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M E M O R A N D U M

TO: RHCF and Community Services Members

FROM: Patrick Cucinelli, Senior Director of Public Policy Solutions

DATE: March 1, 2012

SUBJECT: **2012 MPFS and Telehealth Policies**

ROUTE TO: Administrator, CFO, Medical Director, Billing Director

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ABSTRACT: CMS revises guidance on 2012 Medicare Physician Fee Schedule

Introduction

The Centers for Medicare and Medicaid Services (CMS) has revised their *MLN Matters Article # MM7671 Summary of Policies in the Calendar Year (CY) 2012 Medicare Physician Fee Schedule (MPFS) Final Rule and the Telehealth Originating Site Facility Fee Payment Amount*. These revisions do not reflect recent Congressional action that resulted in a zero payment adjustment in Medicare Physician Fee Schedule (MPFS) rates and changes to the therapy caps exceptions process (please refer to LeadingAge Doc. ID # n00005407 for more details on these changes).

While the freezing of the Medicare Part B rates and the extension of the therapy caps exceptions process are the issues of most immediate concern, there are several other important policy changes being implemented as part of the calendar year 2012 MPFS final rule. MM7671 provides a detailed summary of these changes, including the following items of note:

- The Five-Year Review of Work Relative Value Units;
- Misvalued Codes Under the Physician Fee Schedule;
- Multiple Procedure Payment Reduction Policy;
- Revisions to the Practice Expense Geographic Adjustment;
- Annual Wellness Visit Providing a Personalized Prevention Plan;

- Telehealth Services; and
- Telehealth Originating Site Facility Fee Payment Amount.

In addition to the final MPFS rule issued on November 1, 2011, MM7671 also summarizes details from two other related CMS issuances:

- The Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule (published in the "Federal Register" on June 6, 2011), and

- The Medicare Program: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2012 (published in the "Federal Register" on July 19, 2011).

2012 Conversion Factor

The conversion factor, which forms the dollar basis for the calculation of individual Medicare Part B rates, for 2012 is $34.0376. This represents a substantial increase from the original 2012 conversion factor of $24.6712, which would have been used to implement the 27.4 percent reduction in rates. Although essentially the 2012 rates are supposed to be level with the 2011 rates, there are some minor adjustments in some of the factors used to calculate the current year rates. For example the 2011 conversion factor was slightly lower at $33.9764. Therefore, you will see minor variations in the 2012 rates as compared with 2011. The LeadingAge Part B Calculation Tool© has been updated to reflect the adjusted conversion factor for 2012.

The Five-Year Review of Work Relative Value Units

As part of a five-year plan, CMS is reviewing and identifying potentially misvalued codes and adjusting the relative value units of the services. CMS is engaged in a concerted effort to identify and revise potentially misvalued codes. The final rule adopts coding changes and revisions to values for about 300 services, reducing payments for these services by approximately $100 million. CMS has also identified additional categories of services that may be misvalued, including some of the highest expenditure codes in each specialty that have not been reviewed in the past five years.

Multiple Procedure Payment Reduction Policy

Started in 2011, CMS is continuing their policy of Multiple Procedure Payment Reduction (MPPR) in 2012. For more details on *MPPR for Selected Therapy Services* please refer to Medlearn Matters Article # MM7050. Also, beginning CY 2012, the physician professional component payment will be reduced for subsequent procedures furnished to the same patient, by the same physician, in the same session. Although the final rule also applies this policy to procedures furnished to the same patient in the same session by physicians in the same group practice, CMS is not applying the imaging MPPR to group practices for 2012 due to operational considerations..

Revisions to the Practice Expense Geographic Adjustment

CMS is applying several changes to the geographic practice cost indices (GPCIs) as a result of additional analyses. For CY 2012, CMS will use the Bureau of Labor Statistics Occupational Employment Statistics index. In addition, CMS is replacing the U.S Department of Housing and Urban Development rental data as the proxy for physician office rent with rent data from the

2006-2008 American Community Survey. Lastly, CMS is creating a purchased service index to account for the labor-related industries within the "all other services" and "other professional expenses" Medicare Economic Index (MEI) categories. They have also begun implementing recommendations from the *Institute of Medicine Releases Second Edition of Geographic Adjustment Factors in Medicare Payment*. Overall, CMS believes that these changes result in only minor refinements to the impacted Part B rates, with no major swings or fluctuations in the rates.

Annual Wellness Visit Providing a Personalized Prevention Plan

The Affordable Care Act provided for Medicare coverage for an Annual Wellness Visits (AWV) providing personalized prevention plan services. The statute required that a Health Risk Assessment (HRA) be included and taken into account in the provision of personalized prevention plan services as part of the annual wellness visit. As a result, CMS included the HRA as a part of the AWV.

The Centers for Disease Control and Prevention (CDC) published "A Framework for Patient-Centered Health Risk Assessments: Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries."

CMS is providing payment for the AWV through the same Level II HCPCS codes as were used in CY 2011 and is adjusting the payment rate for these HCPCS codes to accommodate the additional physician office staff time that is expected to be expended in assisting a beneficiary with the completion of the HRA.

Telehealth Services

CMS is adding smoking and tobacco cessation counseling to the list of Medicare telehealth services. These services are similar to other services, such as Kidney Disease Education (KDE) counseling services and Medical Nutrition Therapy (MNT) services, already on the telehealth list. In addition, CMS is changing the criteria for adding codes to the List of Medicare Telehealth services under the "category 2" methodology ("category 1" are services that are similar to services already on the telehealth list). Currently, CMS requires evidence of similar diagnostic findings or therapeutic interventions of a requested service via telehealth to an in-person service prior to adding it to the telehealth list under category 2. In the 2012 final rule with comment period, CMS eases the standard by no longer requiring telehealth services to demonstrate equivalence to the same service provided face-to-face and instead requires that the service demonstrate clinical benefit when furnished through telehealth. The refined category 2 review criteria are effective for services requested to be added to the telehealth benefit beginning in CY 2013.

Telehealth Originating Site Facility Fee Payme0nt Amount

The Medicare telehealth originating site facility fee for telehealth services was originally set at $20.00 for the period of October 1, 2001, through December 31, 2002. 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). For CY 2012, the MEI increase for 0.6 percent. For CY 2012, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014

(Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or $24.24. The beneficiary is responsible for any unmet deductible amount or coinsurance.

Conclusion

For more information and access to the CY 2012 Final Rule, go to the "Physician Fee Schedule" available at **http://www.cms.gov/PhysicianFeeSched/01_Overview.asp#TopOfPage** on the CMS website. The official instruction, CR7671, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at: **http://www.cms.gov/Transmittals/downloads/R2379CP.pdf** on the CMS website.

Please contact me at pcucinelli@leadingageny.org or call 518-867-8827 with any questions.

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