

## NEWS BREAK

*December 21, 2011*

### Medicare SGR Faces a Bitter End

The 2011 Congressional legislative session came to a bitter end yesterday. Members of Congress will go home for the holidays in a rare standoff that will not result in a last-minute agreement to stop the Medicare SGR 27.4% fee-for-service program payment cut, or extend the payroll tax cut and unemployment benefits.

**CMA is absolutely outraged that Congress will adjourn and let this devastating nearly 30% payment cut take effect.** For a decade, CMA and organized medicine has been calling upon Congress to eliminate the Medicare SGR. All year, Members of Congress made commitments to CMA physicians and seniors that they would stop the cuts and adopt a long-term solution to the failed Medicare SGR physician payment formula. In the height of irresponsibility, Congress will go home for the holidays and deal a terrible blow to physician practices and their patients. Most physicians will not be able to sustain such a cut and remain in the Medicare program. Others could be forced to close their doors. Seniors in California are already experiencing difficulty finding physicians. This will have a devastating impact on access to physicians for California's 5 million seniors and nearly 1 million military families.

Late last week, when negotiations failed between the House and the Senate, a bipartisan group of Republican and Democratic Senators crafted a short term two-month extension on the Medicare SGR, payroll tax cut and unemployment issues to avoid the devastating cuts that will occur next week. The Senate passed the measure with overwhelming support 89-11. However, under the direction of Speaker Boehner, the House Leadership rejected the 2 month extension and are holding out for a longer term deal. The standoff will remain unresolved until Congress returns in January 2012.

CMA has been advocating for legislation that eliminates the SGR and adopts a longer-term path to an alternative payment system. Within the last few days, to avoid the inevitable, CMA supported the 2-month stop-gap on the Medicare SGR to avoid devastating cuts and a retroactive payment restoration.

Unfortunately, the Medicare SGR was tied to much larger controversial issues in the year-end legislative package. While no formal statements have been made by either the Senate or House Leadership about their intent to return in January to stop the cuts, we expect Congress to return on January 3 rather than January 17 to address these issues. The House has created a conference committee to bargain over the differing House and Senate bills.

**The Centers for Medicare & Medicaid Services (CMS) announced that it has instructed Medicare claims administration contractors to hold claims containing 2012 services paid under the Medicare physician fee schedule for the first 10 business days of January (January 1-17, 2012). CMS says the hold should have minimal impact on provider cash flow because, under current law, clean electronic claims are not paid sooner than 14**

calendar days (29 days for paper claims) after the date of receipt. CMS said they will be forced to process claims at the lower rate starting January 18 if Congress does not stop the cut.

Medicare physician fee schedule claims for services rendered on or before December 31, 2011, are unaffected by the 2012 claims hold and will be processed and paid under normal procedures and time frames.

CMS says it will notify physicians on or before January 11, 2012, with more information about the status of Congressional action to avert the cuts and next steps regarding the claims hold.

CMA encourages physicians to review their Medicare participation options in the CMA [Medicare Participation Medical-Legal Document](#) available on the [CMA website](#).

CMA will keep you informed as the debate continues. We have expressed our anger to our Congressional delegation for failing to keep their obligation to appropriately finance the Medicare program and to protect access to care.

Thank you for your efforts this year to restore the Medicare program. CMA will “fight like hell” in 2012 to develop a proactive Medicare payment alternative and to hold Congress accountable for these actions.

## CMA Announces Their 2012 Webinar Schedule

We are happy to announce CMA's preliminary 2012 educational calendar (below)! This calendar is subject to change as the year unfolds and it does NOT currently include CMA's ICD-10 training courses to be offered in 2012. We will update you as those dates are finalized. Look for the reminder flyers that MMCMS sends about a week prior to each webinar, registration will open soon!

### **Jan. 25: Medicare E&M Audits**

*Arthur Lurvey/Mike Barlow* • 12:15 – 2:00 p.m.

### **Feb. 1: Key Financial Ratios to Increase Profitability**

*Debra Phairas* • 12:15 – 1:15 p.m.

### **Feb. 15: Risk Analysis for Meaningful Use**

*David Ginsberg* • 12:15 – 1:15 p.m.

### **March 7: Managing Difficult Employees and Reducing Conflict in the Practice**

*Debra Phairas* • 12:15 – 1:15 p.m.

### **March 21: HIPAA Update 2012**

*David Ginsberg* • 12:15 – 1:15 p.m.

### **April 4: A Guide to Managing Upset and/or Difficult Patients**

*Debra Phairas* • 12:15 – 1:15 p.m.

### **April 18: Best Practices for Managing Your Accounts Receivable**

*Mary Jean Sage* • 12:15 – 1:15 p.m.

### **May 2: Medicare: Top 10 Claim and Documentation Errors That Cost Your Practice Money**

*TBD/Kevin Garrick* • 12:15 – 1:15 p.m.

### **May 16: Telephone Etiquette for Medical Personnel**

*Mary Jean Sage* • 12:15 – 1:15 p.m.

**June 6: A Manager's Guide to Lowering Practice Costs**

*Debra Phairas • 12:15 – 1:15 p.m.*

**June 20: Writing Effective Appeals**

*Mary Jean Sage • 12:15 – 1:15 p.m.*

**July 18: Preparing for a Medicare and/or Medi-Cal Audit**

*Mary Jean Sage • 12:15 – 1:15 p.m.*

**Aug. 1: Coding for Medical Necessity**

*Arthur Lurvey, M.D. • 12:15 – 1:15 p.m.*

**Sept. 19: Creating and Implementing Financial and Office Policies**

*Debra Phairas • 12:15 – 1:15 p.m.*

**Oct. 17: Establishing Expectations for High Performance from Medical Staff**

*Debra Phairas • 12:15 – 1:15 p.m.*

**Nov. 7: Understanding ARC and CARC Revenue Codes**

*David Ginsberg • 12:15 – 1:15 p.m.*

**Time is Running Out to Take Advantage of CalHIPSO's Subsidized Services!**

Achieving meaningful use is easier with CalHIPSO and Priority Primary Care Providers (PPCPs) who **join by February 29, 2012 will not have to pay CalHIPSO membership fees through January 2014!** Priority Primary Care Providers are defined as: Internal Medicine, Family Medicine, Pediatrics, Geriatrics, OBGyn or Adolescent Medicine providers in practices of 10 or fewer physicians. Specialists and providers in practices of 10 or more can also access services for a fee.

CalHIPSO and their network of local extension centers, including Lumetra Healthcare Solutions, your local resource for achieving meaningful use, can help you! Contact them today! Lumetra 415.677.8447 or CalHIPSO 888.589.4897.



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# Medicare Part B Changes: What They Mean to Your Practice

On November 1, 2011, the Centers for Medicare & Medicaid Services (CMS) updated payment policies and Medicare payment rates for physicians' services furnished in 2012.

Highlights of major changes in the fee schedule that impact payment policy and physician billing include:

## **E-prescribing**

CMS finalized the rules for the 2012 and 2013 e-prescribing incentive payment, and the 2013 and 2014 payment penalty programs.

E-prescribing incentive payments will continue for 2012 and 2013. To qualify for an incentive payment, physicians:

- May use claims, registry or electronic health record (EHR)-based reporting methods.
- Must electronically prescribe on the same day as the denominator service, and submit 25 claims containing the e-prescribing measure code (G8553) with one of the denominator codes (90801-90802, 90804-90809, 90862, 92002, 92004, 92012, 92014, 96150-96152, 99201-99205, 99211-99215, 99304-99310, 99315-99316, 99324-99328, 99334-99337, 99341-99345, 99347-99350, G0101, G0108, G0109).

The incentive payment for 2012 is 1 percent, and for 2013 it is .5 percent of the total estimated allowed charges for professional services covered by Medicare Part B and furnished by an eligible professional during the reporting period.

There are three methods to avoid the penalty for 2013 and 2014:

- Physicians who are successful e-prescribers in 2011 (those who receive the incentive payment) will be exempt from penalty in 2013. Physicians who are successful e-prescribers in 2012 will be exempt in 2014.
- Physicians who successfully report the measure code G8553 at least 10 times during the first six months of 2012 (for the 2013 calendar year penalty) and in the first six month of 2013 (for the 2014 calendar year penalty) will avoid application of the e-prescribing penalty. CMS improved the program to allow physicians to submit the measure code G8553 without linking to qualifying visit (denominator) codes. The measure code can be used with any fee schedule service during which an electronic prescribing event occurred. The claim must still be submitted to Medicare for payment.
- Physicians will be allowed to apply for additional hardship exemptions online, but only from January through June 30 of each calendar year.

## **Physician Quality Reporting System (PQRS)**

As in prior years, there have been changes to the individual measures and measure groups. The final rule:

- Finalized 211 individual measures, including 26 new ones.
- Retained 44 EHR measures currently reportable in the EHR incentive program.
- Finalized 23 new measure groups, including eight new measures groups for reporting: Cardiovascular Prevention, COPD, Inflammatory Bowel Disease, Sleep Apnea, Dementia, Parkinson's, Elevated Blood Pressure and Cataracts.

Check measures carefully for proper reporting. A complete listing of the 2012 measures will be posted to the CMS website <http://www.cms.gov/PQRS//> in the near future.

CMS finalized its proposal to provide interim feedback reports for physicians reporting individual measures and measure groups through claims-based reporting for 2012 and beyond. These reports will be a simplified version of annual feedback reports that CMS currently provides and will be

based on claims for the first three months of each program year. The interim feedback reports will be provided to physicians during the summer of each program year.

The rule redefined “group practice” under the Group Practice Reporting Option as a group of 25 or more eligible professionals. Organizations wishing to use the GPRO method must again self-nominate.

CMS finalized its proposal to use 2013 as the reporting period for the 2015 PQRS penalty. If CMS determines that a physician or group practice has not satisfactorily reported quality data for the 2013 reporting period, then its 2015 payments will be reduced 1.5 percent. Now is a good time to become familiar with the PQRS reporting system before your payments are negatively affected.

### **Advanced Imaging Services Multiple Procedure Pricing**

CMS has finalized a proposal to apply a 25 percent reduction to the payment for the professional component of second and subsequent advanced imaging services such as CT, MRI, PET, and MRA furnished by the same physician on the same patient in the same session on the same day.

The highest fee schedule service will be allowed at 100 percent of the fee schedule. Subsequent advanced imaging services will be allowed at 50 percent for the technical component, as in the past, and 75 percent for the professional component.

### **Lab Test Signatures No Longer Required**

CMS has retracted the requirement for physicians to sign paper lab requisitions for clinical diagnostic laboratory tests.

### **Annual Wellness Visit (AWV) Changes**

CMS has adopted criteria for a health risk assessment (HRA) to be used in conjunction with the AWV. The HRA is self-reported information which can be done by the patient alone or with assistance, takes no more than 20 minutes to complete and addresses demographic data, psychosocial risks, behavioral risks, activities of daily living (ADL), and instrumental ADLs.

CMS is increasing the payment for the AWV codes to recognize the additional office staff time required to administer and HRA to the Medicare population. CMS is also continuing its policy of not covering a routine physical exam as part of these services.

Additional information about coverage and payment changes will be published by CMS over the next few months through MLN Matters articles at <http://www.cms.gov/MLN MattersArticles/>.

Contact: CMA Reimbursement Help Line at 888-401-5911, or [economicservices@cmanet.org](mailto:economicservices@cmanet.org).

