

# HEALTH LAW UPDATE

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

## **And Now For The “Nuts and Bolts:” Non-Health Reform Provisions Of The Final 2011 Medicare Physician Fee Schedule**

November 29, 2010

In two previous editions of *Health Reform IMPACT*, we reported on aspects of the final 2011 Medicare Physician Fee Schedule (the “2011 MPFS Final Rule”) that implement mandates of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the “Health Reform Legislation”).<sup>1</sup> In this edition of *Health Law Update*, which represents the final installment of our three-part series covering the 2011 MPFS Final Rule, we highlight some of the “nuts and bolts” payment policy and payment rate updates, not necessarily related to the Health Reform Legislation, which are effective for calendar year 2011 (“CY 2011”).

*Medicare Economic Index.* In the 2011 MPFS Final Rule, the Centers for Medicare & Medicaid Services (CMS) rebases and revises the Medicare Economic Index (MEI), which is the price index used in conjunction with the Sustainable Growth Rate (SGR) system to update the MPFS. In modifying the MEI, CMS notes that periodic rebasing and revising of the MEI allows the index to more accurately reflect current conditions with regard to physician practice expenses. Essentially, “rebasings” refers to moving the base year for the cost structure of the price index, and “revising” refers to changes in data sources, cost categories, or price proxies used in the index. The MEI was last revised and rebased in the 2004 MPFS final rule, with a base year of 2000 (so that the cost weights in the index reflect physician expenses in 2000).<sup>2</sup> In the 2011 MPFS Final Rule, CMS sets 2006 as the new base year for the MEI, since 2006 is the most recent year for which CMS has determined that comprehensive physician data are available, and for which CMS believes that the data reflect an accurate proxy for the physician expense distribution in CY 2011.

*Sustainable Growth Rate and the Physician Fee Schedule Update.* Under current law, CMS is required to adjust annually the payment rates under the MPFS using a formula based, in part,

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<sup>1</sup> The 2011 MPFS Final Rule’s impact on advanced imaging services is discussed in our November 19, 2010 issue of *Health Reform IMPACT*, entitled “Part III of Putting the Squeeze on Ancillaries: CMS Issues Final Payment and Physician Disclosure Rules for Advanced Imaging,” [available here](#); and other highlights of the 2011 MPFS Final Rule related to the Health Reform Legislation were discussed in our November 22, 2010 issue of *Health Reform IMPACT*, entitled “The Primacy Of Primary And Preventive Care (And Other Health Reform-Related Highlights of the 2011 Medicare Physician Fee Schedule),” [available here](#).

<sup>2</sup> See 75 Fed. Reg. 73262, citing 68 Fed. Reg. 63239.

on the application of the “SGR” that was adopted under the Balanced Budget Act of 1997. The intended purpose of the SGR is to limit growth in Medicare expenditures for physicians’ services.

The application of the SGR has resulted in annual reductions to the reimbursement rates under the MPFS since 2002. In each of the past several years, Congress has passed legislation to avert reduction to the MPFS that would have otherwise been required under the SGR. Most recently, in June 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 was signed into law. This Act provided for a 2.2% update to the 2010 MPFS, effective from June 1, 2010 through November 30, 2010.<sup>3</sup>

Under current law, MPFS rates are currently set to be reduced on December 1, 2010, and then again on January 1, 2011 as a result of the updated 2011 MPFS Final Rule. The total reduction in MPFS rates effective January 1, 2011, unless Congress averts the reduction, will be 24.9%. CMS states in the 2011 MPFS Final Rule that “while Congress has provided temporary relief from these reductions every year since 2003, a long-term solution is critical...[w]e are committed to permanently reforming the Medicare payment formula.”<sup>4</sup> In a press release following the release of the 2011 MPFS Final Rule, CMS quotes CMS Administrator Donald Berwick, MD, as affirming that “[b]road physician participation in Medicare is essential to ensuring that beneficiaries continue to have access to care, and physician engagement is critical to our efforts to strengthen the quality of care...Medicare needs to be a strong, dependable partner with physicians – and that means the SGR must be fixed. The Administration supports permanently reforming the Medicare payment formula.”<sup>5</sup>

On November 18, 2010, the Senate passed The Physician Payment and Therapy Relief Act of 2010 that would delay the cut in MPFS rates that would otherwise occur on December 1 of this year by one month, to January 1, 2011.<sup>6</sup> As of the time of publication of this *Health Law Update*, the House had not acted on this bill.

*Physician Quality Reporting Initiative (PQRI).* The 2011 MPFS Final Rule extends and revises the PQRI, which was implemented in 2007 as required by the Tax Relief and Health Care Act of 2006 and provides an incentive payment to certain eligible professionals (EPs) who adequately report data on specific quality measures. CMS comments on the transition of the PQRI incentive from a temporary incentive program to, under Health Reform Legislation, a “permanent quality reporting program.” CMS therefore advises that the PQRI will hereafter be referred to as the “Physician Quality Reporting System (“PQRS”).”

The 2011 MPFS Final Rule creates a new group practice reporting option that will allow participation by group practices with fewer than 200 EPs. The group practice reporting option is helpful because it allows individual EPs who are affiliated with group practices to establish their compliance with the PQRS requirements through their groups. Previously, group practices were required to have more than 200 EPs in order to be eligible for group reporting. Now, however, “Group Practice” means a single taxpayer identification number (TIN) with two or

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<sup>3</sup> Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, Pub. L. No. 111-192, § 101(a)(2), 2010 (to be codified at 42 U.S.C. 1395w-4(d)(11)(A)) [available here](#).

<sup>4</sup> See CMS-1503-FC at 380.

<sup>5</sup> See CMS, *Press Release: Medicare Improves Access to Preventive Services for 2011/ New Physician Payment Policies Emphasize Role of Primary Care* (Nov. 3, 2010) [available here](#).

<sup>6</sup> See The Physician Payment and Therapy Relief Act of 2010, H.R. 5712, 111<sup>th</sup> Cong. § 2 (as amended and passed by Senate on Nov. 18, 2010) [available here](#).

more EPs, as identified by their individual National Provider Identifier (NPI) numbers, who have reassigned their billing rights to the TIN. CMS also deemed certain group practices participating in Medicare demonstration projects to constitute Group Practices. As an added measure of flexibility for 2011, CMS will allow EPs who work with more than one group practice to qualify for PQRS compliance through any practice to whom they have reassigned benefits.<sup>7</sup>

The 2011 MPFS Final Rule adds 16 new individual quality measures, retires five quality measures, and replaces two for a net increase of 11 additional measures. At the same time, CMS reduces the PQRI reporting threshold for claims-based reporting from 80% of the EP's Medicare Part B fee-for-service (FFS) patients seen during the reporting period to 50%, which will likely allow a greater number of EPs to earn the incentive (or avoid penalties in the future).

Also included in the 2011 MPFS Final Rule are regulations implementing an additional .5% incentive payment mandated by the Health Reform Legislation. In order to be eligible to receive the additional .5% incentive payment, EPs must, in addition to complying with PQRS, participate in a qualified "Maintenance of Certification Program" (a Health Reform-required mechanism operated by a specialty body of the American Board of Medical Specialties) as well as successfully complete a Maintenance of Certification Program "practice assessment," in each case more frequently than is required to maintain board certification status.

Note that the Health Reform Legislation also mandates payment *reductions* beginning in 2015 for those EPs who do not satisfactorily submit data on quality measures for covered professional services during the year. The applicable percent reduction for 2015 is 1.5%, so that the EP would receive only 98.5% of the fee schedule amount for such services, and is 2.0% for 2016 and each subsequent year, so that the eligible professionals would receive only 98.0% of the fee schedule amount for such services.

Finally, the 2011 MPFS Final Rule provides for a new Web site, "Physician Compare," on which CMS will post the names of physicians who satisfactorily report the 2011 PQRS measures. The new Web site is further evidence of the trend toward transparency for federal healthcare program providers.

*Electronic Prescribing Incentive Program.* In order to "continue to encourage significant expansion of the use of electronic prescribing by authorizing a combination of financial incentives and payment adjustments"<sup>8</sup> CMS expands the Electronic Prescribing Incentive Program ("eRx Incentive Program"). The 2011 eRx Incentive Program is separate from, and in addition to, incentive payments that EPs may earn through the PQRS. Individual EPs do not have to participate in the PQRS in order to participate in the eRx Incentive Program (and vice versa). However, Group Practices who wish to participate in the eRx Incentive Program will be required to participate in the PQRS. Note, too, that CMS EPs who receive an incentive payment under the Medicare Electronic Health Records (EHR) Incentive Program<sup>9</sup> remain precluded from receiving a separate e-prescribing incentive payment.

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<sup>7</sup> See 75 Fed. Reg. 73505.

<sup>8</sup> See 75 Fed. Reg. 73551.

<sup>9</sup> The EHR Incentive Program was discussed in our February 9, 2009 *Health Law Update*, entitled "Healthcare IT Spending In The Economic Stimulus Bill: Incentive Payments May Be Available To Some Healthcare Providers," [available here](#).

CMS revises the eRx Incentive Program by establishing a 1% incentive payment for successful e-prescribers in CY 2011, which is smaller than the 2% payment for CY 2010. As with the PQRS, Group Practices with fewer than 200 members may participate in the eRx Incentive Program if they meet the definition of Group Practices set forth in the PQRS.

The 2011 MPFS Final Rule also establishes criteria for penalizing EPs and group practices that do not successfully participate in the eRx program during CY 2012. CMS notes that although EPs who have earned an incentive payment under the EHR Incentive Program are precluded from also earning an eRx Incentive Program incentive payment, the statute does not preclude the EPs from being subject to the reductions mandated by the eRx program. In order to avoid the reduction, an EP participating in the Medicare EHR Incentive Program still must meet the relevant eRx Incentive Program payment adjustment criteria for being a successful electronic prescriber. Specifically, with respect to covered professional services furnished by an EP in 2012, if the EP is not a successful electronic prescriber, the amount the EP will be paid for such services will be reduced to 99% of the fee that would otherwise apply.

*Clinical Laboratory Fee Schedule: Signature on Requisition.* Historically, CMS has not required a practitioner's signature on a requisition for clinical diagnostic laboratory tests paid on the basis of the clinical laboratory fee schedule (CLFS). The 2011 MPFS Final Rule adds such a requirement in order to better allow reference laboratory technicians to know whether a test has been appropriately requested and to avoid compliance problems that could arise due to the lack of a signature. CMS clarifies that a "requisition" is the physical paperwork provided to the laboratory showing the specific tests to be performed for the patient. As such, a requisition is distinct from an "order," which is defined as a communication (which may be verbal) from the treating practitioner requesting that a diagnostic test be performed for a beneficiary. CMS further clarifies that many practitioners do not use requisitions, and the 2011 MPFS Final Rule does not impose a requirement that requisitions be used. However, if requisitions are used, they must be signed by the ordering practitioner.

*Change in Reimbursement for Therapy Services.* CMS identifies therapy services in the 2011 MPFS Final Rule as an area in which services have historically been misvalued and greater efficiencies should be recognized. As such, CMS indicates that it is adopting a multiple procedure payment reduction (MPPR) policy with regard to therapy services. CMS notes that this new policy is in accordance with the directive to CMS in the Health Reform Legislation to identify potentially misvalued codes by examining codes that are frequently billed in conjunction with furnishing a single service.<sup>10</sup> Specifically, this MPPR policy will reduce by 25% the payment for the practice expense component of the second and subsequent therapy services billed by the same therapy practitioner or facility on the same date of service.<sup>11</sup> This policy will apply both to office-based and institutional-based therapy services paid under Part B.<sup>12</sup> Notably, The Physician Payment and Therapy Relief Act as recently passed by the Senate on November 18 would reduce this payment cut for therapy services from 25% to 20%.<sup>13</sup> However, as noted above, as of the time of publication of this *Health Law Update*, the House has not voted on this bill.

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<sup>10</sup> See 75 Fed. Reg. 73186.

<sup>11</sup> See 75 Fed. Reg. 73238-73239.

<sup>12</sup> See 75 Fed. Reg. 73241.

<sup>13</sup> See The Physician Payment and Therapy Relief Act of 2010, H.R. 5712, 111<sup>th</sup> Cong. § 3 (as amended and passed by Senate on Nov. 18, 2010) [available here](#).

If you have any questions about any of the topics in the *Health Law Update*, please contact one of the attorneys in our Healthcare Practice Group Listed below.

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