



The 2010 Medicare Physician Payment Final Rule

The 2010 Medicare physician payment final rule was released on October 30 and will be published in the *Federal Register* on November 25. Key provisions are outlined below.

2010 Update: The rule establishes a 2010 payment update of -21.2%. A cut of this magnitude is without precedent and is due largely to the approach Congress has used in a series of short-term band-aid approaches used to stop previous cuts. The AMA is aggressively pursuing sustainable growth rate (SGR) repeal this year as part of health system reform to eliminate the threat of steep pay cuts once and for all. The rule also indicates that the 2010 Medicare Economic Index (MEI) is 1.2%.

SGR Drugs: The major highlight of the rule is that it finalizes the Centers for Medicare and Medicaid Services' (CMS's) proposal to retroactively remove drugs from SGR calculations, restoring \$122 billion to funding for physician services over 10 years. The AMA has long called for this action and appreciates the Obama administration's change in policy.

Practice Expense: While attention has focused on practice expense proposals that are new for 2010, this year will also see the completion of a transition to a revised methodology that continues to produce significant redistributions. In the final rule, CMS announced that 2010 will be the first of a four-year transition to two new practice expense revisions: (1) CMS will utilize the results of the Physician Practice Information (PPI) Survey, sponsored by the AMA and 72 specialty societies and health professional organizations (more information at www.ama-assn.org/go/ppisurvey), and (2) it will adopt an assumption that diagnostic imaging equipment such as CT and MRI are in use 90 percent of the time an office is open instead of 50 percent. (The proposed rule would have applied this assumption to therapeutic equipment as well, but the final rule does not.) The combined impacts of completing the transition to the revised methodology, starting the transition to the new values based on the survey, and the higher equipment use assumption produce significant 2010 practice expense cuts for some specialties, including 5 percent for cardiology and 10 percent for nuclear medicine. Impacts during the final three years of the new transition will be more modest than in 2010 because the methodological change already underway will have been completed.

Consultations: CMS has finalized its proposal to eliminate Medicare payment for consultations and use the money from these services to increase payments for visits, including visits bundled into global surgical services. The AMA had expressed strong concern to CMS about finalizing its proposal this month and implementing it in January because there is not enough time to educate physicians on such a major change in coding practice. CMS decided to finalize the policy as proposed and move forward in January, however.

Misvalued Codes: CMS has accepted the AMA/Specialty Society RVS Update Committee (RUC) recommendations for nearly 200 physician services identified as potentially misvalued. Savings from these RUC recommendations will be redistributed within the payment schedule through a positive adjustment to the 2010 conversion factor. CMS also accepted 98 percent of the RUC recommendations for new and revised CPT® 2010 codes.



E-Prescribing: The AMA had expressed strong concerns to CMS about the reporting burden for the e-prescribing incentive program. In response, for 2010 physicians will only have to report the e-prescribing code 25 times instead of reporting it for 50 percent of visits in order to qualify for the incentive payment. In addition, in 2010 there will only be one code instead of three, eligible services will be expanded to include home and nursing home visits, and there will be a reporting option for qualified group practices. Also, physicians will be able to choose whether to submit e-prescribing data through claims or a qualified registry or electronic health record (EHR) product.

PQRI: The rule expands the number of measures and measure groups for 2010. Successful 2010 PQRI participants may earn an incentive payment of 2% of their total Part B allowed charges. For 2010, the rule adds an EHR reporting mechanism for 10 quality measures and a six-month reporting period for claims-based reporting of individual measures, for a total of five PQRI reporting options. CMS has also added a group practice reporting option for practices with a minimum of 200 physicians. In response to AMA advocacy for improved access to PQRI feedback reports, starting with 2008 feedback reports, physicians are now able to access their reports via secure e-mail. CMS decided to not move forward with its proposal to establish a minimum patient sample size for reporting. Instead, it will reconsider adding a minimum patient sample requirement for future years upon further analysis of PQRI data.

PLI values: The professional liability insurance (PLI) relative values have been updated to reflect more current data and from more specialties than the previous values. CMS has also established resource-based PLI values for the first time for services with technical components.

Resource Use Reports: The rule finalizes several proposed changes in the Congressionally mandated confidential physician feedback program. To date, CMS has focused on eight medical conditions and provided reports focusing on physician resource use to about 300 individual physicians in 13 cities. CMS now intends to: add diabetes to the list of conditions, include information on quality as well as resource use, provide reports in both electronic and paper form, and include reporting on "groups" of two or more physicians. In addition to organized group practices, groups could include physicians who practice within the same practice, facility, or geographic area.

Prevention: The rule finalizes a significant increase in the relative value for the Welcome to Medicare visit, with the work value going from 1.34 up to 2.30. CMS has also accepted and will publish the RUC's recommendations for 90470 HINI immunization administration, although CMS will continue to recognize G codes to report this service for Medicare patients.

Teaching Anesthesia: As requested by the AMA and the American Society of Anesthesiologists, in finalizing a new policy restoring full Medicare payment to academic anesthesiology programs, the final rule permits different anesthesiologists in the same anesthesia group practice to be considered the teaching physician for purposes of being present at the key or critical portions of the case.



Mental Health: As required by law, patient cost-sharing for mental health services is being transitioned down to the same share as other physician services, which is 20 percent. For 2010, instead of the 50/50 split as in the past, patients' cost-sharing will be 45 percent and the Medicare program will pay 55 percent.

GPCIs: Although no changes are made to the geographic adjustment factors or locality definitions, the rule confirms that the work GPCI floor will expire December 31, 2009, unless Congress acts to extend it.

Impacts: Impacts of the work, practice expense, and PLI relative value changes in the rule are displayed in Table 49 of the rule, attached and available at: http://federalregister.gov/OFRUpload/OFRDData/2009-26502_PI.pdf. This table does not include the impact of the -21.2% pay cut. The various policy changes in the rule combine to produce significant payment redistributions for a number of specialties. For example, combined changes to work, practice expense, and PLI relative values are projected to lead to an 8 percent decrease for cardiology in 2010, due to:

- Final transition year of practice expense methodology (-2%)
- Implementation of PPI survey data (-2%)
- Elimination of payment for consultation services (-1.5%)
- Implementation of resource-based PLI values for technical component services (-1%)
and
- Coding changes, CT/MRI equipment utilization changes, and other CMS policy changes (-1.5%)