



Medicare Physician Fee Schedule Final Rule for Calendar Year 2010

The Centers for Medicare and Medicaid Services (CMS) released the Medicare Physician Fee Schedule (PFS) final rule for calendar year (CY) 2010 on October 30, 2009 (Final Rule).¹ It will be published in the Federal Register on November 25, 2009. CMS will accept comments on certain issues in the Final Rule until December 29, 2009. Unless otherwise specified, the new payment rates and policies will apply to services furnished to Medicare beneficiaries on or after January 1, 2010.

Highlights of the Final Rule

- Finalizes proposal to remove drugs from the sustainable growth rate (SGR) formula and announces -21.2% update to the final CY 2010 conversion factor.
- Finalizes proposal to use new data source to update practice expense (PE) relative value units (RVUs) but adds four-year transition period and exempts medical oncology, hematology, and hematology/oncology.
- Increases utilization rate assumption for magnetic resonance imaging (MRI) and computed tomography (CT) equipment over \$1 million from 50% to 90% and phases in the new RVUs over four years. CMS does not apply this assumption to therapeutic equipment such as Gamma Camera and intensity-modulated radiation therapy (IMRT), however.
- Eliminates consultation codes and increases the RVUs for other visit codes.
- Finalizes proposals to simplify reporting requirements for the Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing Incentive Program (e-Prescribing Program).
- Implements accreditation requirements for suppliers of the technical component of advanced imaging services.

¹ The text of the Final Rule is available at http://www.federalregister.gov/OFRUpload/OFRData/2009-26502_PI.pdf.



The following chart shows the cumulative effect on total Medicare payments to physicians involved in cancer care under the Proposed and Final Rules, prior to the application of the conversion factor.

Specialty	Proposed Rule		Final Rule		
	Allowed Charges (Mil)	Combined Impact	Allowed Charges (Mil)	Combined Impact	
				Full	Trans
Hematology/Oncology	\$1,888	-6%	\$1,897	-6%	-1%
Radiation Oncology	\$1,799	-19%	\$1,809	-5%	-1%
Radiology	\$5,254	-11%	\$5,056	-16%	-5%

Physician Fee Schedule Update for CY 2010

CMS finalizes its proposal to remove physician-administered drugs from the calculation of the SGR beginning with 2010 and from the calculation of allowed and actual expenditures for CY 2010 and retrospectively to the 1996/1997 base year in this final rule. As noted in the Proposed Rule, the changes to the SGR calculations will have no effect on the 2010 PFS update. CMS announces that the final conversion factor for CY 2010 is -21.2, up from -21.5 in the Proposed Rule on the basis of the most recently available data on CMS spending for physician services. The final physician payment rate update for CY 2010 is -21.3 (the -21.2% change to the conversion factor plus an additional 0.1% budget neutrality adjustment for changes to the RVUs).

Practice Expense Relative Value Units

Adoption of New PE Data Source

CMS finalizes its proposal to use the Physician Practice Information Survey (PPIS) to update PE RVUs for specialties that participated in that survey, standing by its conclusion that the PPIS is the most comprehensive, multispecialty, contemporaneous, consistently collected PE data source available. Recognizing, however, the magnitude of payment reductions some specialties will experience with the use of the PPIS data, CMS has included a four-year transition (75/25, 50/50, 25/75, 0/100) from the current PE RVUs to the PE RVUs developed using the new PPIS data as part of the Final Rule.

The change will not apply to medical oncology, hematology, and hematology/oncology that will continue to use supplemental survey data to update PE RVUs. This is due to a provision in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L 108-173) (MMA) that requires the agency to use the supplemental survey data submitted in 2003



for oncology drug administration services. As a result, instead of decreasing to \$129.94, the PPIS indirect practice expense per hour (PE/HR) for medical oncology will increase to \$145.81.

With regard to freestanding radiation oncology centers, CMS finalizes its proposal to use PPIS data, but agrees to adjust the practice expense per hour (PE/HR) by removing the 21 survey responses whose physician hour information was missing from the data and imputed by CMS and to update the weights used to blend the hospital-based and freestanding radiation oncology center survey data based on more recent claims data. The result of these changes is an increase in the PPIS indirect PE/HR from \$126.66 under the Proposed Rule to \$165.10 under the Final Rule.

Drug Administration Rates

The following chart compares the drug administration rates for CY 2009, CY 2010, and CY 2013, when the RVU transition period will be complete, calculated using the 2009 conversion factor.

Code	Description	2009 Non- Facility Total	2009 Facility Total	2010 Non- Facility Total	2010 Facility Total	2013 Non- Facility Total	2013 Facility Total
96360	Hydration iv infusion, init	\$56.62	NA	\$53.74	NA	\$47.61	NA
96361	Hydrate iv infusion, add-on	\$16.59	NA	\$15.15	NA	\$12.98	NA
96365	Ther/proph/diag iv inf, init	\$68.89	NA	\$66.72	NA	\$60.23	NA
96366	Ther/proph/dg iv inf, add-on	\$22.00	NA	\$20.56	NA	\$19.12	NA
96367	Tx/proph/dg addl seq iv inf	\$34.62	NA	\$32.46	NA	\$27.05	NA
96368	Ther/diag concurrent inf	\$20.56	NA	\$19.12	NA	\$16.95	NA
96369	Sc ther infusion, up to 1 hr	\$149.68	NA	\$145.71	NA	\$129.12	NA
96370	Sc ther infusion, addl hr	\$15.87	NA	\$14.79	NA	\$14.79	NA
96371	Sc ther infusion, reset pump	\$72.49	NA	\$75.38	NA	\$78.99	NA
96372	Ther/proph/diag inj, sc/im	\$20.92	NA	\$21.28	NA	\$21.64	NA
96373	Ther/proph/diag inj, ia	\$18.03	NA	\$18.03	NA	\$18.03	NA
96374	Ther/proph/diag inj, iv push	\$54.46	NA	\$52.66	NA	\$46.53	NA
96375	Ther/proph/diag inj add-on	\$23.80	NA	\$22.00	NA	\$18.75	NA
96401	Chemo, anti-neopl, sq/im	\$67.44	NA	\$66.72	NA	\$61.31	NA
96402	Chemo hormon antineopl sq/im	\$36.79	NA	\$34.98	NA	\$27.77	NA
96405	Chemo intralesional, up to 7	\$84.40	\$28.85	\$82.23	\$28.85	\$72.13	\$29.57
96406	Chemo intralesional over 7	\$116.50	\$41.84	\$114.33	\$42.56	\$101.71	\$44.00
96409	Chemo, iv push, sngl drug	\$111.81	NA	\$107.48	NA	\$89.81	NA
96411	Chemo, iv push, addl drug	\$63.84	NA	\$60.23	NA	\$50.85	NA
96413	Chemo, iv infusion, 1 hr	\$147.51	NA	\$140.66	NA	\$115.41	NA
96415	Chemo, iv infusion, addl hr	\$33.54	NA	\$30.30	NA	\$25.97	NA
96416	Chemo prolong infuse w/pump	\$160.86	NA	\$153.64	NA	\$125.87	NA
96417	Chemo iv infus each addl seq	\$73.58	NA	\$69.25	NA	\$57.71	NA

96420	Chemo, ia, push technique	\$107.84	NA	\$103.87	NA	\$87.28	NA
96422	Chemo ia infusion up to 1 hr	\$173.84	NA	\$166.63	NA	\$137.05	NA
96423	Chemo ia infuse each addl hr	\$77.54	NA	\$75.74	NA	\$64.20	NA
96425	Chemotherapy,infusion method	\$171.32	NA	\$167.71	NA	\$146.79	NA
96440	Chemotherapy, intracavitary	\$597.98	\$132.36	\$653.89	\$140.66	\$760.64	\$137.77
96445	Chemotherapy, intracavitary	\$285.29	\$116.86	\$277.35	\$117.94	\$240.92	\$118.30
96450	Chemotherapy, into CNS	\$208.10	\$88.00	\$198.73	\$86.56	\$161.94	\$80.79
96521	Refill/maint, portable pump	\$126.95	NA	\$123.71	NA	\$108.92	NA
96522	Refill/maint pump/resvr syst	\$107.84	NA	\$104.95	NA	\$91.97	NA
96523	Irrig drug delivery device	\$25.25	NA	\$24.53	NA	\$20.20	NA
96542	Chemotherapy injection	\$134.17	\$45.44	\$126.59	\$44.00	\$100.27	\$41.48

Equipment Utilization Rate

In the Proposed Rule, CMS proposed to increase the equipment usage rate to 90% for all services containing equipment that cost in excess of \$1 million. CMS finalizes this proposal with two significant modifications. First, CMS includes in the Final Rule a four-year transition of RVUs (25/75, 50/50, 75/25, 100/0) using the 90% utilization rate. Second, CMS limits the increased utilization rate to MRI and CT and will not apply the change to therapeutic equipment. In making this decision, CMS was “persuaded by PPIS data on angiography, IMRT, and Gamma Camera that the extrapolation of the MRI and CT data to all expensive equipment may be inappropriate.” This has a significant positive impact on the PE RVU changes for radiation oncology (in addition to the changes described above regarding use of PPIS data for freestanding radiation oncology centers). Under the Proposed Rule, the impact of the PE RVU changes was -17%; under the Final Rule, it is -3%.

Reimbursement for Brachytherapy and Echocardiography Services

At CMS’s request, the American Medical Association (AMA) Relative Value Update Committee (RUC) reviewed the high dose radiation brachytherapy procedures codes 77785-77787 and recommended revisions to the practice expense inputs for these codes. Based on the AMA RUC’s recommendations, other comments, and further analysis, in the Final Rule CMS changes the useful life of the Iridium-192 source from five years to one year and will consider it to be equipment. CMS also is revising the direct PE inputs for clinical labor staff type, supplies, and equipment. Attached to this summary is a chart that compares the equipment costs of these codes in 2009 and 2010. CMS did not change the staff types and times for these codes, except to eliminate the separate registered nurse staff time.

Consultation Codes

CMS finalizes its proposal to eliminate the use of all consultation codes in a budget neutral manner by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into the PE and malpractice RVU calculations. CMS cites the continuing confusion over the use of such codes and its belief that the rationale for a differential payment

for a consultation service is no longer supported because documentation requirements are now similar across all evaluation and management (E/M) services as the reasons for its decision.



CMS also rejects requests to delay implementation of the decision finding it unnecessary to do so to avoid physician confusion or to give the agency more time to explore alternatives. With regard to the impact of such a change on various specialists, CMS states,

It is in the nature of any budget neutral payment system for changes such as this to have a somewhat differential impact on various groups of providers and/or practitioners. In this particular case, we do not believe that these impacts are disproportionate to the goals we have sought to achieve in making and finalizing this proposal.

Potentially Misvalued Services

CMS has been working to address the issue of potentially misvalued services. In the Proposed Rule, CMS discusses some of the steps it is taking in this regard, including looking more closely at the fastest growing codes and codes furnished together more than 75% of the time, and establishing a separate group of experts to assist in the review of relative values. CMS does not directly address comments regarding these issues in the Final Rule. Instead, CMS states that it will consider comments and concerns as it continues examining the valuation of services under the misvalued code initiative.

Physician Quality Reporting Initiative (PQRI)

In the Final Rule, CMS implements a number of changes to the PQRI to simplify the reporting requirements and broaden the ability of providers to participate, including providing a mechanism for participants to submit quality measure data from qualified electronic health records (EHRs), creating a process for group practices to use for reporting quality measures, and adding measures for eligible professionals to report.

CMS finalizes the option for an eligible professional to report data on 2010 PQRI quality measures through a qualified EHR product (contingent on there being a qualified 2010 EHR product). The addition of EHR-based reporting, however, does not mean the elimination of claims-based reporting in the near future; CMS states that

since it is unlikely that there will be an adequate number of measures available for EHR reporting in 2011 for us to completely eliminate the claims-based reporting mechanism, we anticipate continuing to offer claims-based reporting options for the PQRI beyond 2010. We may, however, avoid introducing new claims-based measures and increasingly limit the circumstances in which

claims-based reporting is an available reporting mechanism in order to encourage wider adoption of registry or EHR-based reporting.



CMS also finalizes the group practice reporting option for CY 2010 and the proposed requirement that group practices choosing this option have at least 200 individual eligible professionals. CMS states that it will use the “initial implementation year to further develop and refine aspects of the group practice reporting option and anticipate[s] adapting and expanding this option to group practices less than 200 individual eligible professionals in future program years.” In one change from its Proposed Rule, CMS is not requiring public reporting of the group practices’ PQRI performance results. Although the agency continues to believe that “public reporting of performance information at the group level does not present some of the same issues that public reporting of performance information at the individual eligible professional would,” it recognizes in the Final Rule “the importance of giving participating group practices an opportunity to review their results from the first year of the group practice reporting option before any information is publicly reported.” CMS will limit public disclosure of information on the PQRI group practice reporting for 2010 to the information required by section 1848(m)(5)(G)(i) of the Act (that is, the names of group practices that satisfactorily submitted data on 2010 PQRI quality measures).

CMS adds 30 individual PQRI measures and six measures groups on which individual eligible professional may report in the Final Rule. In response to commenters’ concerns about adopting measures that have not been endorsed by the National Quality Forum (NQF), CMS reiterates its statutory authority to do so. The agency goes on to state, however, that

inclusion of measures that are not NQF endorsed or AQA adopted is an exception to the requirement under section 1848(k)(2)(C)(i) of the Act that measures be endorsed by the NQF. Therefore, we do believe that this exception authority should be exercised in very limited circumstances, such as when few or no measures are available for a particular specialty or category of eligible professionals to report.

With regard to specific measures, CMS had proposed to eliminate Measure #143 Oncology: Medical and Radiation – Pain, Intensity Quantified and Measure # 144 Oncology: Medical and Radiation Plan of Care for Pain because they were too complex to calculate via claims. Instead of eliminating these measures, CMS retains them as registry-only measures for the 2010 PQRI in the Final Rule. CMS adopted all of the proposed new quality measures, including the quality measure for Cancer Stage Documented.

Other highlights include the following:

- Adds a six-month period for claims-based reporting of individual measures.
- Does not finalize a proposed minimum patient sample requirement for individual measures reported by individual eligible professionals because “a significant number of eligible professionals who would otherwise meet the criteria for satisfactory

reporting would be adversely impacted by the addition of a minimum patient sample size requirement.”



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- Retains the minimum patient sample size requirements for eligible professionals who choose to report on measures groups but lowers the threshold to 15 patients for those who report on 80% of the Medicare Part B FFS patients seen during the 12-month reporting period (eight patients for the six-month reporting period). For those who choose the alternative means of satisfactory reporting (reporting on at least 30 patients in the 12-month reporting period), eliminates the requirement that the patients been seen consecutively.

Value-Based Purchasing Program

In the Final Rule, CMS discusses the progress it is making regarding the transition to value-based purchasing as it prepares to report to the Congress in May of next year. CMS states that it plans “to continue to explore ways to measure and incentivize practitioners for higher value care at multiple levels of accountability,” and “is considering approaches that allow for participation by a wide variety of health care practitioners.” CMS also states that it is “actively engaged with [the Office of the National Coordinator for Health Information Technology (ONC)] on how to align any [value-based purchasing] incentives for health IT with the HITECH provisions [relating to the Medicare and Medicaid incentives for adoption of health information technology].” The agency also responds to commenters’ concerns about stakeholder participation and the potential impact of value-based purchasing on medical innovation in the following exchange:

Comment: Commenters commended CMS for involving stakeholders in [value-based purchasing] plan development, and encouraged CMS to continue to involve stakeholders as plan development proceeds. Commenters urged CMS to ensure that any [value-based purchasing] plan does not impede the evolution of medical practice, discourage innovation, or interfere with practitioner-patient decision-making.

Response: We appreciate the opportunity to hear from stakeholders regarding plan recommendations, and we value the input stakeholders have provided thus far. We are carefully considering options and taking an iterative approach to [value-based purchasing] plan development to avoid the potential pitfalls mentioned by commenters.

Incentives for E-Prescribing

The Final Rule includes a number of provisions to simplify the e-Prescribing Incentive Program and reduce the reporting burden for eligible prescribers. First, CMS eliminates the several e-prescribing codes and replaces them with one code that will be used only when a

patient visit results in an electronic prescription being placed. In addition, instead of having to report the e-prescribing codes at least 50% of the time, prescribers will have to report the single



e-prescribing code 25 times during the 12-month reporting period to be considered a successful e-prescriber eligible for an incentive payment. CMS also is expanding the available reporting mechanisms for e-prescribing by adding registry and EHR-based reporting in addition to claims reporting. Finally, group practices will be able to qualify for a 2010 e-prescribing incentive payment.

Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services

In the Final Rule, CMS implements the requirement that suppliers of the TC of advanced imaging services be accredited beginning January 1, 2012 by establishing criteria for designating organizations to accredit such suppliers. The Final Rule adopts the criteria in the Proposed Rule with the following clarifications (among others): equipment used by the supplier must meet performance specifications; accrediting organizations (AOs) may maintain or adopt standards that are more stringent than those of Medicare; AOs are required to notify Medicare of the accreditation decision of those suppliers billing Medicare; AOs are required to notify CMS of significant changes from what CMS approved in the AO's initial approved application, not all revisions; and the accreditation requirement does not apply to hospitals. CMS also adds additional requirements in the Final Rule, including a requirement that AOs respond to complaints from any source with respect to an accredited supplier. CMS will address suppliers' accountability, business integrity, physician and technician training, service quality, and performance management through additional guidance.

Compendia for Determination of Medically-Accepted Indications for Off-Label Anti-Cancer Chemotherapeutic Regimens

Section 182(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) amended section 1861(t)(2)(B) of the Social Security Act (42 U.S.C. 1395x(t)(2)(B)) by adding the sentence, "On and after January 1, 2010, no compendia may be included on the list of compendia [used to determine medically-accepted indications of drugs and biologicals used off-label in anti-cancer chemotherapeutic regimens] unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests." In the Proposed Rule, CMS proposed revisions to the compendia standards to implement this requirement. CMS finalizes its proposal with a few changes, including the following:

- shortens the time frame for including materials used in the evaluation process on the compendia' website from 5 years to 3 years, although compendia are still required to retain, and make available to the public, such information for not less than 5 years;

- eliminates the requirement that compendia publish the identified information relating to potential conflicts of interests and instead requires that such information be disclosed if requested by the public;



- amends the provision concerning the process for public disclosure of immediate family members to be less extensive and more consistent with the current Food and Drug Administration (FDA) *Guidance for the Public, FDA Advisory Committee Members, and FDA Staff on Procedures for Determining Conflict of Interest and Eligibility for Participation in FDA Advisory Committees*, released in August of 2008.

CMS declines to include a grandfathering provision for patients that begin an off-label anti-cancer chemotherapeutic regimen based on the recommendation of a compendium that is subsequently removed from the list of statutorily-recognized compendia due to noncompliance with the new requirements. CMS indicates that such a provision is unnecessary to address concerns that the immediate removal of a compendium that fails to meet the January 1, 2010 implementation date would adversely impact a patient being treated with an off-label anti-cancer chemotherapeutic regimen because local contractors have the authority to make determinations regarding medically-accepted off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen that do not appear in a compendia. CMS also declines to establish a specific dollar value that would trigger disclosure of financial conflicts of interests, instead leaving it to “the discretion of the compendia publisher as to whether a specific dollar value would be publicly disclosed.”

Competitive Acquisition Program (CAP) Issues

The Final Rule is silent about when the CAP will resume. It does, however, include the following provisions related to the CAP:

- Finalizes all of the proposals related to the frequency of drug payment amount updates under the CAP Program without change, including discontinuation of the annual payment amount adjustments, implementation of quarterly payment amount increases that begin in the first quarter of the CAP claims contract period, and the Average Sales Price (ASP)+6% limit on payment amount increases.
- Narrows the CAP drug list to a specific list of 41 items. CMS uses volume-based filtering and the concept of filling to establish the drug list. It also finalizes the proposed approach for approved CAP vendor-requested additions of drugs that have similar uses to drugs on the bid list.
- Finalizes the proposed process whereby an approved CAP vendor may request the permanent removal from its CAP drug list of a HCPCS code for which no National Drug Codes (NDCs) are available.

- Finalizes the proposal to temporarily limit the CAP geographic area to the 48 contiguous states and the District of Columbia. CMS will continue to assess the CAP and update plans for phase-in activity in future rulemaking efforts, including determining the circumstances under which CAP participation will be offered to



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- physicians in Alaska, Hawaii, and the Territories. It also will continue to consider modifying the definition of competitive acquisition area on the basis of regions, states, or some smaller geographic area, potentially expanding the number of vendors that could bid to participate in the program.
- Finalizes the proposal to allow approved CAP vendors to utilize electronic transactions to furnish CAP drugs from nominal quantities of approved CAP vendor-owned stock, and clarifies that “nominal quantities of stock” means quantities that do not exceed what is typically used by the participating CAP physician’s office between the approved CAP vendor shipment periods. CMS does not specify what the shipment periods must be, but does not intend this process to mean that large quantities of CAP drug would be kept at a physician’s office.
- Abandons the proposal to expand the definition of CAP physician to include non-physician providers because of concerns that such a change would exceed the agency’s statutory authority.
- Finalizes the proposal to ease the transportation restrictions between a participating CAP physicians’ offices using voluntary agreements between the approved CAP vendors and participating CAP physicians.