

HEALTH REFORM IMPACT

What you need to know NOW

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

Part III of Putting the Squeeze on Ancillaries: CMS Issues Final Payment and Physician Disclosure Rules for Advanced Imaging

November 19, 2010

The 2011 Medicare Physician Fee Schedule ("MPFS") implements portions of the recent historic health reform legislation (the "Act")¹ that put further financial and operational pressure on advanced imaging providers, particularly physicians who provide advanced imaging services. These changes include final physician disclosure requirements under the federal Stark law, which we have discussed in two previous issues of *Health Reform IMPACT*,² and new reimbursement methodologies that will reduce payments for certain imaging services.

Changes to Stark Law Disclosure Requirements

Physicians who provide certain imaging services in their own offices will be subject to new disclosure obligations as of January 1, 2011. The new disclosure obligations apply to physicians who provide computerized tomography (CT), magnetic resonance imaging (MRI), or positron emission tomography (PET) scans in their own offices under the "in office ancillary services" exception to the federal physician self-referral or "Stark" law. In order to continue meeting the "in office ancillary services" exception, physicians will now have to provide patients with a list of five other suppliers within a 25-mile radius of the physician's office as alternatives from which the patient can receive imaging services. The list must include the name, address and phone number of each of these alternate suppliers. The notice must be written in a manner sufficient to be reasonably understood by all patients and must be given at the time of *each* referral (even if a patient previously received the notice at the time of an earlier referral).

The Act afforded the Centers for Medicare & Medicaid Services (CMS) flexibility to establish certain parameters of this new disclosure requirement. As we discussed in our July 19 issue of *Health Reform IMPACT*, the agency originally proposed that the list include 10 alternate

¹ The 2011 MPFS was released by CMS on November 2, 2010. It is scheduled to appear in the Federal Register on November 29, 2010. The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Act") mandated a number of the changes that now appear in the MPFS.

² The physician ownership disclosure obligations as originally set out in the Act are discussed in our April 6 issue of *Health Reform IMPACT*, entitled "Putting The Squeeze on Ancillaries," [available here](#), and in our July 19 issue of *Health Reform IMPACT*, entitled, "Part II of Putting The Squeeze on Ancillaries," [available here](#).

suppliers, but reduced this to five in the final rule.³ CMS is not requiring that patients sign the disclosure form. Please note that CMS reads the term “supplier” literally. This means that including a hospital imaging department on the list does not count as one of the five alternate sites because a hospital is technically defined as a “provider” rather than a “supplier.” However, there is no restriction on including hospitals on the list as well, as long as the five required suppliers are also included.⁴

Changes in Reimbursement for Certain Imaging Services

The MPFS changes payment methodology for diagnostic imaging services in two important ways. First, as required by the Act, the MPFS adjusts the equipment utilization rate assumption for diagnostic imaging equipment costing over \$1 million that is used in diagnostic CTs and MRIs. Starting January 1, 2011, CMS will assume that providers are using this equipment productively 75% of the time, and therefore they can spread the fixed costs and overhead associated with the equipment over a corresponding number of procedures. Essentially, the higher the assumed utilization rate, the lower the reimbursement from CMS. The assumed utilization rate for this equipment had historically been 50%, but CMS had begun to gradually phase-in increases that would have raised the rate to 90% after several years. The Act, however, fixes the assumed rate to 75% effective January 1, 2011.⁵

A second change is a further reduction in Medicare payment for certain diagnostic imaging procedures when multiple procedures are performed on contiguous body areas during the same session.⁶ Previously when certain imaging procedures were performed on contiguous body areas during the same session, Medicare would pay 100% of its standard payment for the highest paying procedure, but only 75% of its standard rate for additional procedures performed during the same session. Under the Act, effective as of July 2010 and continuing in 2011, when these procedures are performed during the same session payment will be made at 100% of the standard rate for the highest paying procedure, and only 50% of the standard rate for each additional procedure during the same session. This would apply regardless of whether the second and subsequent procedures used the same or a different imaging modality. This reduction applies only to the technical component and not to the professional component of these imaging procedures.

If you have any questions about how these imaging changes and the 2011 MPFS impact your organization, please contact any of the attorneys in our Healthcare Practice Group listed below. Watch for future updates that will address other health reform and non-health reform related provisions of the 2011 MPFS.

³ CMS also removed a proposed requirement that the disclosure list how many miles away each alternate supplier is located. The disclosure obligations under the original *proposed* 2011 MPFS rule are discussed in more detail in our July 19 *Health Reform IMPACT* [available here](#).

⁴ If there are fewer than five other suppliers of the imaging service located within the 25-mile radius of the physician's office then the physician must list all of the other suppliers of the imaging service within the 25-mile radius. If no other suppliers provide the services within 25 miles, the physician does not have to provide a written list.

⁵ The utilization rate assumption remains at 50% for all other equipment included in the physician fee schedule practice expense methodology.

⁶ The imaging multiple procedure payment reduction (MPPR) policy currently applies to computed tomography (CT) and computed tomographic angiography (CTA), magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA), and ultrasound services within 11 families of codes based on imaging modality and body region. The 2011 MPFS adds some new CPT codes that will be subject to a multiple procedures reduction.

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