A Highly Idiosyncratic Review of the 2010 Medicare Physician Fee Schedule Final Rule

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Before 2010 gets too far away from us, it seems appropriate to take a brief look at key regulatory changes finalized under the Medicare Physician Fee Schedule Calendar Year (CY) 2010 Final Rule[1] (PFS Final Rule). This article will discuss selected highlights of the PFS Final Rule, with an emphasis on broad changes to Medicare's reimbursement policies, rather than the minutiae of adjustments to work and practice expense Relative Value Units (RVUs).

The Centers for Medicare & Medicaid Services (CMS) publishes the Medicare Physician Fee Schedule Final Rule for each CY to update payment to physicians and other suppliers for services provided to Medicare beneficiaries during the upcoming year, and to precipitate Congressional action to avoid the reduction in payment to physicians and other suppliers mandated by the sustainable growth rate adjustments to the conversion values. This year was no exception.

In addition, CMS uses the annual PFS Final Rule to finalize related regulations and implement statutory requirements. Following are some of the more significant regulatory changes from the PFS Final Rule.

Telehealth Services

CMS is adding the individual Health and Behavioral Assessment and Intervention (HBAI) codes (CPT 96150-95152) to the list of approved telehealth codes and has updated 42 C.F.R. § 410.78 and § 414.65 accordingly, but it declined to add the group HBAI code (CPT 96153) or family-with-patient HBAI code (CPT 96154) to the list. In addition, CMS has revised § 410.78 to restrict physicians and other practitioners from using telehealth to furnish the initial and subsequent personal visits required for residents in Skilled Nursing Facilities (SNFs) under § 483.40(c). Similarly, CMS declined to add Nursing Facility Services (CPT 99304-99318) to the telehealth list. CMS did, however, revise § 410.78 to reflect that the G-codes for follow-up inpatient telehealth consultations (HCPCS G0406-G0408) include follow-up consultations furnished to beneficiaries in hospitals and SNFs. No other codes were added to the approved telehealth list.[2]

Consultations

All consultations (except consultations furnished by telehealth) were deleted from the PFS. This change will be the subject of a future article in another AHLA newsletter.[3]

Outpatient Psychiatric Copayments

This year will be the first year of the phase-out of the outpatient mental health treatment limitation. The limitation was that, until this year, Medicare paid only 50% of the approved amount for outpatient mental health services, thereby requiring the patient to pay the remaining 50%. In 2010, Medicare's portion of the payment will increase to 55% of the approved amount, and the Medicare payment will increase each subsequent year until in 2014, when Medicare will pay the usual 80% of the fee schedule amount, leaving only 20% for the patient to pay.[4] This change was mandated by Section 102 of the Medicare Improvements for Patients and Providers Act of 2008[5] (MIPPA).

Physician Quality Reporting Initiative

The Physician Quality Reporting Initiative (PQRI) was established under MIPPA Section 131 and permits certain physicians and other practitioners who report various defined quality indicators in connection with the codes that they bill to receive incentive payments of up to 2% of their total Medicare paid charges for the year. For 2010, CMS finalized changes permitting a group practice consisting of at least 200 physicians to submit PQRI data and receive incentive payments as an entity, rather than as individual physicians. The reporting periods for 2010 will consist of one full-year period beginning January 1, 2010, and one six-month period beginning July 1, 2010. Most individual eligible professionals will be able to submit PQRI data in one of three ways: claims-based reporting, registry reporting, and quality measure data extracted from a qualified electronic health record (EHR) product. However, it bears mentioning that not every indicator may be submitted in all three ways. In addition, certain eligible professionals are entitled to report on "measures groups," which are collections of individual measures related to particular conditions. Finally, CMS updated the lists of measures and measures groups on which eligible professionals may report.[6]

E-Prescribing Incentive Program

Just as with PQRI reporting, eligible professionals implementing and successfully reporting on electronic prescribing measures during CY 2010 will be eligible for an incentive payment of up to 2% of Medicare allowed charges. Eligible professionals will be able to submit data through claims, registry, or a qualified EHR product. Under the e-Prescribing Incentive Program, if 10% of an eligible professional's Medicare charges are related to codes associated with the program and the eligible professional reported at least twenty-five electronic prescribing events, the eligible professional will receive an incentive payment. Finally, CMS finalized its proposal to permit group practices consisting of at least 200 eligible professionals to submit electronic prescribing data as an entity.[7]

Accreditation Standards for Advanced Diagnostic Imaging Suppliers

Under Section 135(a) of MIPPA, beginning January 1, 2012, Medicare payment may only be made for the technical component of advanced imaging services to suppliers that are accredited

by an accreditation organization designated by the U.S. Department of Health and Human Services Secretary. The PFS Final Rule finalized requirements for those accrediting agencies.[8] Note that CMS has recently named three accrediting agencies for these services.[9]

Teaching Anesthesiologists

CMS finalized its proposal to pay teaching anesthesiologists the full fee schedule rate for supervising: (1) one anesthesiology resident; (2) two anesthesiology residents concurrently; or (3) one anesthesiology resident and one certified registered nurse anesthetist, anesthesia assistant, or other individual qualified to provide anesthesia under medical direction.[10]

Stark

Fortunately, the only change to the Stark Law regulations is to clarify that the stand-in-the-shoes regulations were not intended to alter any substantive requirements of any direct exceptions. CMS explained that some concerned stakeholders had asked whether § 411.354 (c)(3)(i) was intended to impose a requirement that a contract between a designated health service (DHS) entity and a physician organization must be signed by all physicians affiliated with the physician organization. In response, CMS modified that section to clarify that the physicians affiliated with a physician organization are not required to be "parties" (i.e., signatories) to any particular arrangement; rather, they will be deemed to have a direct relationship with the DHS entity by virtue of their association with the physician organization.[11] CMS also solicited comments on the changes to business relationships that various stakeholders undertook in response to the change in the definition of "entity" that went into effect on October 1, 2009. It will be interesting to see what kind of response CMS receives.

Stay tuned for more excitement when CMS releases the CY 2011 Medicare Physician Fee Schedule proposed rule, which typically occurs around July.

1 74 Fed. Reg. 61738 (Nov. 25, 2009).
2 74 Fed. Reg. at 61761-61765.
3 *Id.* at 61767-61775.
4 *Id.* at 61786-61788.
5 Pub. L. 110-275.
6 74 Fed. Reg. 61788-61844.
7 *Id.* at 61849-61861.
8 *Id.* at 61861-61867.
9 75 Fed. Reg. 4088 (January 26, 2010).
10 74 Fed. Reg. at 61868-61870.
11 *Id.* at 61932-61933.

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