Fee schedule updates, penalties explained for 2012

By Debra Lansey

A s always, the Medicare program has some changes for the new year. For internal medicine physicians, the changes are incremental rather than the wholesale changes seen in recent years. This column and February’s column will highlight the changes.

Fee schedule update

When this column was written, the 2012 update to the Medicare Physician Fee Schedule (PFS) was ~2.3%, resulting in a conversion factor of $24.6712. For internal medicine, the overall effect on the Relative Value Unit (RVU) and Multiple Procedure Payment Reductions (MPPR) complexity and the impact in the update, is nearly flat, at 1% increase in allowable charges.

The effect of those particular changes on the subspecialties varies:

<table>
<thead>
<tr>
<th>Subspecialty</th>
<th>Impact of calendar year (CY) 2012 RVU and MPPR changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy and immunology</td>
<td>1%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>3%</td>
</tr>
<tr>
<td>Critical care</td>
<td>1%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>1%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>0%</td>
</tr>
<tr>
<td>General practice</td>
<td>2%</td>
</tr>
<tr>
<td>Hematology/oncology</td>
<td>2%</td>
</tr>
<tr>
<td>Infectious diseases</td>
<td>1%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>0%</td>
</tr>
<tr>
<td>Pulmonary disease</td>
<td>1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0%</td>
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</tbody>
</table>

The College has long been concerned that inaccurate valuation of services is adversely impacting our health care system, including undervaluing office visits and other cognitive-oriented services and discouraging interest in primary care and other specialties. This cycle of rulemaking explicitly demonstrated that the Centers for Medicare and Medicaid Services (CMS) wants to address the changes in medical practice and remedy the shortage of primary care physicians through changes in the Medicare PFS.

CMS would otherwise force the College and other specialty societies to conduct Relative Value Scale Update Committee (RUC) surveys, which poll internists about their impressions of the complexity and intensity of performing medical services of all the evaluation and management codes. Instead, the agency will be working on innovative methods of properly valuing and reimbursing chronic disease care and primary care services. ACP suggested a number of ideas that could be implemented quickly, such as establishing Medicare payment for existing Current Procedural Terminology (CPT) codes that describe non-face-to-face evaluation and management services. CMS is not taking action on these suggestions immediately, but they may be under consideration for future implementation.

Values for observation services

Extensive RUC surveys of observation services had been conducted by ACP and other specialty societies in 2009 and 2010. Because ACP and other specialty societies believed CMS’s initially proposed values for hospital observation services codes were too low, they submitted formal comments to CMS, and held several meetings with CMS officials. This extensive advocacy resulted in adoption of the higher relative values recommended by CMS to ACP, the collaborating specialty societies, and the RUC. CMS approved these values for payment beginning in January 2012.

CPT codes for initial observation

99218 99219 99220

CY 2010 Medicare PFS work RVU

1.28 2.14 2.99

RUC-recommended work RVU

1.92 2.60 3.56

CMS CY 2012 proposed work RVU

1.92 2.60 3.56

CMS CY 2012 final work RVU

1.92 2.60 3.56

CPT codes for observation with same-day discharge

99234 99235 99236

CY 2010 Medicare PFS work RVU

2.56 3.41 4.26

RUC-recommended work RVU

2.56 3.24 4.20

CMS CY 2012 proposed work RVU

1.92 2.78 3.63

CMS CY 2012 final work RVU

2.56 3.24 4.20

Electronic prescribing

CMS revised its definition of a qualified electronic prescribing (eRx) system that includes certified EHR technology as follows: “... A qualified electronic prescribing system, which we further propose to define as either a system with functionalities identified in the electronic prescribing measure specification, or Certified EHR Technology as defined at 42 CFR 495.4 and 45 CFR 170.102.”

CMS has also modified the definition of a group practice to be a single tax identification number (TIN) with at least 25 eligible professionals (EPs), as identified by their individual National Provider Identifiers (NPIs), who have reassigned their Medicare billing rights to the TIN.

For the electronic prescribing provision of the Physician Quality Reporting System (PQRS), CMS decided that it will:

- Simplify the reporting criteria for group practices using the eRx Group Practice Reporting Option (GPRO),
- Finalize its proposal for the 2012 and 2013 incentive payments and 2013 and 2014 payment adjustments,
- Require that a group practice (made up of 25 to 99 eligible professionals) using the eRx GPRO must successfully report the electronic prescribing measure’s numerator or denominator for at least 625 unique visits and
- Require that a group practice (composed of ≥100 eligible professionals) using the eRx GPRO must successfully report the electronic prescribing measure’s numerator for at least 2,500 unique visits.

CMS finalized criteria for applying penalties in 2013 and 2014 for physicians and group practices who are eligible for eRx incentives but choose not to participate or do not successfully participate in the eRx program. Physicians who are eligible but choose not to participate in the 2013 or 2014 Medicare eRx incentive program and do not qualify for a hardship exemption will be subject to penalties of a 1.5% payment reduction based on the 2013 Medicare PFS amounts during the year and a 2% payment reduction in 2014. The penalty is applicable each year, regardless of whether or not the eligible professional or group fulfilled the criteria during the previous year.

CMS finalized that physicians can avoid an eRx penalty in 2013 if they successfully participated in the 2011 eRx incentive program (submitted ≥25 e-prescriptions between Jan. 1, 2011 through Dec. 31, 2011) or e-prescribe and report at least 10 e-prescriptions during the first six months of CY 2012.

To avoid the 2014 eRx penalties, physicians must successfully participate in the 2012 eRx incentive program (submit ≥25 e-prescriptions between Jan. 1, 2012 through Dec. 31, 2012) or e-prescribe and report at least 10 e-prescriptions during the first six months of CY 2013. Submissions during this six-month period must be submitted by claims and can be submitted for any Medicare Part B PFS service.

The law states that the penalty will apply “with respect to covered professional services furnished by an EP during 2012, 2013, or 2014.” CMS will allow several reporting mechanisms for eRx activity during the 12-month reporting option to qualify for the incentive or avoid a penalty; this is an expansion from the previous “claims-only” limitation. Thus, physicians may report Healthcare Common Procedure Coding System (HCPCS) code G8553 to CMS on their Medicare Part B claims, to a qualified registry, or to CMS via a qualified EHR product to avoid penalties. Physicians may select only one mechanism and cannot report the eRx measure by using more than one reporting mechanism.

CMS lists several categories for exempting eligible physicians from the eRx penalty:

- Physicians or group practices in rural areas with no high-speed Internet access;
- Physicians or group practices in areas without a sufficient number of available pharmacies for eRx;
- Physicians who are unable to e-prescribe because of local, state, or federal law or regulation; and
- Physicians who write fewer than 100 prescriptions during the six-month reporting period required to avoid the eRx penalty.

Annual wellness visits

Medicare beneficiaries likely will need assistance from physician office staff in completing the health risk assessment visits. See Coding, page 9

EHR training is mission critical

Implementation of an electronic health record (EHR) is an arduous process and an extremely challenging time for any practice to endure. The selection process alone can take months of reviewing products, visiting practices and negotiating an agreement.

Preparing the practice for conversion to an electronic record (or conversion from one EHR to another), including re-engineering workflows, forms, templates and screens leading up to the go live date, can cause plenty of anxiety for both staff and physicians. But one aspect of EHR implementation is often undervalued, and that is training.

Training allows a practice to use an EHR the way it is designed to work. It’s not just about being able to turn the system on and start using it. Many tech-savvy people can learn the basics by teaching themselves. Training is more about learning to use the EHR to enhance patient care in a productive and meaningful way, as a coaching tool to engage your patients without spending more time than you did using paper.

A recent survey report released by AmericanEHR Partners proves just how important training is. The survey data indicate a significant correlation between the length of initial training and overall user satisfaction with the EHR product. Ratings on ease of use for basic EHR functions required for meaningful use continued to improve with two or more weeks of training. For the advanced meaningful use features, such as formulary checking and medication reconciliation, receiving at least one week of training showed a significant improvement in usability.

Given how much a practice invests in an EHR both financially and operationally, it is short-sighted to skimp on the training. Resist the temptation to dive right in after only a day or two. It is important to devote adequate time to learning how to use some of the more advanced features and functions. The method of training (on-site, off-site, or online) doesn’t matter as much as the amount of time spent learning the system.

The report also found that another key indicator of EHR satisfaction is involvement in the selection. If you are going down the EHR selection road, it pays to be involved. More details on the AmericanEHR Partners survey are available at www.americanehr.com/education/research/reports.aspx.