



2008 Medicare physician payment schedule final rule: AMA summary and analysis

On Nov. 1, the Centers for Medicare & Medicaid Services (CMS) released the final rule with the 2008 Medicare physician payment schedule. The rule will be published in the *Federal Register* on Nov. 27, but it is available online at: www.cms.hhs.gov/physicianfeesched/downloads/CMS-1385-FC.pdf. There is a 60-day comment period on the rule, concluding on Dec. 30, 2007.

This final rule sets in motion a 10.1 percent cut in the Medicare conversion factor on Jan. 1, 2008, meaning that, unless Congress acts soon, the 2008 conversion factor will be \$34.0682. Physicians and medical societies are strongly urged to contact your senators at (800) 833-6354 and urge immediate action to replace the cut with a positive update linked to the increase in practice costs.

2008 Impacts

Table 39 of the final rule, which shows expected payment impacts for specialties and health professionals, is attached to this summary. Payment rates for services, localities and specialties are likely to change by percentages that differ from 10.1 percent for several reasons:

- The final rule includes the every-three-years update to the geographic practice cost indexes or GPCIs, which includes significant changes in professional liability insurance and practice expense GPCIs for many localities. CMS acknowledges, however, that there are many errors in the list of 2008 GPCIs that appears in Addendum E. In addition to the updated GPCIs, the work GPCI floor of 1.00 and the physician scarcity area extra payments established in the 2003 Medicare law will expire at the end of this year. The combined effects of the GPCI changes and the expiring provisions could make the cuts steeper in many localities, although in some areas GPCI increases may slightly offset the conversion factor cut. **We are asking Congress to extend the expiring provisions to prevent added cuts to rural physicians.**
- Against the urging of the AMA and 75 specialty societies, CMS is continuing to employ a separate adjustment to the physician work relative values to achieve budget neutrality from the five-year review instead of applying budget neutrality across-the-board through the conversion factor. The work adjustment will increase from 10 percent in 2007 to 12 percent in 2008 and this will have differential effects on payment rates for different services and specialties. **We are asking Congress to take action to require CMS to apply the budget neutrality adjustment across-the-board to the conversion factor instead of applying it to the work values.**
- There are changes in the work relative values for some services due to CMS adoption of recommendations from the RVS Update Committee (RUC), and 2008 will be second year of a four-year transition to revised practice expense relative values.

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RUC recommendations

With respect to recommendations from the RUC, CMS accepted *all* of the RUC's 266 work value recommendations in principal, but it made payment policy decisions related to non-coverage, bundling, and restricting payment for some of the new CPT codes for 2008. For example, CMS published new CPT codes and relative value units for telephone calls, but indicated that the Medicare program will not cover and pay for these services. CMS also applied a budget neutrality adjustment to a series of orthopaedic trauma codes that is inconsistent with the RUC recommendation. CMS also accepted all of the RUC's recommendations for direct practice expense inputs (clinical staff, medical supplies, medical equipment), with a few minor exceptions. The following RUC recommendations are of note:

- New CPT codes and RUC recommendations for smoking cessation counseling replace existing G-codes.
- Increases to the Eye Exam codes reflect the corresponding 2007 increases to office visits.
- A 32 percent increase to the work valuation of Anesthesia services. CMS acknowledges an error in the published 2008 conversion factor for anesthesia services, which will increase to \$17.83.

Practice expense payments

2008 will be the second year in the transition to a revised practice expense methodology that derives direct cost from actual service level data; incorporates supplemental survey data from seven specialties; and eliminates the former special methodology for services without physician work. Payments will now be a blend of 50 percent old methodology and 50 percent new methodology.

CMS has acknowledged the urgent need for more recent data on physician practice costs for both practice expense payment at the individual service level and in Medicare Economic Index (MEI) determinations. In this Final Rule, CMS acknowledges that the AMA and more than 70 national medical specialty societies and health care professional organizations are fielding a study in 2007 and 2008 to collect this information. CMS indicates its support for this effort and its hope that the data will be "sufficiently robust" to incorporate into future physician payment determinations.

2008 Medicare Economic Index

The final Medicare Economic Index (MEI) for 2008 is 1.8 percent. It is notable that the final MEI includes a *reduction* of 0.8 percent in professional liability insurance costs. The MEI is also reduced by 1.4 percent for a productivity adjustment, nearly halving the government's estimate of inflation in medical practice costs. CMS does not adjust the market baskets for any other Medicare provider to account for productivity and in comments on the proposed rule, the AMA urged CMS to reduce this adjustment but no action was taken in the final rule. **The AMA will continue to press CMS to revise the MEI so that it better reflects physicians' increasing costs, as well as to remove drugs from its SGR calculations, account for increased costs due to Medicare coverage expansions, and take other steps that would improve the accuracy of payment update calculations and reduce the cost of legislation to provide a long-term replacement for the SGR.**

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Physician Quality Reporting Initiative measures

The AMA had also urged CMS to use the \$1.35 billion Physician Assistance and Quality Initiative Fund established by the Tax Relief and Health Care Act of 2007 to help offset the 10.1 percent Medicare pay cut in 2008 but CMS has finalized its proposal to use these funds to instead pay for quality reporting. **If enacted, the CHAMP Act would redirect these funds to help pay for positive payment updates.**

The rule includes the final list of quality measures for the 2008 Physician Quality Reporting Initiative (PQRI). CMS plans to publish full specifications for each measure on its website in the near future. Ninety-one of 119 (76 percent) measures in the rule were developed and approved through the AMA-convened Physician Consortium for Performance Improvement process.

The rule did not include a number of new measures developed in 2007 despite efforts by the AMA and more than 40 specialties who sent a sign-on letter to CMS. The letter urged CMS to provide the utmost flexibility for the inclusion of quality measures in the 2008 program in order to allow for broad, yet voluntary, physician participation in PQRI. **The AMA will continue its work with the specialties to further this goal.**

Revised physician self-referral regulations

The proposed rule also contained numerous changes to the physician self-referral regulations which the AMA urged CMS to withdraw and reevaluate. In the final rule, CMS has finalized its “anti-markup” proposal for diagnostic tests but it has deferred taking final action on most of the remaining proposals until some later rulemaking process, simply stating that to do so in this rule “would not be prudent.” A future final rule will address burden of proof standards, liability insurance subsidies for obstetricians, the period of disallowance for noncompliant financial relationships, ownership or investment interest in retirement plans, certain compensation arrangements, alternative criteria for satisfying certain exceptions, services furnished “under arrangements” and other provisions of the proposed rule. **The AMA will continue to urge that the onerous new proposed regulations be withdrawn and that no new self-referral rules be imposed.**

The final rule does impose an anti-markup provision on the technical component (TC) of diagnostic tests that are ordered by the billing physician or other supplier, if the TC is outright purchased or if the TC is performed at a site other than the office of the billing physician or supplier. This means that physicians cannot charge Medicare for any amounts above the cost of the diagnostic test despite administrative and/or overhead costs associated with the test. Similarly, the final rule imposes an anti-markup provision on the professional component (PC) of diagnostic tests that are ordered by the billing physician or other supplier if the PC is outright purchased or if the PC is not performed in the office of the billing physician or supplier.

Two other provisions of the final rule clarify that part-time employees are treated no differently than full-time employees or contractors who reassign benefits, and revise the definition of “entity” so that physician practices no longer are permitted an exception when they bill Medicare for the TC or PC of a diagnostic test. *(continued...)*



Removal of fax exemptions for e-prescribing

Effective Jan. 1, 2009, the final rule removes the fax exemption for electronic prescribing. As e-prescribing is not mandatory, only those who choose to e-prescribe for Medicare Part D must comply with the standard adopted by Medicare. According to CMS, software is available to physicians through “automatic version upgrades built into annual software vendor maintenance fees.” Physicians whose e-prescribing software cannot be upgraded to meet Medicare standards, however, would need to either purchase new software or return to paper prescriptions. In case of outages or minor interruptions that preclude transmission of the prescription electronically, faxes will be allowed for brief periods. CMS paid no heed to comments that removal of the fax exemption should be deferred until the DEA changes its rules to allow e-prescribing for controlled substances. **The AMA is pressing Congress to provide financial incentives to physicians to facilitate wider adoption of e-prescribing and continues to advocate to Congress and the DEA that e-prescribing of controlled substances be permitted.**

Average sales price payments for Part B drugs

The AMA expressed concern in its comment letter that ASP does not provide physicians in small practices adequate access to the drugs they need to administer to their patients. In addition, some specialties experience additional access barriers because of payment policies that further depress the payment below ASP. The final rule does not address any of these concerns. **We will continue to work through the regulatory process to address the lack of access based on the methods currently used to calculate the ASP.**

Competitive Acquisition Program

Against the recommendations of the AMA, CMS finalized its proposal to require Competitive Acquisition Program (CAP) vendors to conduct medical necessity reviews. As a result, physicians could potentially be subject to two medical necessity reviews since their claims could also be reviewed by Medicare carriers. CMS accepted several of the AMA’s comments regarding the definition of “exigent circumstances” that allow physicians to opt-out of annual elections to obtain drugs and biologicals from a CAP vendor. The final rule expands the window for having the election set-aside from 30 to 60 days and CMS indicates that it will take an expansive view of what constitutes an exigent circumstance, including those related to administrative and business burdens as well as uncooperative vendors. **We will continue to monitor the implementation of the new CAP provisions and seek changes as appropriate.**

Other provisions of the final rule

- CMS decided not to finalize its proposed changes to the payment locality definitions for the State of California and will continue to study this issue.
- CMS finalized its proposed process for updating the drug compendia used to determine off-label coverage of physician-administered drugs covered by Medicare Part B, which the AMA supported. The AMA had also urged immediate approval of a compendial listing for anti-cancer treatment, but the final rule does not accommodate this request.

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TABLE 39: Combined CY 2008 Total Allowed Charge Impact for the Remaining 5-Year Review of Work RVUs and Practice Expense Changes, OPPIs Imaging Cap, and the CY 2008 Update

Specialty	Allowed charges (mil)	Impact of work and PE RVU changes*	Impact of DRA 5102	Combined impact RVU and DRA 5102**	CY 2008 update	Combined impact with CY 2008 update**
TOTAL	\$ 76,551	0%	0%	0%	-10%	-10%
ALLERGY/IMMUNOLOGY	\$ 173	2%	0%	2%	-10%	-8%
ANESTHESIOLOGY	\$ 1,579	14%	0%	14%	-10%	4%
CARDIAC SURGERY	\$ 396	-2%	0%	-2%	-10%	-12%
CARDIOLOGY	\$ 7,519	-2%	0%	-2%	-10%	-12%
COLON AND RECTAL SURGERY	\$ 122	0%	0%	0%	-10%	-10%
CRITICAL CARE	\$ 199	-1%	0%	-1%	-10%	-11%
DERMATOLOGY	\$ 2,248	2%	0%	2%	-10%	-8%
EMERGENCY MEDICINE	\$ 2,203	-2%	0%	-2%	-10%	-12%
ENDOCRINOLOGY	\$ 350	-1%	0%	-1%	-10%	-11%
FAMILY PRACTICE	\$ 5,060	0%	0%	0%	-10%	-10%
GASTROENTEROLOGY	\$ 1,750	0%	0%	0%	-10%	-10%
GENERAL PRACTICE	\$ 974	0%	0%	0%	-10%	-10%
GENERAL SURGERY	\$ 2,309	-1%	0%	-1%	-10%	-11%
GERIATRICS	\$ 147	3%	0%	3%	-10%	-7%
HAND SURGERY	\$ 80	-2%	0%	-2%	-10%	-12%
HEMATOLOGY/ONCOLOGY	\$ 1,917	-1%	0%	-1%	-10%	-11%
INFECTIOUS DISEASE	\$ 504	-1%	0%	-1%	-10%	-11%
INTERNAL MEDICINE	\$ 9,981	0%	0%	0%	-10%	-10%
INTERVENTIONAL RADIOLOGY	\$ 244	-2%	0%	-2%	-10%	-12%
NEPHROLOGY	\$ 1,664	-3%	0%	-3%	-10%	-13%
NEUROLOGY	\$ 1,398	-1%	0%	-1%	-10%	-11%
NEUROSURGERY	\$ 576	-2%	0%	-2%	-10%	-12%
NUCLEAR MEDICINE	\$ 78	4%	0%	5%	-10%	-5%
OBSTETRICS/GYNECOLOGY	\$ 628	-1%	0%	-1%	-10%	-11%
OPHTHALMOLOGY	\$ 4,664	1%	0%	1%	-10%	-9%
ORTHOPEDIC SURGERY	\$ 3,248	-1%	0%	-1%	-10%	-11%
OTOLARNGOLOGY	\$ 913	1%	0%	1%	-10%	-9%
PATHOLOGY	\$ 948	-2%	0%	-2%	-10%	-12%
PEDIATRICS	\$ 74	0%	0%	0%	-10%	-10%
PHYSICAL MEDICINE	\$ 784	-1%	0%	-1%	-10%	-11%
PLASTIC SURGERY	\$ 272	-1%	0%	-1%	-10%	-11%
PSYCHIATRY	\$ 1,099	0%	0%	0%	-10%	-10%
PULMONARY DISEASE	\$ 1,691	-1%	0%	-1%	-10%	-11%
RADIATION ONCOLOGY	\$ 1,612	0%	0%	0%	-10%	-10%

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Specialty	Allowed charges (mil)	Impact of work and PE RVU changes*	Impact of DRA 5102	Combined impact RVU and DRA 5102**	CY 2008 update	Combined impact with CY 2008 update**
RADIOLOGY	\$ 5,245	0%	0%	0%	-10%	-10%
RHEUMATOLOGY	\$ 494	-1%	0%	-1%	-10%	-11%
THORACIC SURGERY	\$ 436	-2%	0%	-2%	-10%	-12%
UROLOGY	\$ 2,033	-1%	0%	-1%	-10%	-11%
VASCULAR SURGERY	\$ 641	-1%	-1%	-1%	-10%	-11%
AUDIOLOGIST	\$ 31	12%	0%	12%	-10%	2%
CHIROPRACTOR	\$ 725	-2%	0%	-2%	-10%	-12%
CLINICAL PSYCHOLOGIST	\$ 531	-3%	0%	-3%	-10%	-13%
CLINICAL SOCIAL WORKER	\$ 354	-3%	0%	-3%	-10%	-13%
NURSE ANESTHETIST	\$ 608	22%	0%	22%	-10%	12%
NURSE PRACTITIONER	\$ 796	2%	0%	2%	-10%	-8%
OPTOMETRY	\$ 790	4%	0%	4%	-10%	-6%
ORAL/MAXILLOFACIAL SURGERY	\$ 37	1%	0%	1%	-10%	-9%
PHYSICAL/OCCUPATIONAL THERAPY	\$ 1,391	1%	0%	1%	-10%	-9%
PHYSICIAN ASSISTANT	\$ 600	0%	0%	0%	-10%	-10%
PODIATRY	\$ 1,575	2%	0%	2%	-10%	-8%
DIAGNOSTIC TESTING FACILITY	\$ 1,191	0%	0%	0%	-10%	-10%
INDEPENDENT LABORATORY	\$ 1,087	3%	0%	3%	-10%	-7%
PORTABLE X-RAY SUPPLIER	\$ 81	2%	0%	2%	-10%	-8%

*PE changes are CY 2008 second-year transition changes. For fully implemented CY 2010 PE changes see Table 1.

**Components may not sum to total due to rounding.