Proposed 2012 Medicare Physician Fee Schedule

Summary

On July 1, the Centers for Medicare & Medicaid Services (CMS) released the proposed 2012 Medicare Physician Fee Schedule. This proposed rule addresses changes to the physician fee schedule and other Medicare Part B payment policies, and it implements certain provisions of the *Affordable Care Act* of 2010 (ACA) and the *Medicare Improvements for Patients and Providers Act* of 2008 (MIPPA). It also discusses payments for Part B drugs, the 2012 Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, the Physician Resource-Use Feedback Program, and implementation of the value-based payment modifier.

Comments on the proposed rule are due to CMS no later than August 30, 2011. The AAFP will analyze the proposed regulation extensively and submit a formal response to CMS. The agency is expected to release the final 2012 Medicare physician fee schedule in early November 2011.

Conversion Factor for 2012

The *Medicare and Medicaid Extenders Act* of 2010 provided for a 1-year zero percent update resulting in the 2011 conversion factor currently being $33.9764. Since this 1-year extension expires at the end of 2011, CMS currently estimates that the statutory formula used to determine Medicare physician payments will result in a 2012 conversion factor of $23.9635 which represents a physician fee schedule update – that is a decrease of 29.5 percent.

The AAFP continues to call on Congress to prevent these drastic payment cuts and to end the practice of enacting retroactive "fixes". In a statement issued when the fee schedule was released, the AAFP urged Congress before 2012 to pass a five-year extension of Medicare physician payment updates at current rates, include a differential payment rate that is at least 3 percent higher for primary care physicians providing primary care services, and increase payments associated with the Primary Care Incentive Program.

Changes to the Relative Value Units

Background
Since 1992, Medicare pays for physician services based on relative value units (RVUs) for physician work, practice expenses (such as office rent and personnel wages), and malpractice expenses.

CMS establishes physician work RVUs for new and revised codes based in part on recommendations received from the American Medical Association's (AMA) Specialty Society Relative Value Update Committee (RUC).

In the past, CMS used the Clinical Practice Expert Panel and the AMA's Socioeconomic Monitoring System (SMS) data to develop practice expense RVUs, but more recently begun utilizing the AMA's Physician Practice Information Survey (PPIS). In the 2007 final Medicare physician fee schedule, CMS revised the methodology and data source used to calculate direct practice expense RVUs and provided for a 4-year transition to the new values.

CMS develops malpractice RVUs based on malpractice insurance premium data. In the 2010 final Medicare physician fee schedule, CMS implemented the second and most recent 5-year review and update of the malpractice RVUs. In the 2011 final Medicare physician fee schedule, CMS described their approach for determining malpractice RVUs for new or revised codes that become effective before the next five year review and update.

CMS is required to review all RVUs at least every 5 years; the most recent (fourth) review began in the 2010 Medicare physician fee schedule. To calculate the payment for a physician's service, the components of the fee schedule (physician work, practice expense, and malpractice RVUs are adjusted by a geographic practice cost index (GPCI). The GPCIs reflect the relative costs of physician work, practice expense, and malpractice in an area compared to the national average costs for each component. RVUs are converted to dollar amounts through the application of a conversion factor.

The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

> Payment = [(RVU work x GPCI work) + (RVU practice expense x GPCI practice expense) + (RVU Malpractice x GPCI Malpractice)] x conversion factor.

Proposed changes
Proposed 2012 revisions to work RVUs and corresponding changes to practice expense and malpractice RVUs affecting payment for physicians' services for the fourth 5-year review of work RVUs were published as an Addenda (ZIP, 922KB) and CMS solicits comments on these proposed adjustments. Available at the end of this summary, Table 64 of the proposed payment rule contains an estimated breakdown per medical specialty of the 2012 physician fee schedule's estimated impact on total allowed charges with RVU changes. Also available at the end of this summary, Table 65 contains a similar impact chart by selected procedures.

In 2012, the third year of the transition, the practice expense RVUs are calculated based on a 75/25 blend of the new practice expense RVUs developed using the PPIS data and the previous practice expense RVUs based on the SMS and supplemental survey data.

To develop the 2012 malpractice RVUs for new or revised codes, CMS crosswalked the new or revised code to the malpractice RVUs of a similar source code and adjusted for differences in work between the source code and the new or revised code.

Review of Potentially Misvalued Codes

Background
In addition to the 5-year review of RVUs, CMS and the AMA RUC have identified and reviewed several potentially misvalued codes on an annual basis. Section 3134 of the *Affordable Care Act* requires CMS periodically to identify, review, and adjust values for potentially misvalued codes with an emphasis on codes that:

- Have grown the most,
- Have experienced substantial changes in practice expenses,
- Are recently established for new technologies or services,
- Are multiple ones frequently billed in conjunction with furnishing a single service,
- Have low relative values, particularly those that are often billed multiple times for a single treatment,
- Are so-called 'Harvard valued codes', and
- Are determined appropriate by CMS.

Proposed changes
Starting in 2012, CMS plans to consolidate the formal 5-year review of work and practice expense RVUs with the annual review of potentially misvalued codes. Given that CMS annually is engaging in extensive reviews of work RVUs and direct practice expense inputs of potentially misvalued codes, the agency believes that separate 5-year reviews of work and practice expense RVUs have become redundant. CMS would accept nominations from the public of potentially misvalued codes for review coinciding with the release of the annual final Medicare physician fee schedule. CMS plans to continue reviewing malpractice RVUs at 5-year intervals.

Of particular interest to primary care physicians, CMS notes that Evaluation & Management (E&M) codes consistently appear in the top 20 high physician fee schedule expenditure services and have not been reviewed since 2006. CMS requests that the AMA RUC conduct a comprehensive review of all E&M codes. In this section, CMS states:

There has been significant interest in delivery system reform, such as patient-centered medical homes and making the primary care physician the focus of managing the patient's chronic conditions. The chronic conditions challenging the Medicare population include heart disease, diabetes, respiratory disease, breast cancer, allergy, Alzheimer's disease, and factors associated with obesity. Thus, as the focus of primary care has evolved from an episodic treatment-based orientation to a focus on comprehensive patient-centered care management in order to meet the challenges of preventing and managing chronic disease, we believe a more current review of E&M codes is warranted. We note that although physicians in primary care specialties bill a high percentage of their services using the E/M codes, physicians in non-primary care specialties also bill these codes for some of their services.

Since we believe the focus of primary care has evolved to meet the challenges of preventing and managing chronic disease since the last comprehensive review of the E&M codes, we would like the AMA RUC to prioritize review of the E&M codes and provide us with recommendations…by July 2012 in order for us to include any revised valuations for these codes in the CY 2013 physician fee schedule final rule with comment period.

We would expect the AMA RUC to review the remaining E&M codes listed in Table 6 by July 2013 in order for us to complete the comprehensive re-evaluation of E&M services and include the revised valuations for these codes in the CY 2014 physician fee schedule final rule with comment period.

The agency also requests that the AMA RUC review a list of high physician fee schedule expenditure procedural codes representing services furnished by a variety of medical specialties as identified in Table 7. In Table 8, CMS also publishes a complete list of the 40 codes with site-of-service anomalies.

Geographic Practice Cost Indices

Background
CMS is required to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three components (physician work, practice expense, and malpractice) of the fee schedule. The agency must review and adjust as necessary the GPCIs at least every 3 years. Since 2009, a permanent 1.5 work GPCI floor for services furnished in Alaska has existed. In a separate law, Congress set a permanent 1.0 practice expense GPCI floor for services furnished in “frontier states” (i.e., at least 50 percent of the state’s counties have a population density of less than 6 persons per square mile) beginning January 1, 2011. CMS identified five frontier states (Montana, Wyoming, North Dakota, Nevada and South Dakota). For other states, the current 1.0 physician work floor will expire at the end of 2011 unless Congress intervenes before 2012. CMS last updated the physician work GPCI in 2011 based on 2006-2008 Bureau of Labor Statistics (BLS) Occupational Employment Statistics data

Proposed changes
CMS is not proposing to make further revisions in 2012 to the work GPCI, though the agency notes the work GPCIs as published reflect the expiration of the statutory work floor.

Regarding the 2012 practice expense data sources, CMS proposes to:

- Revise the occupations used to calculate the employee wage component of practice expense using wage data from the federal Bureau of Labor Statistics specific to the office of physicians' industry;
- Utilize two bedroom rental data from the 2006-2008 American Community Survey as the proxy for physician office rent;
- Create a purchased service index that accounts for regional variation in labor input costs for contracted services from industries comprising the "all other services" category within the Medicare Economic Index (MEI) office expense; and
- Use the 2006-based MEI (most recent MEI weights finalized in the 2011 final rule) to determine the GPCI cost share weights.

The malpractice GPCIs are calculated based on insurer rate filings of premium data for $1 million to $3 million mature "claims-made" policies. Based on the data analyzed, CMS proposes to revise the cost share weight for the malpractice GPCI from 3.865 percent to 4.295 percent.

Telehealth Services

Background
Medicare telehealth services can only be furnished to an eligible beneficiary in an “originating site”. An originating site is defined as one of the specified sites where an eligible individual is located at the time the telehealth service is being furnished via a telecommunications system. In general, originating sites must be located in a rural health professional shortage area (HPSA) or in a county outside of a Metropolitan Statistical Area. The originating sites include offices’ of a physician or practitioner, hospitals, critical access hospitals, rural health clinics, federally qualified health centers, hospital-based or critical access hospital-based renal dialysis centers (including satellites), skilled nursing facilities, and community mental health centers.

Medicare telehealth services currently include initial inpatient consultations, follow-up inpatient consultations, office or other outpatient visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end-stage renal disease (ESRD) related services, individual and group medical nutrition therapy (MNT), neurobehavioral status exam, individual and group health and behavior assessment and intervention (HBAI), subsequent hospital care, subsequent nursing facility care, individual and group kidney disease education (KDE), and individual and group diabetes self-management training services (DSMT).

Provided that the health care professional is licensed under state law to deliver the service being furnished via a telecommunications system, eligible providers at the distant site include physicians, physician assistants, nurse practitioners, clinical nurse specialist, nurse-midwives, clinical psychologists, clinical social workers, or registered dietitian or nutrition professionals.

Proposed changes
Over the past year, CMS received requests to add as newly covered Medicare telehealth services smoking cessation, critical care, domiciliary or rest home E&M, genetic counseling, online E&M, data collection, and audiology.

CMS proposes to add CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) to the list of telehealth services for 2012 on a category 1 basis and proposes to add HCPCS codes G0436 (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes) and G0437 (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes) to the list of telehealth services for 2012.

CMS discusses but ultimately does not propose adding the other requested services to the list of Medicare telehealth services. CMS concludes this section by proposing a few revisions to the formal process used to request additions to the Medicare telehealth list.

Medicare Coverage and Payment of the Annual Wellness Visit

Background
The *Affordable Care Act* expanded the preventive care benefits available to Medicare Part B beneficiaries. In addition to the existing “Welcome to Medicare” visit (also known as the Initial Preventive Physical Exam or IPPE) for new Medicare Part B beneficiaries, as of 2011 Medicare now also covers an Annual Wellness Visit (AWV) for personal prevention plan services.

For 2011, HCPCS code G0438, Annual wellness visit; includes a personalized prevention plan of service (PPPS), first visit includes:

- Establishment of an individual's medical and family history;

- Establishment of a list of current medical providers and suppliers involved in providing medical care to the individual;
- Measurement of an individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the beneficiary's medical and family history;
- Detection of any cognitive impairment that the individual may have;
- Review of the individual's potential (risk factors) for depression;
- Review of the individual's functional ability and level of safety;
- Establishment of a written screening schedule for the individual such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered by Medicare;
- Establishment of a list of risk factors for which primary, secondary or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination, and a list of treatment options and their associated risks and benefits;
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management; and
- Any other element determined appropriate through the national coverage determination process (NCD).

For 2011, HCPCS code G0439, Annual wellness visit; includes a PPPS, subsequent visit includes:

- An update of the individual's medical and family history;
- An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual;
- Measurement of an individual's weight (or waist circumference), blood pressure and other routine measurements as deemed appropriate, based on the individual's medical and family history;
- Detection of any cognitive impairment that the individual may have;
- An update to the written screening schedule for the individual;
- An update to the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual;
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services; and
- Any other element determined appropriate through the NCD process.

The ACA specifies that a personalized prevention plan for an individual includes a health risk assessment (HRA) that meets the guidelines established by CMS. In general, an HRA is an evaluation tool designed to provide a systematic approach to obtaining accurate information about the patient's health status, injury risks, modifiable risk factors, and urgent health needs. The information from the HRA is reflected in the personalized prevention plan that is created for the individual.

Although the availability of payment for AWV was effective at the beginning of 2011, the ACA provided additional time for CMS to establish guidelines for HRAs after consulting with relevant groups and entities. The Agency for Healthcare Research and Quality (AHRQ) was responsible for determining the key features of HRAs, examining which features were associated with successful HRAs, and determining the applicability of HRAs to the Medicare population. CMS worked with the Centers for Disease Control and Prevention (CDC) to develop guidelines for a personalized prevention plan tool. The AAFP offered guidance to the CDC on their development of a Health Risk Assessment (HRA) in a December 16, 2010 letter. The CDC intends to publish "A Framework for Patient-Centered Health Assessments, a Morbidity and Mortality Weekly Report (MMWR)."

Proposed changes

CMS proposes to add the term "health risk assessment" and its definition into revised definitions of “first annual wellness visit providing personalized prevention plan services” and “subsequent annual wellness visit providing personalized prevention plan services”, and incorporate the use and results of an HRA into the provision of personalized prevention plan services during the AWV.

The proposed definition of a "Health Risk Assessment" is an evaluation tool that, at a minimum:

- Collects self-reported information about the beneficiary;
- Can be administered independently by the beneficiary or administered by a health professional prior to or as part of the AWV encounter;
- Is appropriately tailored to and takes into account the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy need;
- Takes no more than 20 minutes to complete;
- Addresses, at a minimum, the following topics:
    - Demographic data, including but not limited to age, gender, race, and ethnicity;
    - Self-assessment of health status, frailty, and physical functioning;
    - Psychosocial risks, including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, or fatigue;
    - Behavioral risks, including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual practices, motor vehicle safety (seat belt use), and home safety;
    - Activities of daily living (ADLs), including but not limited to dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing; and
    - Instrumental activities of daily living (IADLs), including but not limited to shopping, food preparation, using the telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.

CMS proposes to incorporate the HRA as a required element in AWVs beginning in 2012 by revising the definitions of first and subsequent AWVs as follows:

- Specify that the AWV take into account the results of an HRA;
- Add the review (and administration, if needed) of an HRA as an element of both first and subsequent AWVs; and
- Specify that the establishment of a written screening schedule for the individual, such as a checklist, includes and takes into account the HRA.

In the 2011 physician fee schedule, CMS stated "*that when the HRA is incorporated in the AWV, we will reevaluate the values for HCPCS codes G0438 and G0439*" and the services described by CPT codes 99204 and 99214 already include 'preventive assessment' forms. For 2012, CMS believes that the current payment crosswalk for HCPCS codes G0438 and G0439 continue to be most accurately equivalent to a level 4 E&M new or established patient visit and therefore CMS proposes to continue to crosswalk HCPCS codes G0438 and G0439 to CPT codes 99204 and 99214, respectively.

Physician Quality Reporting System

Background
The Physician Quality Reporting System (PQRS) provides incentive payments and payment penalties to identified eligible professionals who satisfactorily report (via Medicare Part B claims, qualified PQRS registry, or qualified PQRS electronic health record), data on quality measures for covered professional services furnished during a specified reporting period (full and half year options).

In 2011, the incentive payment for successful PQRS participation is 1 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. For 2011 through 2014, an additional 0.5 percent is available if the individual professional participates via a "continuous assessment program" such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program as determined by CMS. In 2012 through 2014, the incentive payment is lowered to 0.5 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. Under current law, CMS will impose a -1.5 percent penalty on practices in 2015 that are not successfully participating in the PQRS. In 2016 and beyond the penalty threshold is lowered to -2 percent.

Proposed PQRS core measures
CMS discusses the need to promote the prevention of cardiovascular conditions. As such, CMS proposed seven PQRS core measures in Table 29 that are aimed at promoting the prevention of cardiovascular conditions. CMS proposes that eligible professionals specializing in internal medicine, family practice, general practice, or cardiology be required to report on at least one proposed PQRS core measure.

Specifically, CMS proposes that individual eligible professionals specializing in internal medicine, family practice, general practice, or cardiology must report (via claims-, registries-, or EHR- based methods) on at least one PQRS core measure, report on at least two additional measures that apply to the services furnished by the professional, and report each measure for at least 50 percent of the eligible professional's Medicare Part B fee for service patients for whom services were furnished during the reporting period to which the measure applies.

For all other eligible professionals, CMS proposes they must report on at least three measures that apply to the services furnished by the professional and report each measure for at least 50 percent of the eligible professional's Medicare Part B fee for service patients for whom services were furnished during the reporting period to which the measure applies.

Proposed changes to PQRS reporting periods
CMS proposes to specify:

- A 12-month reporting period for the satisfactory reporting of PQRS quality measures for claims-, registry-, and Electronic Health Record- based reporting.
- A 12-month reporting period for the PQRS Group Practice Reporting Option (GPRO).

This proposal eliminates the 6-month reporting period for claims- and registry- based participation previously available under the PQRS. CMS justifies this by noting that the 12-month reporting period aligns with other CMS quality reporting programs.

Proposed 2012 PQRS measures
CMS proposes to retain all measures (55 registry-only measures and 144 individual quality measures for either claims-based reporting or registry-based reporting) currently used in the 2011 PQRS. CMS proposes 26 new individual measures for inclusion in the 2012 PQRS. Of these measures, 13 would be reportable via registry-only. The remaining 13 measures would be available for claims and registry reporting. For 2012, CMS proposes that any 2012 PQRS measure included in the Back Pain measures group would not be reportable as individual measures through claims-based reporting or registry-based reporting. In order to better align PQRS measures with those under the Medicare EHR Incentive Program, for 2012 CMS proposes to have 44 clinical quality measures in the Medicare EHR Incentive Program available for EHR-based reporting under the 2012 PQRS. CMS proposes to retain 14 of the 2011 PQRS measures groups for the 2012 PQRS and add 10 new PQRS measures groups for the 2012 PQRS

Proposed changes to group practices
For purposes of the PQRS GPRO II, CMS had defined “group practice” as “*a single Tax Identification Number (TIN) with two or more eligible professionals, as identified by their individual National Provider Number (NPI), who have reassigned their Medicare billing rights to the TIN”.* Because many smaller group practices that self-nominated to participate in the GPRO II in 2011 eventually elected to opt out so that members of the group practice could instead participate in the PQRS individually, CMS now proposes to change this definition as a TIN with 25 or more individual eligible professionals who have reassigned their billing rights to the TIN. CMS also proposes to consolidate the GPRO I (designed for TINs with more than 200 NPIs) and GPRO II into a single GPRO.

CMS proposes that group practices selected to participate in the 2012 PQRS would be required to report on 40 proposed measures listed in Table 56 of the draft rule. CMS proposes to retain most of the measures available under the 2011 PQRS GPRO because of their continued interest in those measures and to maintain program consistency. However, CMS proposes to retire three measures that were required under the 2010 and 2011 GPRO and to add eighteen measures to the PQRS GPRO.

Although CMS makes no proposals at this time, the agency invites public comment on possibly expanding the definition of group practice for PQRS purposes to be comprised of multiple TINs.

PQRS Maintenance of Certification Program Incentive
For the additional 0.5 percent incentive payment for the individual professional who participates via a "continuous assessment program," CMS proposes for 2012, eligible professionals must satisfactory meet the PQRS reporting requirements for the applicable program year. As an alternative, the provider may satisfactorily report under the PQRS based on submission of PQRS data by a Maintenance of Certification (MOC) program that is qualified as a PQRS registry for 2012. In addition to meeting the proposed requirements for satisfactory reporting for the PQRS for a program year, the eligible professional must have data with respect to the eligible professional's participation in a MOC program submitted by a qualified medical specialty board or other entity sponsoring a MOC program.

The qualified medical specialty board or other entity sponsoring a MOC program must submit data to CMS certifying that the eligible professional "more frequently than is required" qualified for or maintained board certification. CMS does not propose to specify how a physician must meet the "more frequently" requirement, but rather that the MOC program determine what a physician must do. CMS proposes, as a basic requirement, successful completion in at least one MOC program practice assessment for each year the physician participates in the MOC program incentive, regardless of whether or how often the physician is required to participate in a MOC program to maintain board certification.

PQRS feedback reports and informal review process
Section 1848 of the *Affordable Care Act* requires CMS to provide timely feedback to PQRS participants. Typically, CMS issues PQRS feedback reports and incentive payments around July of the year following the reporting period. CMS proposes to continue issuing feedback reports for 2012 and beyond around the same time incentive payments are issued. CMS proposes to provide interim feedback reports in the summer of the respective program year to eligible professionals that are reporting individual measures and measures groups through the claims- based reporting.

The 2011 PQRS informal appeals process allows eligible professionals to contact the Quality Net help desk (via phone or e-mail) to request an informal review. Quality Net must respond to this request within 60 days of receiving the original request. Citing an anticipated growth in volume of informal review requests, CMS proposes to allow a 90 day informal review response time.

2015 PQRS penalty based on 2013 PQRS reporting
Beginning in 2015, a payment penalty will apply under the PQRS. Specifically, if the eligible professional does not satisfactorily participate in the PQRS, the fee schedule amount for services furnished by such professionals during the year shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services. The applicable percent is:

- 98.5 percent for 2015; and
- 98.0 percent for 2016 and each subsequent year.

CMS proposes a 12-month reporting period for the 2015 payment penalty and proposes that the reporting period for purposes of the 2015 payment penalty be the 2013 calendar year.

Electronic Prescribing Incentive Program

Background
From 2009 through 2013, CMS is authorized to provide eligible professionals who are successful electronic prescribers an incentive payment equal to a percentage of the eligible professional's total estimated Medicare Part B physician fee schedule allowed charges for all covered professional services furnished by the eligible professional during the respective reporting period. However, CMS is also authorized to conduct the Medicare EHR Incentive Program, which specifies that the eRx incentive does not apply to an eligible professional, if, for the EHR reporting period, the eligible professional earns an incentive payment under the Medicare EHR Incentive Program beginning in 2011. For years 2012 through 2014, CMS will apply a payment penalty to

eligible professionals who are not successfully electronic prescribing. The applicable eRx percent for payment incentives and penalties under the eRx Incentive Program are as follows:

- 2011: 1.0 percent for successful electronic prescribers.
- 2012: 1.0 percent for successful electronic prescribers or -1.0 percent for non-successful electronic prescribers.
- 2013: 0.5 percent for successful electronic prescribers or -1.5 percent for non-successful electronic prescribers.
- 2014: -2.0 percent for non-successful electronic prescribers.

Proposed changes

In this proposed rule, CMS sets forth proposals for the 2012, 2013, and 2014 electronic prescribing reporting periods. For purposes of the incentive payment and the payment penalties, CMS proposes to determine success at the NPI level. CMS proposes to modify the electronic prescribing group practice reporting option to align with their proposed definition of group practice for purposes of the 2012 PQRS (that is, TINs with at least 25 NPIs). For purposes of the 2012 and 2013 incentives and 2013 and 2014 payment penalties, CMS proposes to retain the denominator codes contained in the 2011 electronic prescribing measure. CMS also proposes to modify the Part D electronic prescribing standards required for a "qualified" electronic prescribing system under the eRx Incentive Program to have these standards consistent with current, CMS Part D electronic prescribing standards.

Physician Compare website

Background

Section 10331 of the *Affordable Care Act* requires that, no later than January 1, 2013, CMS implement a plan for making information on physician performance publicly available through the Physician Compare Website. To the extent that scientifically sound measures are developed and are available, CMS is required to include

- Measures collected under the Physician Quality Reporting System;
- An assessment of patient health outcomes and functional status of patients;
- An assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;
- An assessment of efficiency;
- An assessment of patient experience and patient, caregiver, and family engagement;
- An assessment of the safety, effectiveness, and timeliness of care; and
- Other information as determined appropriate by CMS.

Proposal

CMS proposes to make public the performance rates of the quality measures that group practices submit under the 2012 PQRS GPRO. CMS proposes that group practices participating in the 2012 PQRS GPRO would agree in advance to have their reporting performance results publicly reported as part of their self-nomination. CMS also proposes to publicly report the performance rates of the quality measures that the group practices participating in the Physician Group Practice demonstration report on the Physician Compare Web site as early as 2013 for performance information collected in 2012. To eliminate the risk of calculating performance rates based on a small denominator, CMS proposes to set a minimum patient sample size of 25 patients will have to be met in order for the group practice's measure performance rate to be reported on the Physician Compare website. For groups reporting using GPRO information made public in 2013, CMS does not propose to post information with respect to the measure performance of individual physicians associated with the group. However, CMS proposes to identify the individual eligible professionals who were associated with the group during the reporting period by posting a list of the eligible professionals on the Physician Compare website.

Medicare Electronic Health Record Incentive Program

Background

The *American Recovery and Reinvestment Act* of 2009 (ARRA) provides incentive payments to eligible professionals, eligible hospitals, and critical access hospitals participating in the Medicare and Medicaid

programs that successfully adopt, implement, upgrade, or demonstrate meaningful use of certified electronic health record (EHR) technology.

Proposed changes
CMS proposes that:

- For the 2012 payment year, eligible professionals may continue to report clinical quality measure results as calculated by certified EHR technology by attestation,
- For the 2011 payment year a voluntary pilot mechanism would be established through which eligible professionals participating in the Medicare EHR Incentive Program may report clinical quality measures information electronically using certified EHR technology for the 2012 payment year.
- The agency initiate a “Physician Quality Reporting System-Medicare EHR Incentive Pilot” to allow eligible professionals on a voluntary basis to participate in the Medicare EHR Incentive Program and meet the clinical quality measures reporting requirements of the EHR Incentive Program for payment year 2012 by submitting quality measure information electronically.

Physician Feedback Program and Establishment of the Value-Based Payment Modifier

Background
Sections 3003 and 3007 of the *Affordable Care Act* call for CMS to improve the existing physician feedback pilot program (Phase I and II already completed) and establish a value-based payment modifier. CMS discusses how these sections mutually reinforce their goal to provide physicians with fair, actionable and meaningful information concerning resource use and quality. CMS anticipates that the physician feedback reports will serve as the testing basis to develop and implement the value modifier, which will be applied to certain physicians and physician groups under the physician fee schedule starting in 2015. CMS is required to establish by 2012 the quality measures for the value modifier. CMS is also required to specify an initial performance period for the application of the value modifier with respect to 2015.

Proposals
CMS proposes to increase production and dissemination of Physician Feedback reports when it starts Phase III. To satisfy the requirement that CMS establish the quality measures used for the value modifier by 2012, CMS proposes to use information from:

- The measures in the core set of the PQRS for 2012;
- All measures in the GPRO of the PQRS for 2012; and
- The core measures, alternate core, and 38 additional measures in the 2012 Medicare EHR Incentive Program.

To satisfy the CMS requirement to specify an initial performance period for the application of the value modifier with respect to 2015, CMS proposes the initial performance period be the calendar year 2013.

Applicability of the 3-Day Payment Window Policy for Services Furnished in Physician Practices

Background
Certain services furnished to Medicare beneficiaries in the 3 days preceding an inpatient admission are considered "operating costs of inpatient hospital services" and are included in the hospital's payment under the hospital Inpatient Prospective Payment System (IPPS). This policy is generally known as the "3-day payment window." Under the 3-day payment window, a hospital must include on the claim for a Medicare beneficiary's inpatient stay, the technical portion of any outpatient diagnostic services and admission-related non-diagnostic services provided during the payment window.

Proposed changes
In circumstances where the 3-day payment window applies to non-diagnostic services related to an inpatient admission furnished in a wholly owned or wholly operated physician practice, CMS proposes that Medicare would make payment under the physician fee schedule for the physicians' services that are subject to the 3-day payment window at the facility rate.

TABLE 64: CY 2012 PFS PROPOSED RULE TOTAL ALLOWED CHARGE ESTIMATED IMPACT FOR RVU AND MPPR CHANGES*

Specialty (A)	Allowed Charges (mil) (B)	Impact of Work and MP RVU Changes (C)	Impact of PE RVU Changes		Combined Impact	
			Full (D)	Tran (E)	Full (F)	Tran (G)
TOTAL	$83,014	0%	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$194	0%	1%	1%	1%	1%
ANESTHESIOLOGY	$1,847	0%	4%	2%	4%	2%
CARDIAC SURGERY	$384	0%	-2%	-1%	-2%	-1%
CARDIOLOGY	$6,778	0%	-3%	-1%	-3%	-1%
COLON AND RECTAL SURGERY	$146	0%	2%	1%	2%	1%
CRITICAL CARE	$252	0%	1%	0%	1%	0%
DERMATOLOGY	$2,931	0%	0%	0%	0%	0%
EMERGENCY MEDICINE	$2,658	0%	-1%	-1%	-1%	-1%
ENDOCRINOLOGY	$415	0%	1%	0%	1%	0%
FAMILY PRACTICE	$5,640	0%	2%	1%	2%	1%
GASTROENTEROLOGY	$1,837	0%	1%	0%	0%	0%
GENERAL PRACTICE	$656	0%	2%	1%	2%	1%
GENERAL SURGERY	$2,277	0%	1%	0%	1%	0%
GERIATRICS	$200	0%	2%	1%	2%	1%
HAND SURGERY	$121	0%	3%	1%	2%	1%
HEMATOLOGY/ONCOLOGY	$1,912	0%	-1%	0%	-2%	0%
INFECTIOUS DISEASE	$597	0%	1%	1%	1%	0%
INTERNAL MEDICINE	$10,737	0%	1%	1%	1%	1%
INTERVENTIONAL PAIN MGMT	$448	0%	3%	2%	2%	1%
INTERVENTIONAL RADIOLOGY	$211	-1%	-3%	-1%	-4%	-2%
MULTISPECIALTY CLINIC/OTHER	$84	1%	1%	1%	2%	1%
NEPHROLOGY	$2,011	0%	0%	0%	0%	0%
NEUROLOGY	$1,520	0%	4%	2%	4%	2%
NEUROSURGERY	$669	0%	1%	0%	1%	0%
NUCLEAR MEDICINE	$53	0%	-4%	-2%	-5%	-3%
OBSTETRICS/GYNECOLOGY	$678	0%	0%	0%	0%	0%
OPHTHALMOLOGY	$5,316	0%	3%	2%	3%	2%
ORTHOPEDIC SURGERY	$3,572	0%	2%	1%	2%	1%
OTOLARNGOLOGY	$1,001	0%	2%	1%	1%	1%
PATHOLOGY	$1,122	0%	-2%	-1%	-2%	-1%
PEDIATRICS	$68	0%	1%	1%	1%	1%
PHYSICAL MEDICINE	$928	0%	3%	2%	3%	2%
PLASTIC SURGERY	$339	0%	2%	1%	1%	0%
PSYCHIATRY	$1,134	0%	0%	0%	0%	0%
PULMONARY DISEASE	$1,758	0%	1%	0%	1%	0%
RADIATION ONCOLOGY	$1,968	0%	-8%	-4%	-8%	-4%
RADIOLOGY	$4,722	-1%	-5%	-2%	-6%	-4%
RHEUMATOLOGY	$530	0%	0%	0%	0%	0%
THORACIC SURGERY	$371	0%	-2%	-1%	-1%	-1%
UROLOGY	$1,919	0%	-3%	-2%	-3%	-2%
VASCULAR SURGERY	$749	0%	-2%	-1%	-2%	-1%
AUDIOLOGIST	$56	0%	-6%	-3%	-6%	-3%
CHIROPRACTOR	$743	0%	2%	1%	2%	1%
CLINICAL PSYCHOLOGIST	$559	0%	-5%	-3%	-5%	-3%
CLINICAL SOCIAL WORKER	$386	0%	-6%	-3%	-6%	-3%
DIAGNOSTIC TESTING FACILITY	$833	0%	-8%	-2%	-8%	-3%
INDEPENDENT LABORATORY	$1,047	0%	-3%	-1%	-3%	-1%
NURSE ANES / ANES ASST	$769	0%	5%	2%	5%	2%
NURSE PRACTITIONER	$1,376	0%	2%	1%	2%	1%
OPTOMETRY	$980	0%	4%	2%	4%	2%
ORAL/MAXILLOFACIAL SURGERY	$43	0%	2%	1%	2%	1%
PHYSICAL/OCCUPATIONAL THERAPY	$2,324	0%	5%	3%	5%	3%
PHYSICIAN ASSISTANT	$1,055	0%	1%	0%	1%	0%
PODIATRY	$1,902	0%	3%	2%	3%	2%
PORTABLE X-RAY	$97	0%	4%	3%	4%	3%
RADIATION THERAPY CENTERS	$73	0%	-9%	-5%	-9%	-5%
OTHER	$17	0%	5%	4%	5%	4%

* Table 64 shows only the payment impact on PFS services. We note that these impacts do not include the effects of the January 2012 conversion factor change under current law.

TABLE 65: IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON CY 2012 PAYMENT FOR SELECTED PROCEDURES

CPT/ HCPCS[1]	MOD	Short Descriptor	Facility					Nonfacility				
			CY 2011[2]	CY 2012[3] (pre-update)	% Change (pre-update)	CY 2012[4]	% Change (post-update)	CY 2011[2]	CY 2012[3] (pre-update)	% Change (pre-update)	CY 2012[4]	% Change (post-update)
11721		Debride nail 6 or more	$25.82	$25.17	-3%	$17.73	-31%	$41.79	$41.83	0%	$29.48	-29%
17000		Destruct premalg lesion	$55.38	$55.44	0%	$39.06	-29%	$79.50	$79.92	1%	$56.31	-29%
27130		Total hip arthroplasty	$1,440.26	$1,437.28	0%	$1,012.70	-30%	NA	NA	NA	NA	NA
27244		Treat thigh fracture	$1,224.51	$1,223.69	0%	$862.21	-30%	NA	NA	NA	NA	NA
27447		Total knee arthroplasty	$1,539.47	$1,535.22	0%	$1,081.71	-30%	NA	NA	NA	NA	NA
33533		Cabg arterial single	$1,984.22	$1,942.33	-2%	$1,368.56	-31%	NA	NA	NA	NA	NA
35301		Rechanneling of artery	$1,128.70	$1,108.74	-2%	$781.21	-31%	NA	NA	NA	NA	NA
43239		Upper gi endoscopy biopsy	$174.64	$173.45	-1%	$122.21	-30%	$345.20	$346.22	0%	$243.95	-29%
66821		After cataract laser surgery	$296.95	$303.71	NA	$213.99	-28%	$314.62	$321.74	2%	$226.69	-28%
66984		Cataract surg w/iol 1 stage	$742.38	$753.67	2%	$531.03	-28%	NA	NA	NA	NA	NA
67210		Treatment of retinal lesion	$647.59	$657.08	1%	$462.97	-29%	$669.00	$678.85	1%	$478.31	-29%
71010		Chest x-ray	NA	NA	NA	NA	NA	$23.78	$23.47	-1%	$16.53	-30%
71010	26	Chest x-ray	$8.83	$8.84	0%	$6.23	-29%	$8.83	$8.84	0%	$6.23	-29%
77056		Mammogram both breasts	NA	NA	NA	NA	NA	$110.76	$110.19	-1%	$77.64	-30%
77056	26	Mammogram both breasts	$43.49	$42.17	-3%	$29.71	-32%	$43.49	$42.17	-3%	$29.71	-32%
77057		Mammogram screening	NA	NA	NA	NA	NA	$81.20	$79.92	-2%	$56.31	-31%
77057	26	Mammogram screening	$35.00	$34.01	-3%	$23.96	-32%	$35.00	$34.01	-3%	$23.96	-32%
77427		Radiation tx management x5	$180.41	$174.81	-3%	$123.17	-32%	$180.41	$174.81	-3%	$123.17	-32%
88305	26	Tissue exam by pathologist	$36.35	$35.71	-2%	$25.16	-31%	$36.35	$35.71	-2%	$25.16	-31%
90801		Psy dx interview	$123.33	$119.38	-3%	$84.11	-32%	$153.91	$151.35	-2%	$106.64	-31%
90862		Medication management	$44.85	$44.21	-1%	$31.15	-31%	$57.76	$58.16	1%	$40.98	-29%
90935		Hemodialysis one evaluation	$74.75	$72.44	-3%	$51.04	-32%	NA	NA	NA	NA	NA
92012		Eye exam established pat	$50.62	$51.36	1%	$36.18	-29%	$79.84	$81.62	2%	$57.51	-28%
92014		Eye exam & treatment	$77.13	$77.88	1%	$54.88	-29%	$115.86	$118.36	2%	$83.39	-28%
92980		Insert intracoronary stent	$873.19	$834.95	-4%	$588.30	-33%	NA	NA	NA	NA	NA
93000		Electrocardiogram complete	NA	NA	NA	NA	NA	$19.71	$18.71	-5%	$13.18	-33%
93010		Electrocardiogram report	$8.83	$8.50	-4%	$5.99	-32%	$8.83	$8.50	-4%	$5.99	-32%
93015		Cardiovascular stress test	NA	NA	NA	NA	NA	$92.42	$87.41	-5%	$61.59	-33%
93307	26	Tte w/o doppler complete	$47.57	$45.91	-3%	$32.35	-32%	$47.57	$45.91	-3%	$32.35	-32%
93458	26	L hrt artery/ventricle angio	$320.06	$315.96	-1%	$222.62	-30%	$320.06	$315.96	-1%	$222.62	-30%
98941		Chiropractic manipulation	$30.92	$30.61	-1%	$21.57	-30%	$35.34	$35.71	1%	$25.16	-29%
99203		Office/outpatient visit new	$74.75	$74.48	0%	$52.48	-30%	$102.95	$104.41	1%	$73.57	-29%
99213		Office/outpatient visit est	$49.27	$49.66	1%	$34.99	-29%	$68.97	$69.72	1%	$49.13	-29%
99214		Office/outpatient visit est	$75.77	$75.84	0%	$53.44	-29%	$102.27	$103.05	1%	$72.61	-29%
99222		Initial hospital care	$132.17	$132.64	0%	$93.46	-29%	NA	NA	NA	NA	NA
99223		Initial hospital care	$194.01	$194.88	0%	$137.31	-29%	NA	NA	NA	NA	NA
99231		Subsequent hospital care	$38.39	$38.09	-1%	$26.84	-30%	NA	NA	NA	NA	NA
99232		Subsequent hospital care	$69.31	$69.38	0%	$48.89	-29%	NA	NA	NA	NA	NA
99233		Subsequent hospital care	$99.55	$99.65	0%	$70.21	-29%	NA	NA	NA	NA	NA
99236		Observ/hosp same date	$214.05	$184.34	-14%	$129.88	-39%	NA	NA	NA	NA	NA
99239		Hospital discharge day	$101.25	$102.37	1%	$72.13	-29%	NA	NA	NA	NA	NA
99283		Emergency dept visit	$61.16	$59.86	-2%	$42.18	-31%	NA	NA	NA	NA	NA
99284		Emergency dept visit	$115.52	$114.27	-1%	$80.52	-30%	NA	NA	NA	NA	NA
99291		Critical care first hour	$217.11	$216.65	0%	$152.65	-30%	$264.34	$265.28	0%	$186.92	-29%
99292		Critical care addl 30 min	$109.06	$108.83	0%	$76.68	-30%	$118.92	$118.70	0%	$83.63	-30%
99348		Home visit est patient	NA	NA	NA	NA	NA	$82.22	$81.62	-1%	$57.51	-30%
99350		Home visit est patient	NA	NA	NA	NA	NA	$169.54	$170.39	1%	$120.06	-29%
G0008		Immunization admin	NA	NA	NA	NA	NA	$23.10	$23.81	3%	$16.77	-27%

1 CPT codes and descriptions are copyright 2010 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2 Payments based on the 2011 conversion factor of 33.9764
3 Payments based on the 2011 conversion factor of 33.9764, adjusted to 34.0103 to include the budget neutrality adjustment.
4 Payments based on the 2012 conversion factor of 23.9635, which includes the budget neutrality adjustment.