CMS Publishes the 2012 Physician Fee Schedule Final Rule

By Adrienne Dresevic, Esq. and Carey F. Kalmowitz, Esq.

On November 28, 2011, the Centers for Medicare & Medicaid Services (CMS) published the 2012 Physician Fee Schedule Final Rule in its effort to ensure that the present Medicare payment system reflects changes in medical practice and the relative value of medical services. The publication of the Final Rule follows in the wake of the heavily debated 2012 Physician Fee Schedule Proposed Rule issued in July of this year. A number of noteworthy modifications brought about by the Final Rule are of special interest to providers and suppliers of radiology services and should be carefully reviewed as the January 1, 2012 Final Rule implementation date fast approaches.

By way of background, in 1992, Medicare began paying for services provided by physicians, non-physician practitioners, and certain other suppliers under the Medicare Physician Fee Schedule (MPFS), a system which reimburses for certain services provided to persons with Medicare Part B. Under the MPFS, a relative value is assigned to every one of the 7,000 included services reflecting the amount of work, practice expenses, and malpractice expenses typically incurred while furnishing the service. Services with higher relative value units (RVUs) receive higher payments because the RVUs are multiplied by a fixed-dollar conversion factor and a geographic adjustment factor to determine payment.

Significant Across-The-Board Reduction in Payment Rates

Under the Final Rule, providers will experience a significant decrease in payment rates in 2012 absent Congressional intervention. Following the Sustainable Growth Rate formula mandated by the Balanced Budget Act of 1997 , CMS decreased payment rates by 27.4% for 2012 (a reduction from a conversion factor of $33.9764 in CY 2011 to a factor of $24.6712 in CY 2012). Pursuant to the Balanced Budget Act, the calculation applies the Medicare Economic Index of 0.6%, the Update Adjustment Factor of negative 4.0%, and the RVU Budget Neutrality Adjustment of 0.2% to the CY 2011 conversion factor as calculated prior to statutory increases ($25.4999) to arrive at the decreased amount. The payment reduction will be implemented in 2012 unless Congress passes a law preventing the significant decrease. Although the legislative branch has provided temporary relief in light of similar reductions yearly since 2003, CMS urged Congress in the Final Rule to adopt a permanent solution to the flawed formula to provide for stability and adequacy of Medicare payments in the future.

Expansion of the Multiple Procedure Payment Reduction Policy

As foreshadowed by the Proposed Rule, the Final Rule expands the Multiple Procedure Payment Reduction (MPPR) policy to the professional component (PC) of certain advanced imagining tests (ie, CT, MRI, and ultrasound) when (i) furnished to the same patient, (ii) by the same physician or group practice, (iii) during the same session on the same day. Under the Final Rule, the PC payments for the second and subsequent advanced imagining tests will be reduced by 25% while the highest PC payments will continue to be paid in full. CMS believes this payment decrease properly captures physician work efficiencies and anticipates further expansion of the policy in the future. To complement the change, CMS proposes the addition of CPT 74174 (Computed tomographic angiography, abdomen and pelvis; with contrast material[s], including noncontrast images, if performed, and image postprocessing) to the MPPR list beginning in 2012.

The change creates a smaller payment decrease than the projected 50% reduction seen in the Proposed Rule, but it is nonetheless significant. CMS estimates that this MPPR policy modification may impact payments for these services by approximately $50 million. In response, radiology providers and suppliers should consider urging their Representatives to support the "Diagnostic Imaging Services Access Protection Act of 2011" (H.R. 3269) in an effort to prevent the MPPR from being applied to the PC of imaging services.

Other Changes

Beyond the significant payment rate reduction and the MPPR policy expansion to PC payments, the Final Rule includes a number of other notable changes. For instance, the Final Rule expands the misvalued code initiative by revising about 300

service values. In addition, the Final Rule increases the number of covered telehealth services, slightly raises payments for annual beneficiary wellness visits, and makes modifications to the process CMS utilizes to adjust payments related to local practice costs. Further, the Final Rule makes modifications to the physician and Electronic Health Records incentive programs in order to update both and continues the implementation process for the new Practice Expense RVUs for the third year of four years.

Crucial Dates

Providers and suppliers of radiology services should note the fast approaching dates relating to the Final Rule as many of the changes within the 2012 Physician Fee Schedule will have significant impact on them. The Final Rule will become effective on January 1, 2012. Comments regarding certain provisions of the Final Rule will be accepted by CMS until January 3, 2012, and CMS is expected to respond to these comments in the 2013 Physician Fee Schedule.

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Commentary

Report: Alliance for Quality Medical Imaging and Radiation Therapy

By Hazel Hacker, FAHRA

AHRA organizational liaisons represent AHRA on occasions involving communication with related organizations. Liaisons attend meetings and provide reports to the AHRA board of directors. As the liaison for the Alliance for Quality Medical Imaging and Radiation (Alliance), I attended a telephone conference regarding the CARE bill in August and summarized my findings here. The Alliance is a coalition of 25 health care organizations dedicated to the provision of safe, high quality medical imaging and radiation therapy. It works with federal lawmakers and the Department of Health and Human Services in developing regulations and standards to ensure patient safety, personnel competency and exam quality.

The Alliance conference call served to review the CARE bill draft with the objective of preparing the bill for submission to the House of Representatives. Previously, the Senate had indicated that they don't want to change the bill – they liked it as is and didn't see a need to change it. They further indicated it would be easier to educate a few new members of Congress on the previous bill rather than educate all members on why the bill is different (albeit the changes are primarily cosmetic); however, they have said they understand the need for the "window dressing" in the House. The Alliance will proceed with making adjustments to the bill before submitting it to the House.

The House representatives involved with the bill were also discussed. Rep. Ed Whitfield (R-KY-1) introduced the bill to the House in June. He is a senior member, #4 on the House Energy & Commerce Committee and #3 on the Health Subcommittee. He is an ideal sponsor for this bill with Rep. John Barrow (D-GA-12) as the lead Democrat.

Two next steps were discussed during the meeting. First, ASRT and SNM-TS will be making joint visits on Capitol Hill as often as possible to endorse the unity of the Alliance. Second, the suggested corrections that were discussed will be made for the House bill and submitted to the Alliance for review.

An on-site meeting was held at the RSNA in Chicago to follow up on the progress of the bill; the details of that report will be published in a future issue of Link. Stay tuned for more updates on the Alliance's work on the CARE bill.

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