



# **MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) PROPOSED PAYMENT RATES & POLICIES FOR 2008**

*Effective Jan. 1, 2008*

On July 2, the Centers for Medicare & Medicaid Services (CMS) posted a proposed notice for Medicare payments in the physician fee schedule for calendar year 2008. CMS will publish this information in the July 12 federal register. The proposed rule affects physicians and office payment for services paid under the Medicare Physician Fee Schedule. A 9.9 percent cut in payment rates for physician-related services absent congressional intervention. **Conversion Factor (CF)** for 2008 would be set at **\$34.1457**.

Important Cardiology proposed CMS policies include:

## **Five Year Review (FYR) Rule**

- A controversial decision to bundle CPT code 93325 (doppler echocardiography color flow velocity mapping) with other echocardiography services. According to CMS: "We believe that the technology of doppler imaging has evolved over the past 2 decades to enable color flow velocity and spectral analysis ... to be performed concurrently or in concert to obtain more accurate interpretation and documentation of the anatomy and physiologic function of the structure(s) and organ being evaluated." The ACC opposes this proposed change and is taking immediate steps to address the issue with CMS.
- A decision to accept recommendations of the RUC with regard to more than 50 procedures which were included in last year's, but were deferred until 2008. Among the adopted recommendations, is a 32 percent increase in the value of work component of anesthesia services. As a result of this increase, CMS has also proposed a negative 11.8 percent adjustment to the work relative value units (RVUs) for all CPT codes to make the overall payments in this system budget neutral. However, because the Budget Neutrality (BN) adjustor is part of the formula for payment and not part of the published RVUs, Addendum B of the Federal Register will **not** match the proposed RVU's. ACC staff is working to calculate proposed payment rates for 2008.

## **Practice Expense**

- Continuing the phase in of a **new methodology** for determining **practice expense (PE)** (such as office overhead) RVUs. Under the four-year phase-in that began in 2007, CMS is expected to apply 50 percent in 2008, 75 percent in 2009 and 100 percent by 2010. Addendum B lists the proposed 2008 transitioned RVUs and the 2010 fully implemented RVUs. Nuclear medicine procedures will be the most affected by the PE methodology changes. In general, procedures with high equipment costs will see a rate increase over time, while procedures with fewer equipment costs will see reductions.
- A request for comments regarding the issue of estimating the percentage of time medical equipment is in use to accurately determine the per use cost of medical equipment. MedPAC and others have repeatedly recommended that CMS raise the utilization percentage assumption – especially for advanced imaging equipment – thus, effectively lowering practice expense payments.
- A proposal to maintain the assumption or 11 percent interest rates for purposes of determining the per use cost of equipment.
- Accepting the American College of Radiology's recommendation that the practice expense per hour data from the CMS 2007 radiology supplemental survey be weighted by practice size. This would increase radiology's practice expense per hour in some categories.
- Accepting the RUC/PERC recommendations for direct practice expense inputs for cardiac catheterization in the non-facility setting.
- A cap, directed under the 2007 Deficit Reduction Act (DRA), on the payment rates for imaging services under the physician fee schedule at the amount paid for the same services when performed in hospital outpatient departments. While CMS did not propose to delete any imaging codes, certain ophthalmologic imaging

procedures were added to the list of DRA affected CPT codes (see Addendum F). *When the proposed 2008 HOPPS rates are posted this bulletin will be updated.* The proposed rule also continues a policy of reducing the payment for the Radiology Families by 25 percent. CMS will apply the multiple imaging reductions first, followed by the OPPI imaging cap, if applicable.

### **GPCIs**

- Updating GPCIs, as required by statute, to reflect current data on geographic differences in practice costs. The new GPCIs will be phased in over two years (2008 and 2009).

### **PQRI**

- A detailed outline of CMS' interpretation of the statutory requirements concerning the type of measures to be included in PQRI, as well as the characteristics of the "consensus organizations" that must endorse measures.
- A proposal to only accept PQRI measures in 2008 that are endorsed by NQF or adopted by the AQA Alliance as of Nov. 15, 2007. CMS plans to select additional measures for PQRI in 2008 from a variety of sources. The complete list of measures under consideration is available on the CMS PQRI website at: [http://www.cms.hhs.gov/PQRI/35\\_2008PQRIInformation.asp#TopOfPage](http://www.cms.hhs.gov/PQRI/35_2008PQRIInformation.asp#TopOfPage).
- An invitation to interested registries to participate in testing several different approaches to reporting PQRI measures through registries in 2008. However, registry participants who wish to participate in PQRI will still need to report the PQRI measures through the claims submission process for 2008.

### **Independent Diagnostic Testing Facility (IDTF) Issues**

- Proposed revisions of existing IDTF performance standards:
  - Clarify current minimum insurance coverage standards and policy change reporting requirements for IDTF;
  - Clarify administrative requirements for IDTF suppliers to "answer, document, and maintain documentation of beneficiaries' questions and responses to their complaints at the physical site of the IDTF;" and
  - Revise the current standard describing the IDTF supervisory physician's responsibilities for IDTF(s).
- Proposed New IDTF Standards:
  - Establish an initial enrollment date for IDTFs in the Medicare program to clarify payment eligibility; and
  - A new performance standard that prohibits fixed-site IDTFs to ". . . share space, equipment, staff, or sublease of its operations to another individual or organization." In addition, the agency is soliciting comments from the public as to whether it should apply this standard to mobile IDTFs, and why or why not.

### **Physician Self-Referral Provisions—**

- Imposing an Anti-Markup Provision to the purchase of the Technical and Professional Components (TC and PC, respectively) of diagnostic tests in the Physician Self-Referral Rules.
- A proposal addressing the issue of appealing claims for Designated Health Services (DHS) denied by Medicare on the basis that the service was provided pursuant to a prohibited referral. Under the rule, only the submitting entity will carry the burden of proving that the DHS was not furnished as part of a prohibited referral.
- A request for comments regarding the In-Office Ancillary Services Exception to the Stark rules. Specifically, CMS is asking for comments on:
  - Whether certain services should not qualify for this exception;

- Whether changes to the definition of “same” or “centralized” building are warranted;
  - Whether non-specialist physicians (sic) should be able to use the exception to refer patients for specialized services involving the use of equipment owned by the non-specialists; and
  - Any other restrictions on ownership or investments that would curtail fraud and abuse.
- A proposal that Space and Equipment Leases may not include Unit-of-Service (Per-Click) payments to a physician-owner for services rendered by an entity-lessee (e.g. hospital, ASC) to patients who are referred by a physician-owner to the entity. In addition, CMS is seeking comments on whether to prohibit similar arrangements where the entity is the owner, and the physician pays on a time- or unit-of-service basis to the extent that such payments reflect services rendered to patients sent to the physician by the entity-owner.
  - A request for comment on whether and how to implement a prohibition period (disallowance) between two parties that have engaged in a non-Stark compliant financial relationship from entering into any new financial arrangements—even if it is to be one compliant with Stark requirements.
  - A prohibition on ownership and investment interests in retirement plans that purchase DHS entities to which they refer patients for such (or similarly) non-compliant purposes.
  - A clarification that percentage compensation arrangements in the context of equipment or medical office space rentals may only be used for: 1) paying for personally performed physician services, or 2) must be based on the revenues directly resulting from the physician services rather than based on some other factor such as a percentage of the savings by a hospital department—which is not directly or indirectly related to the physician services provided.
  - A proposal to revise the analysis of indirect financial relationships such that certain DHS entities having an ownership interest (or otherwise control of) another entity to which a physician refers Medicare beneficiaries for DHS, would “Stand in the Shoes” of the entity it controls as though it were a direct, not indirect, participant in a referral arrangement. For example, a hospital would stand in the shoes of a medical foundation that it owns or controls if the foundation contracts with a physician to provide services at a clinic owned by the foundation, and the hospital would be deemed to have a direct compensation arrangement with the physician. It should be noted, for purposes of avoiding submission of potentially self-incriminating comments, that CMS is considering drafting—or may already have drafted—a separate proposed rule to address this issue.
  - A request for comments on how to amend certain self-referral statute exceptions of the rules to permit an “alternative criteria” for satisfying the exceptions. The request is in response to public comments received with regard to the unfairly high risk of disproportionately severe penalties for minor or inadvertent violations of the self-referral statute—especially where the non-complying entity was attempting to meet an exception in good faith.
  - A proposal to revise the definition of “entity” for purposes of services furnished “under arrangements” (e.g. where a physician is prohibited from making referrals to a DHS entity with which the physician or his/her relations has an ownership interest, the DHS entity is also prohibited from billing CMS of the DHS unless an exception applies). Specifically, the definition for “DHS entity” would include both the person/entity that performs the DHS, as well as the entity who submits claims to Medicare for the DHS. CMS is seeking to address the growing prevalence of hospital/physician joint ventures that provide hospital imaging services formerly provided by the hospital directly.

### **Other Issues**

- A request for comments on how to address the additional costs of replacement devices and the additional physicians’ services and diagnostic tests that these beneficiaries need in light of the recall and replacement of 73,000 ICDs and CRT-Ds.