

Summary – 2012 Final Medicare Physician Fee Schedule Rule

Overall Medicare Physician Payment

The final rule reflects a payment cut of 27.4 percent for each and every service paid under the Medicare Physician Fee Schedule (MPFS), effective January 1, 2012. This cut is due to statutory adjustments mandated under the flawed sustainable growth rate formula (SGR) that serves as the underpinning of Medicare physician payment. Congress must act by the end of this year to ensure that this 27.4 percent cut does not take effect in January 2012.

Multiple Procedure Payment Reduction Policy

The Multiple Procedure Payment Reduction (MPPR) policy currently applies a 50 percent reduction in payment for the technical component (TC) of the second and subsequent imaging services (CT, CTA, MR, MRA and ultrasound services) performed on the same patient in the same session, regardless of the modality and not limited to contiguous body areas. The MPPR for the TC applies within code families and across code families. With this policy, CMS aims to adjust payment to achieve efficiencies in clerical time, patient prep time, and supplies.

As announced in this rule, effective January 1, 2012, CMS will apply a 25 percent payment reduction for the professional component (PC) of second and subsequent imaging services furnished by the same provider (including physicians in a group practice) to the same patient in the same session on the same day. Full payment would be made for the highest procedure.

CMS notes that this policy is consistent with the recommendations of the Government Accountability Office and the Medicare Payment Advisory Commission. CMS notes that scans interpreted at “widely” different times would not be considered in the same session and although performed at the same time, would not be subject to the reduction in the PC payment. CMS cited scans in the emergency department as an example. In such a case, CMS indicates that use of the 59 modifier would be acceptable if the physician feels interpretation at different times is appropriate. CMS clearly states it does not expect use of the modifier to be a frequent occurrence.

CMS will continue to look to expand the MPPR policy to additional imaging procedures beginning in 2013.

Review of Potentially Misvalued Codes

In the coming year, CMS will focus on the codes billed by physicians in each specialty that result in the highest Medicare expenditures under the MPFS to determine whether the codes are overvalued. In the past, CMS acknowledged that it has targeted specific codes for review that may have affected a few

procedural specialties like cardiology, radiology or nuclear medicine but has not taken a look at the highest expenditure codes across all specialties.

Self Referral

In this final rule for the 2012 MPFS, CMS declined to adopt any substantive changes in physician self referral policies, but notes it will continue to look for ways to address overutilization of advanced diagnostic imaging services.

Supplemental Information

As of November 2, 2011, the supplemental tables and addenda associated with the final rule have not yet been posted. Stay tuned to the SCCT website for additional information regarding in office payment levels and a complete list of codes for which the multiple procedure payment reduction policy will apply.