Updated 2011 CMS Policies: Incentive Payments, GPCI Revisions, Multiple Procedure Payment Reductions for Therapy, and Modification of Multiple Procedure Payment Policy for Advanced Imaging Services

Elimination of Deductible and Coinsurance for Most Preventive Services

Effective January 1, 2011, the Affordable Care Act waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services.

Note: I covered this in my post here and it's pretty straightforward.

Coverage of Annual Wellness Visit (AWV) Providing a Personalized Prevention Plan

The Affordable Care Act extends the preventive focus of Medicare coverage, which currently pays for a one-time initial preventive physical examination (IPPE or the "Welcome to

Medicare Visit”), to provide coverage for annual wellness visits in which beneficiaries will receive personalized prevention plan services (PPPS). The law states that the AWV will include at least the following six elements, as determined by the Secretary of Health and Human Services:

- Establish or update the individual’s medical and family history;
- List the individual’s current medical providers and suppliers and all prescribed medications;
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements;
- Detect any cognitive impairment
- Establish or update a screening schedule for the next 5 to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient’s risk factors; and
- Furnish personalized health advice and appropriate referrals to health education or education or preventive services.

CMS has developed two separate Level II HCPCS codes for the first annual wellness visit (G0438 – Annual wellness visit, including personalized prevention plan services, first visit), to be paid at the rate of a level 4 office visit for a new patient (similar to the IPPE), and for subsequent annual wellness visits (G0439 – Annual wellness visit, including personalized prevention plan services, subsequent visit), to be paid at the rate of a level 4 office visit for an established patient.

Note: Payment for annual wellness visits (AWV) is now covered by Medicare and the payment will be equivalent to a established level 4 visit. I’ve received a lot of questions about who can perform the PPPS and CMS says “A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed

practitioner) or a team of such medical professionals, working under the direct supervision of a physician."

An evaluation and management code (EM) may be billed with the annual wellness visit if the EM service is medically necessary. If so, a modifier 25 must be appended to the EM service and the documentation for the EM service must have no components of the annual wellness visit used in determining the level of service for the EM visit. A separate note containing the history, exam and medical decision making, relative to the presenting problem, must be separately documented.

Incentive Payments to Primary Care Practitioners for Primary Care Services

The Affordable Care Act provides for incentive payments equal to 10 percent of a primary care practitioner's allowed charges for primary care services under Part B, furnished on or after January 1, 2011, and before January 1, 2016. Under the final policy, primary care practitioners are: (1) physicians who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner's Medicare Physician Fee Schedule (MPFS) allowed charges for a prior period as determined by the Secretary of Health and Human Services.

The law also defines primary care services as limited to new and established patient office or other outpatient visits (CPT codes 99201 through 99215); nursing facility care visits, and domiciliary, rest home, or home care plan oversight services (CPT codes 99304 through 99340); and patient home visits (CPT codes 99341 through 99350).

In the final rule with comment period, CMS excluded consideration of allowed charges for hospital inpatient care and emergency department visits in determining whether the 60 percent primary care threshold is met. These exclusions will make it easier for practitioners of eligible specialties to become eligible for the payment incentive program. The incentive payments will be made quarterly based on the primary care services furnished in CY 2011 by the primary care practitioner, in addition to any physician bonus payments for services furnished in Health Professional Shortage Areas (HPSAs). CMS will determine a practitioner's eligibility for incentive payments in CY 2011 using claims data and the provider's specialty designation from CY 2009 for practitioners enrolled in CY 2009. For newly enrolled practitioners, CMS will use claims data from CY 2010 to make an eligibility determination regarding CY 2011 incentive payments. For subsequent years, CMS will revise the list of primary care practitioners on a yearly basis, based on updated data regarding an individual's specialty designation and percentage of allowed charges for primary care services.

Note: There is nothing to count or report: the bonuses arrive quarterly. Providers in HPSAs will receive two bonuses. Want to know if you're in a HPSA? Click here.

Incentive Payments for Major Surgical Procedures in Health Professional Shortage Areas

The Affordable Care Act also calls for a payment incentive program to improve access to major surgical procedures "" defined as those with a 10-day or 90-day global period under the MPFS "" that are furnished by physicians in HPSAs on or after January 1, 2011, and before January 1, 2016. To be

eligible for the incentive payment, the physician must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the MPFS payment for the surgical services furnished by the general surgeon. The incentive payments will be made quarterly to the general surgeon when the major surgical procedure is furnished in a zip code that is located in a HPSA. CMS will use the same list of HPSAs that it has used under the existing HPSA bonus program.

Note: 10% bonus for general surgeons in HPSAs. Want to know if you're in a HPSA? Click here.

Revisions to the Practice Expense Geographic Adjustment

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice insurance cost components of each of more than 7,000 types of physicians' services. The final rule with comment period discusses CMS' analysis of PE GPCI data and methods, and incorporates new data as part of the sixth GPCI update, while maintaining the current GPCI cost share weights pending the results of further CMS and Institute of Medicine studies.

The Affordable Care Act establishes a permanent 1.0 floor for the PE GPCI for frontier states (currently, Montana, Wyoming, Nevada, North Dakota, and South Dakota). The Affordable Care Act limits recognition of local differences in employee wages and office rents in the PE GPCIs for CYs 2011 and 2012 as compared to the national average. Localities are held harmless for any decrease in CYs 2011 and 2012 in their PE GPCIs that would result from the limited recognition of cost differences. CMS will continue to review the GPCIs in CY 2011, in

accordance with the Affordable Care Act provision that requires the Secretary of Health and Human Services to analyze current methods of establishing PE GPCIs in order to make adjustments that fairly and reliably distinguish the costs of operating a medical practice in the different fee schedule areas.

Note: Check your GPCI (pronounced "gypsy") for changes this year and every year. The GPCI changes the RVU values so they are specific to your location.

Where do I find my GPCI? Click here, click on Physician Fee Schedule Search at the top, click to accept the AMA terms, click on Geographic Practice Cost Index, enter your locality and click submit.

Improved Access to Certified Nurse-Midwife Services

The Affordable Care Act increases the Medicare payment for certified nurse-midwife services from 65 percent of the PFS amount for the same service furnished by a physician to 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less). The increased payment amount is effective for services furnished on or after Jan. 1, 2011.

Misvalued Codes under the Physician Fee Schedule

The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. The final rule with comment period identifies additional categories of services that may be misvalued,

including codes with low work RVUs commonly billed in multiple units per single encounter and codes with high volume and low work RVUs. The final rule also includes CMS' response to recommendations from the American Medical Association (AMA) Relative Value Update Committee (RUC) for CY 2011 regarding the work or direct practice expense inputs for 325 CPT codes.

Note: People and organizations are always lobbying to change the work or practice expense component of RVUs and some portion of the codes change every year. Make sure your computer is updated with the correct RVU components and total so your productivity reports are spot on.

Multiple Procedure Payment Reduction Policy for Therapy Services

The Affordable Care Act requires CMS to identify and make adjustments to the relative values for multiple services that are frequently billed together when a comprehensive service is furnished. CMS is adopting a multiple procedure payment reduction (MPPR) policy for therapy services in order to more appropriately recognize the efficiencies when combinations of therapy services are furnished together. The policy, as described in the CY 2011 MPFS final rule with comment period, states that the MPPR for "always" therapy services will reduce by 25 percent the payment for the practice expense component of the second and subsequent therapy services furnished by a single provider to a beneficiary on a single date of service. This policy will apply to all outpatient therapy services paid under Part B, including those furnished in office and facility settings.

Since publication of the CY 2011 MPFS final rule with comment period, this policy has been modified by the Physician Payment and Therapy Relief Act of 2010. Per this Act, CMS will apply the CY 2011 MPFS final rule policy of a 25 percent MPPR to

therapy services furnished in the hospital outpatient department and other facility settings that are paid under section 1834(k) of the Social Security Act (referring to durable medical equipment), and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 (payments to physicians) of the Act.

Note: The reduction applies solely to the practice expense (PE) portion of the fee schedule payment for "Always Therapy Services" when more than one service is provided the same patient on the same day. "Always therapy" services are always considered to be therapy regardless who provides the service (qualified therapist, physician, non-physician practitioner (NPP)). This is the list of services being referred to:

- 92506""Speech /hearing evaluation
- 92507""Speech/hearing therapy
- 92508""Speech/hearing therapy
- 92526""Oral function therapy
- 92597""Oral speech device evaluation
- 92604""Exam for speech device
- 92609""Use of speech device service
- 96125""Standardized cognitive performance test
- 97001""PT evaluation
- 97002""PT re-evaluation
- 97003""OT evaluation
- 97001""OT re-evaluation
- 97012""Mechanical traction
- 97016""Vasopneumatic device
- 97018""Paraffin bath
- 97022""Whirlpool
- 97024""Diathermy (microwave)
- 97026""Infrared
- 97028""Ultraviolet
- 97032""Electrical stimulation
- 97033""Electric current

- 97034””Contrast bath
- 97035””Ultrasound
- 97036””Hydrotherapy
- 97110””Therapeutic exercise
- 97112””Neuromuscular reeducation
- 97113””Aquatic therapy
- 97116””Gait training
- 97124””Massage
- 97140””Manual therapy
- 97150””Group therapeutic
- 97530””Therapeutic activities
- 97533””Sensory integration
- 97535””Self-care management
- 97537””Community work reintegration
- 97542””Wheelchair management
- 97750””Physical performance test
- 97755””Assistive technology assessment
- 97760””Orthotic management & training
- 97761””Prosthetic training
- 97762””Checkout for orthotic or prosthetic use
- G0281””Electrical stimulation for ulcers (unattended)
- G0283””Electrical stimulation other than wound (unattended)
- G0329””Electromagnetic therapy for ulcers

Modification of Equipment Utilization Factor and Modification of Multiple Procedure Payment Policy for Advanced Imaging Services

The Affordable Care Act adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition,

beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

Note: These are the services that were added by this policy:

- 70496-CT angiography, head
- 70498-CT angiography, neck
- 70544-MR angiography head w/o dye
- 70545-MR angiography head w/dye
- 70546-MR angiography head w/o & w/dye
- 70547-MR angiography neck w/o dye
- 70548-MR angiography neck w/dye
- 70549-MR angiography neck w/o & w/dye
- 71275-CT angiography, chest
- 71555- MRI angiography chest w/ or w/o dye
- 72159-MRI angiography spine w/o & w/dye
- 72191-CT angiography, pelvis w/o & w/ dye
- 72198-MRI angiography pelvis w/ or w/o dye
- 73206-CT angio upper extremity w/o & w/dye
- 73225-MR angio upper extremity w/o & w/dye
- 73706-CT angiography lower ext w/o & w/dye
- 73725-MR angio lower extremity w or w/o dye
- 74175-CT angiography, abdomen w/o & w/ dye
- 74185-MRI angiography, abdomen w/ or w/o dye
- 75565-Cardiology MRI velocity flow map add-on
- 75574-CT angiography heart w/3d image
- 75635-CT angiography abdominal arteries
- 76380-CAT scan follow-up study
- 77079-CT bone density, peripheral

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