DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201
Office of Communications

FACT SHEET

FOR IMMEDIATE RELEASE
Nov. 1, 2011

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Final CY 2012 policy, payment changes in the Medicare Physician Fee Schedule

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on Nov. 1, 2011 that updates payment policies and Medicare payment rates for services furnished by physicians and nonphysician practitioners (NPPs) that are paid under the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2012. The final rule addresses Medicare public comments on payment policies that were described in two separate proposed rules earlier this year—the Five-Year Review of Work Relative Value Units under the Physician Fee Schedule (published in the *Federal Register* on June 6, 2011) and the Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012 (published in the *Federal Register* on July 19, 2011). The final rule also addresses interim final values established in the CY 2011 MPFS final rule with comment period (published in the *Federal Register* on Nov. 29, 2010). In addition, the final rule assigns interim final values for new and revised codes, as well as for potentially misvalued codes, for CY 2012 and requests comments on these values. Finally, the final rule addresses comments on requirements for signatures on requisitions for clinical laboratory services.

This fact sheet discusses the provisions in the CY 2012 MPFS final rule affecting payment policies and payment rates. The policies relating to the Physician Feedback Reports and Value-based Modifier, Electronic Health Records Incentive Program, and the Physician Quality Reporting System, are addressed in separate fact sheets.

BACKGROUND

Since 1992, Medicare has paid for the services of physicians, NPPs and certain other suppliers under the MPFS, a system that pays for covered physicians' services furnished to a person with Medicare Part B. Under the MPFS, a relative value is assigned to each of more than 7,000 types, of services to capture the amount of work, the direct and indirect (overhead) practice expenses and the malpractice expenses typically involved in furnishing the service. The higher the

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number of relative value units (RVUs) assigned to a service, the higher the payment. The RVUs for a particular service are multiplied by a fixed-dollar conversion factor and a geographic adjustment factor to determine the payment amount for each service furnished.

PROVISIONS INCLUDED IN THE CY 2012 MPFS FINAL RULE WITH COMMENT PERIOD

- *Sustainable Growth Rate (SGR) and MPFS conversion factor for CY 2012:* Under current law, providers will face steep across-the-board reductions in payment rates, based on a formula– the Sustainable Growth Rate (SGR) – that was adopted in the Balanced Budget Act of 1997. Without a change in the law from Congress, Medicare payment rates will be reduced by 27.4 percent for services in 2012—less than the 29.5 percent reduction that CMS estimated would be required under the law earlier this year in March. The President's budget and his fiscal framework call for averting these cuts and finding a permanent solution to this problem.

- *Annual Wellness Visit Providing a Personalized Prevention Plan*: The Affordable Care Act extended the preventive focus of Medicare coverage to provide coverage for annual wellness visits (AWVs) where beneficiaries receive personalized prevention plan services. The Affordable Care Act required that the AWV benefit include a Health Risk Assessment (HRA), and as a result, CMS has included the HRA as a part of the AWV in this final rule with comment period. CMS is providing payment for the AWV through the same Level II HCPCS codes as were used in CY 2011 and is increasing the payment rate for these HCPCS codes to accommodate the additional physician office staff time that is expected to be expended in assisting a beneficiary with the completion of the HRA.

- *Misvalued Codes under the Physician Fee Schedule*: The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has worked over the past several years to identify and revise potentially misvalued codes. The final rule adopts coding changes and revisions to values for about 300 services that have been identified as misvalued. CMS also identified additional categories of services that may be misvalued, including some of the highest expenditure codes in each specialty that have not been reviewed in the past five years. CMS chose not to finalize its proposal to review all Evaluation and Management codes during CY 2012 and will instead focus on other more effective ways of appropriately valuing care coordination and primary care services furnished to Medicare beneficiaries.

- *Revisions to the Geographic Practice Cost Indices (GPCIs)*: As required under current law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses

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(PE), and malpractice cost components of each of more than 7,000 types of physician services. The Affordable Care Act revised the methodology for calculating the PE GPCIs for CY 2010 and CY 2011 so that the employee compensation and rent components of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average, holding harmless any areas that otherwise would experience a payment reduction from this change.

CMS is applying several changes to the GPCIs as a result of additional analyses conducted both in accordance with the Affordable Care Act and commitments made in the CY 2011 final rule with comment period. For CY 2012, CMS will use the Bureau of Labor Statistics Occupational Employment Statistics specific to the offices of physicians industry to calculate the PE employee GPCI. In addition, CMS is replacing the U.S Department of Housing and Urban Development rental data as the proxy for physician office rent with rent data from the 2006-2008 American Community Survey. Lastly, CMS is creating a purchased service index to account for the labor-related industries within the "all other services" and "other professional expenses" Medicare Economic Index (MEI) categories. These changes result in very little change to the GPCIs and indicate that the data CMS has used to adjust for geographic variation is consistent and accurate. However, the expiration of the statutory provisions in the Affordable Care Act and the Medicare and Medicaid Extension Act will result in some payment reductions in the areas that benefitted from them in 2010 and 2011.

CMS is also basing the GPCI cost share weights on the revised and rebased 2006 MEI finalized by OACT in the CY 2011 final rule with comment period. CMS opted not to adopt the 2006-based MEI for GPCI cost share weights in the 2011 final rule in response to public comments. CMS has subsequently addressed many of these commenters concerns' in this CY 2012 final rule through the changes that are described above.

The Institute of Medicine (IOM) also has been evaluating the accuracy of the geographic adjustment factors used for Medicare physician payment. A supplement to their first report, released in September, 2011, includes an evaluation of the accuracy of geographic adjustment factors for the GPCIs and the methodology and data used to calculate them. CMS is already implementing some of the IOMs recommendations through the revisions to the GPCIs adopted in this final rule with comment period and is analyzing whether other recommendations should be adopted in the future. However, some IOM recommended revisions to the GPCIs would require a change in law.

- *Multiple Procedure Payment Reduction Policy*: Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures performed on the same patient by the same physician or group practice in the same session, based on efficiencies in the practice expense (PE) and pre- and post-surgical physician work. Beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction (MPPR) for the technical component of certain single-session

imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session. The MPPR policy currently applies only to the technical component (TC). For CY 2012, CMS is applying the MPPR to the professional component (PC) of certain diagnostic imaging services. The procedures with the highest PC and TC payments would be paid in full, but the PC payment will be reduced by 25 percent for subsequent procedures furnished to the same patient, by the same physician or group practice, in the same session on the same day. The final rule policy reduces payments for these services by approximately $50 million which would be redistributed to other services paid under the MPFS

- *Telehealth Services:* CMS is adding smoking and tobacco cessation counseling, among other services, to the list of Medicare telehealth services. These services are similar to other services (such as kidney disease education and medical nutrition therapy services) already on the telehealth list. In addition, CMS is changing the criteria for adding codes to the List of Medicare Telehealth services under the "category 2" methodology. Category 1 services are services that are similar to services already on the telehealth list. Currently, CMS requires evidence of similar diagnostic findings or therapeutic interventions of a requested service via telehealth to an in-person service prior to adding it to the telehealth list under category 2. In this final rule with comment period, CMS revises the standard by no longer requiring telehealth services to demonstrate clinical equivalence to the service provided face-to-face and instead to require that the service be safe, effective, and of medical benefit when furnished through telehealth. The refined category 2 review criteria are effective for services requested to be added to the telehealth benefit for CY 2013.

- *Transition to new Practice Expense RVUs* - The final rule will implement the third year of a 4-year transition to new practice expense relative value units, based on data from the Physician Practice Information Survey that was adopted in the MPFS CY 2010 final rule.

- *Payment for certain Part B drugs* – CMS will substitute 103 percent of the Average Manufacturer's Price for certain drugs currently paid at 106 percent of the manufacturer's average sales price (ASP). This policy will apply to drugs that have exceeded a price substitution threshold in two consecutive quarters or three of the preceding four quarters, and only if the substituted price is lower than 106 percent of the calculated ASP for the target quarter.

The final rule with comment period will appear in the Nov. 28, 2011, *Federal Register*. CMS will accept comments on those provisions that are subject to comment until Dec. 31, 2011, and will respond in the MPFS for CY 2013.

For more information, see:

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