6% for each office visit service and by 2% for each initial hospital visit service.</p> <p>CMS estimates that this proposed change would have a modest impact on aggregate Medicare payments for many specialties, including general internal medicine and internal medicine subspecialties. General internal medicine revenues would increase 1%. Most internal medicine subspecialty revenues would decrease 1%</p>	<p>ACP supports the goal of the proposed change to the consultation service payment policy proposed for 2010.</p> <p>The College does, however, urge CMS to provide additional guidance in the final rule and take specific actions, which are listed below.</p> <p>ACP urges CMS to clearly articulate that the proposal would resolve the on-going discord between the agency and the physician community in the final rule.</p> <p>CMS should not increase the work RVUs assigned to procedures with 10- and 90-day global periods to reflect the higher work RVUs assigned to the office visit service codes that results from the redistribution of RVUs that were assigned to the no-longer-recognized consultation services.</p> <p>ACP urges CMS to publish the RVUs assigned to the CPT consultation codes because private payers may continue to use them.</p>	<p>CMS finalized its proposal to no longer recognize the CPT codes for consultation services for payment purposes. It vigorously defended its proposal in responding to those opposed. It cited the long experience that shows inaccurate physician billing of consultation services. It again cited that the disagreement between the agency and the physician community about what constitutes a consultation versus a transfer of care and stated that no solution is likely on the horizon. The agency elaborated on its statement that the work associated with office/hospital visits and consultations is “clinically similar.” It stated that the work involved for a specialist to treat a condition for which he or she is specifically trained and has experience is similar to work by all physicians for office and initial hospital visits.</p> <p>CMS stated that physicians will bill consultations as office and initial hospital visits using the CPT descriptions and agency documentation guidelines. The agency states that this is relatively straightforward. It infers that this will resolve audit concerns but states that it generally does not discuss audit approaches and priorities as they are to promote program integrity.</p>

	<p>CMS should clarify the following coding issues that result from its proposed change:</p> <ul style="list-style-type: none"> • The expectation regarding the selection of a level of service for an inpatient consultation service to be billed using the initial hospital care service codes. • How to mitigate problems—e.g. payment delays, record requests, denials—related to the submission of multiple, initial hospital care claims (from multiple physicians) when the admitting physician does not use the required modifier. • The uncertainty related to how Medicare would interact with other payers. <p>ACP recommends that CMS explore how to best recognize physician provision of high-end cognitive work, including by</p> <ul style="list-style-type: none"> • Educating physicians on when it is appropriate to bill critical care. • Educating physicians on appropriate use of the prolonged service codes. • Considering a mechanism that allows physicians to be paid a higher rate for some outpatient consultative services that involve a patient known to them. • Ensuring continued emphasis on optimal patient care through communication among physicians and providers caring for a patient, e.g. handoffs/handshakes; transitions. 	<p>The agreed with comments that it should include the increased work RVU for the office and initial hospital visits into 10 and 90 global surgical period payments. CMS essentially stated that it had to do so for consistency and noted that that the relative impact is minimal.</p> <p>CMS states that it has no control over the policy of other payers pertaining to the billing of consultations and essentially states that it is not the agency’s concern. It states that physicians need to know the policy of other payers and handle as they see fit. For instance, it states that a physician would have to decide whether to bill a private primary payer an office visit instead of a CPT consultation code so that Medicare would make a payment as a secondary. The agency notes that it would Medicare would deny secondary payment if the physician billed a consultation code to a private primary payer because Medicare does not recognize the consultation codes.</p> <p>CMS does not address the ACP recommendations for ensuring appropriate payment for high-end cognitive work. This does not preclude the agency from engaging in the educational efforts the College recommends and ACP can reiterate these recommendations outside of the rulemaking process.</p> <p>CMS responded to comments expressing concern that the lack of requirement that the consultant submit a written report to the requesting physician that accompanies no longer recognizing the consultation codes will adversely affect care</p>
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