CMS Releases Medicare Physician Fee Schedule and Hospital Outpatient Perspective Payment System Final Rules

The Centers for Medicare and Medicaid Services (CMS) recently released the Medicare Physician Fee Schedule (MPFS) and Hospital Outpatient Perspective Payment System (HOPPS) final rules which set the payment regulations for the office and hospital outpatient settings for 2009. Below are the highlights for each payment system. ACR staff is currently reviewing and analyzing the rules and will provide more detailed summaries in the following days.

Medicare Physician Fee Schedule

Effective Jan. 1, 2009, the conversion factor for the MPFS will be $36.066. This is a 5.3 percent decrease from the current 2008 conversion factor of $38.08. Under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) it was mandated that there be a 1.1 percent increase in the conversion factor for 2008. Also in the legislation is a mandate that the $5 billion impacts from the last five year review be removed as a budget neutral adjustment to the physician work values of the MPFS and instead applied to the conversion factor for 2009. The budget neutral impact of the third five year review has caused an 8 percent decrease in the professional component for 2007 and 2008. This 8 percent cut will be returned back into the fee schedule calculations and instead this impact will be felt through an adjustment in the conversion factor. Therefore, radiologist should be realizing and a 2.7 percent increase in their professional component for 2009 although the technical component which was currently not impacted by the third five year review will now experience a cut of 5.3 percent.

The ACR is disappointed that CMS did not implement its proposal to require that all imaging be subject to the Independent Diagnostic Testing Facility (IDTF) quality standards for 2009. CMS cites the enactment of section 135 of MIPPA which requires that all sites that provide CT, MR, and nuclear medicine services including PET for Medicare patients be accredited by January 2012. Therefore, CMS is “deferring the implementation of these proposals while we continue to review the public comments received on this CMS-1403-FC 210 provision and we will consider finalizing this provision in a future rulemaking effort if we deem it necessary.” In addition, CMS is not adopting their proposal to require physicians and nurse practitioners to meet certain quality and performance standards when providing diagnostic testing services, except mammography services, within their medical practice setting. The ACR believes that all providers in every practice setting should be required to meet all quality and performance standards that are required of IDTFs and accredited sites.

The new anti-markup regulations will become effective Jan. 1, 2009. In this regulation, Medicare sought to take the profit out of reassignment of benefits for diagnostic tests billed by one entity but the service, either professional component or technical component, provided by another. Medicare feels that if a physician is willing to provide a service for less than the rates paid in the Medicare Physician Fee Schedule, then Medicare should be billed the lower rate and realize the profit. However, once CMS reviewed the comments from this proposed rule, it has relaxed its requirements on how it defines physicians who are part of a practice and the parameters for site of service where the procedures are performed. The anti-markup up rule and lack of implementation of the IDTF rules also leave the rules relaxed on who provides the PC and supervises the TC which is not specified to be a radiologist or even the same physician.
Medicare admits that relaxing the rules allows for all entities to be in compliance with the anti-markup regulations by Jan. 1, 2009.

**Hospital Outpatient Prospective Payment System**

The conversion factor for hospital outpatient payments will be $66.059, a 3.6 percent increase from $63.694 for 2008. The reduced conversion factor if hospitals do not meet the hospital quality reporting requirements is $64.784.

Medicare has finalized its proposal to move forward with the five new composite APCs for ultrasound, CT/CTA without contrast, CT/CTA with contrast, MR/MRA without contrast and MR/MRA with contrast. This means that when more than one US, CT or CTA, MR or MRA study is performed in the same session, the hospital will submit the claim for the multiple studies and Medicare will send back one bundled payment. The ACR presented analysis to CMS that showed that the methodology for paying for these composites works when two studies are done in the same session but cuts reimbursement by as much as 75 percent for the third and more studies. These severe cuts could have significant effects on payments for trauma cases. However, CMS did not agree with the ACR’s concerns and is moving forward with their composite methodology as proposed.

For 2009, payable drugs and biologicals will be paid at the average sales price plus 4 percent (ASP+4), when their average price is above $60. As mandated by Section 142 of MIPPA, CMS will continue to pay for therapeutic radiopharmaceuticals at charges adjusted to cost for CY 2009. CMS will also continue to package payment for all diagnostic radiopharmaceuticals into the Ambulatory Payment Classification (APC) payment for their associated nuclear medicine procedures.