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Ouch! CMS Proposes 21.5 Percent Physician Pay Cut

On July 1, 2009, the Centers for Medicare and Medicaid Services (CMS) proposed changes to policies and payment rates for services to be provided in calendar year 2010 by practitioners who are paid under the Medicare Physician Fee Schedule (MPFS). The MPFS sets payment rates for thousands of physicians' services in medical offices, hospitals and other health care settings.

The Medicare law requires CMS to adjust the MPFS payment rates annually based on an update formula which includes application of the Sustainable Growth Rate or SGR that was adopted in the Balanced Budget Act of 1997. Because of flaws in its methodology, the formula has mandated physician fee cuts nearly every year for the past decade. CMS took administrative steps to avert the formula-imposed reduction in calendar year 2003 and Congress has taken a series of legislative actions to prevent reductions in calendar years 2004-2009. Based on current data, CMS is projecting a rate reduction of 21.5 percent for calendar year 2010.




The proposed changes, however, are expected to increase the payment rates to general practitioners, family physicians, internists and geriatric specialists by between six to eight percent for primary care services.

Eight key proposed changes discussed below affect physician payment rates in the following areas: the practice expense component of physician fees, the removal of physician-administered drugs from the definition of "physician services," payment rates for consultation codes, payment rates for the initial preventive physical exam, recognition for the cost of professional liability insurance, payment rates for high-cost imaging services, incentives for electronic prescriptions and measures of the Physician Quality Reporting Initiative.

CMS has proposed the following eight changes:

1. The proposal includes an update to the practice expense component of physician fees. For 2010,

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CMS is proposing to include data about physicians' practice costs from a new survey, the Physician Practice Information Survey, which the American Medical Association designed and conducted.

2. CMS is proposing to remove physician-administered drugs from the definition of "physician services." This change is for the purpose of computing the physician update formula in anticipation of legislation which will provide fundamental reforms to Medicare physician payments. This proposal will not change the projected update for services during 2010.
3. CMS proposes an end to payment for consultations typically billed by specialists. These consultations are paid at a higher rate than equivalent evaluation and management ("E/M") services. Practitioners will be required to use existing E/M service codes instead. Savings generated by this change would be redistributed to increase payments for the existing E/M services.
4. CMS is proposing to increase the payment rates for the Initial Preventive Physician Exam. The rates for this plan, also called the "Welcome to Medicare" visit, would be changed to be more in line with payment rates for more complex services.
5. CMS is proposing to refine how Medicare recognizes the cost of professional liability insurance in its payments system. While these changes would have a modest impact, CMS argues they will promote payment equity by redirecting the portion of Medicare's payment for professional liability insurance to those physicians who have the highest malpractice costs.
6. CMS is proposing to add benefit categories for cardiac and pulmonary rehabilitation services, and for chronic kidney disease education as dictated by the Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA").
7. CMS is proposing two changes to address concerns about the rapid growth in the cost of imaging services. First, CMS proposes to reduce the payments for services that require the use of expensive equipment (CMS sets the equipment cap at \$1 million) which would produce savings to be used to increase payments for other services, including primary care services. The current payment rates assume that a physician who owns this type of equipment will use it about 50 percent of the time, but CMS contends that recent survey data suggest this expensive equipment is being used more frequently. CMS is now proposing payment rates that assume the equipment is used 90 percent of the time. CMS rationale is that as the use of this type of expensive equipment increases, the per-treatment costs for purchasing, maintaining and operating the

equipment declines, making a payment reduction appropriate. CMS is also proposing to implement a requirement in the MIPPA that suppliers of the technical component of advanced imaging services be accredited beginning January 1, 2010. The accreditation requirement applies to mobile units, physicians' offices, and independent diagnostic testing facilities that create the images, but does not apply to the physician who interprets them. According to the Government Accountability Office, spending on advanced imaging services, such as computed tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) is growing almost twice as fast as spending on other types of imaging services. While it is a significant contributor to the rapid growth in health care spending in recent years, there is little oversight to ensure the quality of care.

8. Eligible professionals or group practices that meet the requirements of the Electronic Prescribing Incentive Program and the Physician Quality Reporting Initiative in calendar year 2010 will be eligible for incentive payments for each program equal to two percent of their total estimated allowed charges for the reporting periods. CMS is also 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 considered to be successful electronic prescribers.

The changes are unlikely to pass as they stand, but significant improvement to the proposed changes is dependent on the comments CMS receives. CMS will accept comments on the proposed rule until August 31, 2009, and will respond to all comments in a final rule to be issued by November 1, 2009. Unless otherwise specified, the new payment rates and policies will apply to services furnished to Medicare beneficiaries on or after January 1, 2010.

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