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Proposed Physician Fee Schedule Update for 2010

Presented by Integrated Healthcare Strategies
as Authored by Tom Becker

On July 2, 2009, the Centers for Medicare and Medicaid Services (CMS) announced the 2010 proposed Medicare changes to the physician fee schedule (PFS). There are several proposals that refine payments to physicians, but this annual process generally captures the attention of physician practices because of the likely impact on their top line revenue. In recent years, the impact of the annual CMS PFS update has been blunted by the last minute intervention of the Congress. Now, with the uncertainty of health care reform and the potential for back room deals, this annual apprehension has morphed into a real anxiety about what might happen to Medicare reimbursement in 2010.

What are the proposed changes to the PFS? What is the impact on physician practices? We will review the potential impact of some of these proposed changes in this article. However, there is much that is not known to accurately predict practice by practice reimbursement impacts. CMS has proposed changes in the follow areas:

- Practice Expense RVUs
- Medicare Payment Rate – Sustainable Growth Rate (SGR)
- Payment for Consultations
- Initial Preventive Physical Exam
- Malpractice RVUs
- Reforms
- Imaging
 - Payment reduction
 - Accreditation

Practice Expense RVUs

CMS has proposed an update to the Practice Expense component of the RVUs. The Practice Expense RVUs would be based on costs from a new survey, the Physicians Practice Information Survey (PPIS), which was designed and conducted by the American Medical Association (AMA). It is believed that the changes to the Practice Expense RVUs will favor cognitive services, principally primary care practices.

Physician Fee Schedule (PFS)

Medicare law requires CMS to adjust the PFS payment rates annually. This adjustment is based on a formula that includes the application of the Sustainable Growth Rate (SGR). This formula has generated negative updates to the PFS every year beginning in 2002. Administrative action taken in 2003 averted a reduction that year while Congressional and administrative actions in 2004 through 2009 prevented reductions in those years.

Unless intervention is undertaken for 2010, CMS is projecting a rate reduction of 21.5% in 2010. The current PFS national conversion factor (payment rate) is \$36.0666. Reducing this rate by 21.5% reduces the national conversion factor to \$28.31! Table 1 illustrates the impact of this reduction on the three CPT4 codes listed for St. Louis, Missouri (Metropolitan). Note that this reimbursement is based on the published 2009 RVU values.

Table 1. Medicare Reimbursement Selected CPT4 Codes – 2009 v. 2010

CPT4 Code	Relative Value Units			Total RVU's	2009 Natl Conversion Factor	2009 Reimbursement	2010 Natl Conversion Factor	2010 Reimbursement
	Work	Practice Expense	Malpractice					
44950	10.5200	4.2400	1.3100	16.070				
GPCI's	1.0000	0.9190	1.0750					
	10.5200	3.8966	1.4083	15.825	36.0666	\$570.75	28.31	\$448.00
93015	0.7500	1.8900	0.1400	2.780				
GPCI's	1.0000	0.9190	1.0750					
	0.7500	1.7369	0.1505	2.637	36.0666	\$95.12	28.31	\$74.67
99214	1.1000	1.0300	0.0500	2.180				
GPCI's	1.0000	0.9190	1.0750					
	1.1000	0.9466	0.0538	2.100	36.0666	\$75.75	28.31	\$59.46

Physician Payment Reforms

CMS has proposed an assessment of whether the cost of physician administered drugs should continue to be included in the payment formula, i.e., excluded from physician services. This proposal would have no impact on the projected PFS update for 2010. CMS projects that implementation of this proposal would reduce the number of years in which physicians experience negative PFS updates.

Consultations

CMS proposes that payment for consultation CPT4 codes be discontinued. Instead, practitioners would use existing E&M CPT4 codes to report consultations. This proposal also calls for a budget neutral increase in the Work RVUs for new and established office visits, increasing Work RVUs for initial hospital visits and incorporating the increased use of these visits into the PE and malpractice RVU calculations. Table 2 below compares a segment of the inpatient and outpatient consultation codes to reimbursement using initial hospital/outpatient visit CPT4 codes (we acknowledge that the RVUs used in this table do not include the impact of the budget neutral increase proposed by CMS.) We anticipate that the actual cross-walk from the consultation codes to the alternative E&M CPT4 code would be determined by the fiscal intermediary if this proposal is implemented.

Table 2. Medicare Reimbursement Selected Consultation CPT4 Codes vs. Follow up/Return Visit CPT4 Codes

Outpatient			
Consults		Return Visits	
CPT4 Code	2009 Reimbursement	CPT4 Code	2009 Reimbursement
99241	\$46.90	99211	\$17.79
99242	\$88.00	99212	\$35.62
99243	\$120.91	99213	\$59.20
99244	\$179.09	99214	\$89.28
99245	\$220.35	99215	\$120.98

Inpatient			
Consults		Initial Hospital Care	
CPT4 Code	2009 Reimbursement	CPT4 Code	2009 Reimbursement
99251	\$47.95	99221	\$88.42
99252	\$74.49	99222	\$120.74
99253	\$112.65	99223	\$177.50
99254	\$162.48		
99255	\$198.31		

Initial Preventive Physical Exam (IPPE)

It is proposed that the payment rate for IPPEs, i.e., the “Welcome to Medicare” visit, be increased. This increase would result in the IPPE payment being more in line with payment rates for higher complexity services.

Malpractice RVUs

CMS is proposing to refine how Medicare recognizes the cost of professional liability insurance. It is expected that this revision would have a modest impact on reimbursement.

This change would essentially re-direct a portion of Medicare's payment for professional liability insurance to those providers in areas with higher costs.

Imaging

Once again, CMS is proposing to reduce payment for services requiring the use of expensive imaging equipment (CT, MRI and PET).

The current Medicare payment rates assume a 50% utilization rate for expensive imaging equipment. Survey data suggests that this equipment utilization is actually greater than 50%, so the per treatment costs for purchasing, maintaining and operating declines, making this reduction in payment appropriate.

CMS is also proposing that suppliers of technical component diagnostic services be accredited, including:

- Mobile units
- Physicians' offices
- IDTFs

CMS argues that spending on CT, MRI and PET is growing twice as fast as other imaging. CMS will be pursuing separate regulatory action to address technical component suppliers, including:

- Accountability
- Business integrity
- Physician and technician training
- Service quality
- Performance management

PQRI

Eligible professionals or group practices that meet the requirements of each program in CY 2010 will be eligible for incentive payments for each program equal to 2% of their total estimated allowed charges for the reporting periods. In addition, CMS is proposing to add more measures and more measures groups for eligible professionals to report under the PQRI.

CMS would also provide a mechanism for participants to submit quality measure data from a qualified electronic health record and to create a process for group practices to use for reporting the quality measures.

e-Prescribing

CMS is proposing to simplify the reporting requirements for the electronic prescribing measure and to provide eligible professionals with more reporting options. CMS is also proposing a new process for group practices to be considered successful electronic prescribers.

Summary

The key proposals impacting physician practices include:

- Refinement of the Practice Expense RVUs
- Elimination of payment for consultation CPT4 codes
- Refinement of the Malpractice RVUs

CMS has projected that these changes will result in increased reimbursement of 6% to 8% for general practice, family practice, internal medicine and geriatricians (though, we believe this increase would be after the PFS fee reduction of 21.5%).

If the implementation of these proposals goes forward, the bottom line impact on physician practices will be significant. Unfortunately, when CMS discusses cost reduction that translates into revenue reduction for providers. And more than likely that will impact physician compensation.

About the Author

Tom Becker's thirty years of healthcare experience includes administrator positions at hospitals, medical groups, and IPA's. He held the post of Vice President, Chief Operating Officer at the Santa Barbara Medical Foundation Clinic, a multi-specialty group in Santa Barbara, California. He was formerly Administrator of Buenaventura Medical Clinic, Inc., as well as President and Chief Executive Officer of Buenaventura Medical Management Co. Mr. Becker also held the position of Chief Administrative Officer at Bakersfield Family Medical Center, Bakersfield, California. Prior to his administrative roles in medical groups, he was an Associate Director and Assistant Dean at the University of California San Diego Medical Center (UCSD). He directed the Information Systems at the Scripps Clinic and Research Foundation in La Jolla, California. He served as a Senior Consultant with Information Associates, Inc. of Rochester, New York. Tom.Becker@IHStrategies.com

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