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MEMORANDUM

TO: RHCF and Community Services Members

FROM: Patrick Cucinelli, Senior Financial Policy Analyst

DATE: December 30, 2009

SUBJECT: **2010 Medicare Physician Fee Schedule Changes**

ROUTE TO: Administrator, CFO

ABSTRACT: CMS issues summary of changes to the 2010 Medicare Part B payment policies.

Introduction

The Centers for Medicare and Medicaid Services has issued [Change Request \(CR\) 6756](#), which summarizes the Medicare Part B payment policies changes for calendar year (CY) 2010 under the final Medicare Physician Fee Schedule (MPFS) rule, including the new telehealth originating fee. This memo provides members with an important reminder regarding Part B rates for next year along with some highlights from CR 6756 of most interest to long term care providers. For member convenience a copy of CR 6756 in its entirety is attached.

Important Reminder

The president has signed legislation that provides a temporary override to the 21.2 percent reduction to the CY 2010 MPFS, including nursing home and home health agency therapy and ancillary services. The freeze is effective from 1/1/2010 to 2/28/2010.

CMS has instructed its contractors to hold claims for services paid under Part B for up to the first 10 business days of January (January 1 through January 15) for 2010 dates of service. This should have minimal impact on provider cash flow because, by law, clean electronic claims are not paid any sooner than 14 calendar days (29 days for paper claims) after the date of receipt. Meanwhile, all claims for services delivered on or before December 31, 2009, will be processed and paid under normal procedures.

The holding of claims allows Medicare contractors time to receive the updated payment files (i.e., the frozen 2009 rates) and perform necessary testing before paying claims at the frozen rates. CMS has instructed contractors to begin processing claims at the frozen rates **no later than** January 19, 2010. NYAHSa is closely monitoring the situation and will advise members of any developments as additional steps are in process for a potential permanent override to the cuts.

Highlights of CR 5767

- **Telehealth**

CMS had established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31, 2002 at \$20.00. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI). The MEI increase for CY 2010 is 1.2 percent.

For calendar year 2010, the payment amount for HCPCS code “Q3014, Telehealth originating site facility fee” is 80 percent of the lesser of the actual charge or \$24.00. The beneficiary is responsible for any unmet deductible amount or coinsurance.

- **Specific Coding Issues related to Physician Fee Schedule**

In the 2010 MPFS proposed rule, CMS proposed to eliminate the use of all consultation codes (inpatient and office/outpatient consultation codes used for various places of service) except telehealth consultation G codes. CMS justified this proposal on the grounds that, in light of recent reductions in the documentation requirements for consultation services, the resources involved in doing an inpatient or office consultation are not sufficiently different than the resources required for an inpatient or office visit to justify the existing differences in payment levels. According to CMS, eliminating the consultation codes would have the effect of increasing payments for the office visit codes that are billed by most physicians, and most commonly by primary care physicians. Although all physicians would gain from the increased payment for office visits, the net result would be a reallocation of payments from specialists (who bill consultation codes much more frequently) to primary care physicians.

Payments for major surgeries include bundled payment for the related post-operative visits occurring over a 10-day or 90-day global period. When payments for new and established office visits were increased after the third Five-Year Review, CMS also increased the bundled payments for these post-operative visits in the global period. However, given that these post-operative visits are not related to consultations, CMS did not propose to increase the bundled payments to reflect the increase in the visits.

In this rule, CMS finalizes the proposal to eliminate the use of all consultation codes (inpatient and office/outpatient consultation codes used for various places of service) except telehealth consultation G codes. As requested by the surgical specialties, CMS is also increasing the surgical global period relative value units (RVUs) to reflect the resulting increases in the RVUs

for the visit codes. This increase is consistent with the “building block” approach CMS is recommending for the upcoming Five Year Review of work RVUs.

- **Initial Preventative Physical Exam**

For the Initial Preventative Physical Exam, which must be completed no later than 12 months after an individual first qualifies for Medicare Part B, CMS is increasing the RVUs for the service to the same level as a level 4 new patient office visit.

- **Clarification Concerning Certain Audiology Codes**

With the CY 2010 MPFS, CMS is clarifying that therapeutic and/or management activities are not payable to audiologists because they do not fall under the diagnostic tests benefit category designation.

- **Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services**

By statute, Medicare pays 50 percent of the approved amount for outpatient mental health treatment services, while paying 80 percent of the approved amount for outpatient physical health services. Section 102 of the MIPPA gradually phases out the limitation by 2014. When the provision is fully implemented, CMS will pay outpatient mental health services at the same level as other Part B services. For 2010, CMS will pay 55 percent of the approved amount for outpatient psychiatric services.

- **Value-based Purchasing**

Congress has mandated that CMS develop a plan to transition to a value-based purchasing (VBP) program for Medicare payment for physician and other professional services. The statute requires a Report to Congress no later than May 1, 2010. CMS has presented their initial draft report. In the CY 2010 PFS proposed rule, CMS made no specific proposals but summarized the progress of the VBP work to date.

Conclusion

The two most critical issues to be aware of remain the 21.2 percent cut referenced above and the need to renew the therapy caps exceptions process (currently set to expire on 12/31/2009.) NYAHSAs are working with AAHSAs in monitoring and advocating on these issues and will advise members on further developments. Members who have not already done so are encouraged to contact Congress and advocate for permanent solutions to both these issues at: <http://capwiz.com/aahsa/home/>.

Please contact me with any questions at pcucinelli@nyahsa.org or call 518-449-2707 ext. 145.

Attachment