



## SOCIETY OF **CARDIOVASCULAR** COMPUTED TOMOGRAPHY

### Summary - 2011 Proposed Medicare Physician Fee Schedule (MPFS)

On Friday, June 25th CMS announced the Proposed Medicare Physician Fee Schedule Rule for Calendar Year 2011. The following is a brief summary of the proposed rule.

#### Sustainable Growth Rate (SGR)

The rule includes a -6.1 percent cut in payment rates for physician-related services in addition to the -23.5 percent cut anticipated to take effect January 2011. These large cuts are due to the flawed SGR formula, which serves as the foundation for Medicare physician payment. Until physician payment reform receives the attention it deserves in Congress, we can expect to see drastic payment reductions in the Medicare Physician Fee Schedule. In June 2010 Congress acted to halt a -21.3 percent cut and replace it with a 2.2 percent payment update through November 30, 2010. However, this is a temporary measure and cuts near 30 percent can be expected for 2011 if Congress does not act.

#### Practice Expense

The 2011 proposed MPFS does show increases in practice expense relative value unit (RVU) calculations for cardiac computed tomography services. At this time it is too early to determine the exact methodology used to calculate this increase, but SCCT will provide additional details in the coming weeks. An important part of the analysis centers on the 2011 Proposed Hospital Outpatient Prospective Payment System (HOPPS) rule, anticipated for release in the very near future.

As you may know, the Deficit Reduction Act of 2005 (DRA) caps the technical component payment for advanced imaging services performed in the physician office setting at the lesser of the MPFS or HOPPS payment amount. This is why it is necessary to review both the HOPPS and MPFS rules in order to form an accurate assessment of proposed changes in payment policy for 2011.

Overall, this rule contains few surprises. CMS clearly states that it is not proposing broad changes in methodology for calculating practice expense or any new efforts to undertake broad scale data collection to further inform future payment policy. 2011

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marks the second year of a 4-year phase in of the Physician Practice Information Survey (PPIS) data. For 2011, CMS utilizes a 50/50 blend of the older practice expense data and the newer PPIS. The phase-in will continue until the new data is fully implemented by 2014. As you know, the PPIS data resulted in deep cuts in payment for many services performed by cardiologists and radiologists, as promulgated in the final 2010 MPFS.

#### Malpractice Relative Value Units

Medicare law requires CMS to review and appropriately adjust malpractice RVUs at least every five years. The latest review was in 2010. Going forward for new or revised codes, malpractice RVUs will be determined by a direct crosswalk to a similar “source” code. This presumes the same risk factor for the new/revised code as the source code but also uses the work RVUs for the new/revised code to adjust for risk-of-service. CMS plans to continue this policy for 2011-2014. Additionally, CMS will publish a list of new/revised codes and the analytic crosswalk(s) used for determining malpractice RVUs in the 2011 Final MPFS rule with comment period. This is an important step that CMS has not previously undertaken. Revised malpractice RVUs will not be calculated until CMS issues the 2012 Final Medicare Physician Fee Schedule.

#### Equipment Utilization Rate Assumption

As part of the practice expense methodology CMS employs for allocation of equipment costs, CMS currently assumes that expensive diagnostic imaging equipment (priced at over \$1 million) is in use 90 percent of the time a practice is open for business. The health care reform law requires CMS to use a 75 percent utilization rate for 2011 and beyond. This change should result in slightly greater RVUs and is an improvement over the 90 percent assumption CMS now uses.

#### Medicare Claims Submission Deadline

For services furnished January 1, 2010, or later, claims must be submitted to Medicare within a year. Claims for services furnished prior to January 1, 2010, will not be subject to this new requirement.

#### Multiple Procedure Payment Reductions

Under current law, diagnostic imaging services (CT, CTA, MRI and MRA and ultrasound) across eleven families of codes are subject to multiple procedure payment reductions. For the technical component (TC) of certain diagnostic imaging procedures

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performed on contiguous areas of the body in a single session, CMS reduces the TC payment by 25 percent for each additional procedure. The reduction is meant to recognize efficiencies in clinical labor, supplies, and equipment time, particularly clinical labor activities and supplies that are not duplicated for subsequent procedures and, because equipment time and indirect costs are allocated based on clinical labor time, those would also be reduced accordingly. Effective July 1, 2010, the reduction will be 50 percent and not 25 percent, as mandated under the new health care reform law.

CMS proposes an expansion of the multiple procedure payment reduction to include imaging services performed within a family of codes or across all families of codes, regardless of body area. CMS estimates this new policy would reduce payment for 20 percent more services than under the current fee schedule. The goal of the policy is for CMS to capture efficiencies and more appropriately pay for multiple imaging procedure sessions. This change is expected to have the most impact on radiology.

### **Disclosure Requirements for In-Office Ancillary Services**

The new health care reform law requires disclosure with respect to referrals for magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and any other designated health service that the Secretary of Health and Human Services determines appropriate. CMS is soliciting comments on whether to expand this disclosure requirement to other radiology and imaging services and if so, why.

Specifically, the law requires a supplier to inform a patient in writing that the patient may obtain the service from another supplier, and the provider must give the patient a list of alternate suppliers who furnish the service in the area in which the patient resides. CMS proposes that the disclosure notice be written in a manner sufficient to be reasonably understood by all patients and that it must be given to the patient at the time of the referral. This notice must indicate to the patient that the services may be obtained from a person other than the referring physician or his or her group practice and include a list of other suppliers who provide the service being referred (MRI, CT, or PET). CMS notes that the purpose of the disclosure requirement is to inform a patient's decision-making regarding care. Nothing on the disclosure notice or list of suppliers may indicate to the patient that he or she must receive imaging from a supplier on the list if not receiving the service from the referring physician. The patient may receive the imaging service from the referring physician, from a supplier identified on the notice, or from

another supplier of the patient's choice. The patient is free to choose the supplier of the service.

CMS proposes that only suppliers, defined as a physician or other practitioner, a facility or other entity) be included on the written list, and not "providers of services," such as hospitals. CMS does seek comments, however regarding whether inclusion of providers of services on the written notice would benefit patients in choosing an alternate entity for an imaging service by providing more, and varied, options.

CMS proposes that in order to ease the administrative burden of creating multiple lists while still implementing the requirements of the statute, the notice of alternate suppliers should be located within a 25-mile radius of the physician's office location at the time of the referral, even if a patient resides more than 25 miles away. The same standard is proposed for both urban and rural areas but CMS is soliciting comments on whether this is sufficient.

CMS proposes that the written notice include no less than 10 suppliers. CMS is soliciting comments on whether a list of 10 suppliers is sufficient or too burdensome or susceptible to abuse and whether there are alternate criteria that should be used. CMS recognizes that there may be fewer than 10 other suppliers within a 25-mile-radius of the referring physician's office location. If no other suppliers of the imaging services ordered exist within the 25-mile radius of the physician's office location, the physician need not provide a list of alternative suppliers, but must still disclose that imaging services may be received from another supplier.

As proposed by CMS, the supplier list must include the name, address, phone number, and distance from the physician's office location at the time of the referral. Distance is to be documented in order to emphasize to the patient the relative convenience of the listed suppliers.

In order to document that this disclosure requirement has been satisfied, CMS proposes that the patient's signature on the disclosure notification must be maintained as part of the patient's medical record.

CMS will accept comments on the proposed rule until August 24, 2010. SCCT will submit comments to the Agency by the deadline. The final rule is anticipated for release on or near November 1, 2010.