



AMA Analysis: 2012 Medicare Physician Payment Schedule Final Rule

The 1,235 page [final rule](#) contains far more information on 2012 payment policies than can be covered in this brief analysis. The AMA analysis primarily focuses on the CMS response to key points raised in the AMA's [comment letter](#) on the proposed rule.

Sustainable Growth Rate (SGR): On Nov. 1, 2011, the Centers for Medicare & Medicaid Services (CMS) released the 2012 Medicare physician payment schedule final rule, which indicates that, absent congressional action, payments will be cut by 27.4 percent on Jan. 1, 2012, instead of 29.5 percent as stated in the proposed rule. There are several reasons for this change. The 2012 cut represents accumulated cuts over a number of years that have piled up one upon the other as Congress has passed short-term SGR patches. The 2012 component of the total cut was projected to be -6.1 percent but dropped in the final rule to -3.3 percent. The difference is due to reduced 2010 SGR spending per enrollee, which CMS projected would increase 5.5 percent, but actually grew 4.2 percent. In addition, the Medicare Economic Index (MEI) grew 0.6 percent instead of the projected 0.3 percent, and there was a positive 0.2 percent budget neutrality adjustment due to the RVS Update Committee's (RUC) work on misvalued codes.

In a [statement](#) accompanying the rule's release, HHS Secretary Kathleen Sebelius referred to physicians as "the backbone of our health care system" and said the "Obama Administration is 100 percent committed to fixing the flawed Medicare payment system and protecting Medicare beneficiaries' access to doctors." She called on Congress to pass legislation permanently reforming the SGR and said "we pledge to work with legislators on both sides of the aisle to address this issue once and for all. The pattern of threatened SGR cuts and last-minute Congressional rescues is in itself not a sustainable solution and must be remedied."

E-prescribing: CMS finalized its proposal for the 2012 and 2013 incentive and 2013 and 2014 penalty programs. Despite continued AMA opposition, as with the 2012 penalty physicians will need to report 10 times during the first six months of 2012 and 2013 to avoid application of e-prescribing penalties in subsequent years. Improvements to the program which the AMA supported include allowing the use of a certified electronic health record (EHR) to e-prescribe and making it easier to avoid the penalties by (1) not requiring physicians to link the e-prescribing codes to qualifying visits and (2) allowing physicians to apply for hardship exemptions online.

RUC: In a significant accomplishment, the RUC persuaded CMS that the resources involved in hospital observation care visits and hospital inpatient visits are equivalent. CMS also accepted 87 percent of the RUC's 252 recommendations for the 2012 Medicare payment schedule for new and revised codes and those that had been considered potentially misvalued, and 75 percent of the RUC's 290 recommendations for the 4th Five-Year Review. The Five-Year Review acceptance rate would have been 90 percent if CMS had not largely ignored its refinement panels' recommendations, designed to provide commenters with an appeals process. CMS decides on the composition of these panels, administers their meeting and has historically accepted their recommendations, but CMS only accepted 1/3 of the refinement panel recommendations for 2012, which were largely supportive of the original RUC recommendations.

The RUC had recommended that CMS begin paying for telephone calls, anticoagulant management, team conferences, and patient education in 2012. CMS did not announce any plans to consider payment for these services, but emphasized that the agency will continue to work with stakeholders to ensure that care coordination and primary care services are appropriately recognized. CMS agreed with the AMA, RUC, and specialties that a re-review of 91 Evaluation and Management services would not be productive at this time. CMS also had asked the RUC to provide resource cost data for a new system of more than 100 CPT codes for molecular pathology, but CMS is not prepared to implement these codes in 2012.

Physician Quality Reporting System (PQRS): In response to AMA advocacy, 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. Despite strong opposition from the physician community, 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.

Value Modifier: While acknowledging the strong opposition of most commenters (including the AMA), CMS finalized its proposal to base payment adjustments in 2015 on how an as-yet-unidentified subset of physicians perform in 2013 on a set of cost and quality measures that are still not fully determined using a methodology that will be finalized in November 2012. Quality measures for the modifiers will be based on PQRS and EHR measure sets but as noted in the rule, the measures will be updated in 2013 and could change somewhat at that time. Cost measures to be used in the modifier will be based on average total per capita cost for the physician's patients and per capita cost for four conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease and diabetes). In defense of its decision to use 2013 as the base year, the agency says that if physicians start participating in PQRS and EHR reporting now, they will have two years to get ready for value-based reporting. It also says that it is not logistically possible to base the modifier on performance in 2014 or 2015.

Multiple Procedure Cuts: In response to comments from the AMA, the RUC and many specialties, CMS scaled back its proposal to apply a 50 percent reduction to the professional component of all but the highest valued code when more than one procedure on a list of 119 imaging services is performed on the same patient on the same day. CMS did not agree with comments that across-the-board multiple procedure cuts are inappropriate because the degree of overlapping work associated with these cases varies from service to service. However, the agency did concede that its own further analysis did not support a 50 percent cut and the final rule limits the multiple procedure payment reduction on 119 CT, MRI, MRA and ultrasound codes to 25 percent.

Geographic Practice Cost Indexes (GPCIs): CMS finalized proposed changes to the GPCIs with only minor revisions. Citing the lengthy process that would be needed to collect physician office rent information, it did not adopt the AMA recommendation to develop these data and will continue to use apartment rental data as a proxy for physician office rents. CMS promised to provide detailed impacts of the GPCI changes on its website in response to the AMA request.

Lab Test Signatures: CMS has retracted the requirement for physicians to sign lab requisitions, a policy change the AMA strongly and successfully opposed. The rule marks the final step in the agency's retreat from this mandate, which began with postponing implementation from Jan. to April 2011 and then agreeing not to enforce it. CMS has now reinstated its previous policy that physician signatures are not required on requisitions for Clinical Lab Fee Schedule services.

Annual Wellness Visit (AWV): CMS is increasing the relative values for the AWV codes to recognize additional resources associated with adding a health risk assessment to the service's requirements, but is continuing its policy of not covering a physical exam as part of these services.

Impact table: Specialty impacts for 2012 are displayed in Table 84 of the rule, reprinted below. Table 84 does not show the impact of the -27.4 percent SGR cut. Major policy changes for which impacts are displayed in the table are:

- the third year of a four-year transition to revised practice expense values, with the “Tran” column showing the 2012 impact and the “Full” column showing the total impact over the remaining years of the transition;
- a secondary effect of reweighting relative value scale components to match the MEI weights which occurred last year and involves reallocating 2012 indirect practice expenses;
- multiple procedure reductions for 119 imaging services which redistributes \$50 million; and
- RUC recommendations related to identification and review of misvalued work and practice expense relative values, redistributing more than \$200 million within the payment schedule.

TABLE 84: CY 2012 PFS FINAL RULE WITH COMMENT PERIOD TOTAL ALLOWED CHARGE ESTIMATED IMPACT FOR RVU AND MPPR CHANGES*

(A) Specialty	(B) Allowed Charges (in millions)	(C) Impact of Work and MP RVU Changes	(D) Impact of PE RVU Changes		(F) Combined Impact		(G)
			Full	Tran	Full	Tran	
TOTAL	\$83,313	0%	0%	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	\$196	0%	-1%	-1%	-1%	-1%	-1%
ANESTHESIOLOGY	\$1,756	0%	2%	1%	2%	1%	
CARDIAC SURGERY	\$386	0%	-2%	-2%	-3%	-2%	
CARDIOLOGY	\$6,808	0%	-3%	-1%	-3%	-2%	
COLON AND RECTAL SURGERY	\$147	0%	3%	2%	3%	1%	
CRITICAL CARE	\$255	0%	0%	0%	0%	-1%	
DERMATOLOGY	\$2,950	0%	1%	1%	1%	1%	
EMERGENCY MEDICINE	\$2,677	0%	-1%	-1%	0%	-1%	
ENDOCRINOLOGY	\$416	0%	2%	1%	2%	1%	
FAMILY PRACTICE	\$5,689	0%	2%	1%	2%	1%	
GASTROENTEROLOGY	\$1,852	0%	1%	0%	1%	0%	
GENERAL PRACTICE	\$655	0%	2%	1%	2%	1%	
GENERAL SURGERY	\$2,285	0%	1%	0%	1%	0%	
GERIATRICS	\$203	0%	2%	1%	3%	1%	
HAND SURGERY	\$123	0%	2%	1%	2%	1%	
HEMATOLOGY/ONCOLOGY	\$1,922	0%	-1%	0%	-1%	0%	
INFECTIOUS DISEASE	\$601	0%	2%	1%	2%	1%	
INTERNAL MEDICINE	\$10,826	0%	2%	1%	2%	1%	
INTERVENTIONAL PAIN MGMT	\$450	-2%	0%	0%	-1%	-2%	
INTERVENTIONAL RADIOLOGY	\$208	-1%	-3%	-1%	-4%	-2%	
MULTISPECIALTY CLINIC/OTHER	\$91	1%	0%	0%	1%	1%	
NEPHROLOGY	\$2,022	0%	0%	0%	0%	0%	
NEUROLOGY	\$1,533	0%	3%	2%	3%	1%	
NEUROSURGERY	\$650	-1%	0%	0%	-1%	-1%	
NUCLEAR MEDICINE	\$54	0%	-3%	-1%	-3%	-1%	
OBSTETRICS/GYNECOLOGY	\$679	0%	1%	1%	1%	1%	
OPHTHALMOLOGY	\$5,328	0%	3%	2%	3%	1%	
ORTHOPEDIC SURGERY	\$3,584	-1%	0%	0%	0%	-1%	
OTOLARNGOLOGY	\$1,003	0%	2%	1%	2%	1%	
PATHOLOGY	\$1,129	0%	-2%	-1%	-2%	-1%	
PEDIATRICS	\$68	0%	1%	0%	1%	0%	
PHYSICAL MEDICINE	\$933	0%	2%	1%	2%	1%	
PLASTIC SURGERY	\$343	0%	2%	1%	1%	0%	
PSYCHIATRY	\$1,154	0%	0%	0%	0%	0%	
PULMONARY DISEASE	\$1,769	-1%	-1%	-1%	-1%	-2%	
RADIATION ONCOLOGY	\$1,981	0%	-10%	-6%	-10%	-6%	
RADIOLOGY	\$4,716	-1%	-4%	-2%	-5%	-3%	
RHEUMATOLOGY	\$528	0%	-1%	0%	-1%	-1%	

(A) Specialty	(B) Allowed Charges (in millions)	(C) Impact of Work and MP RVU Changes	(D) Impact of PE RVU Changes		(E) Combined Impact	
			Full	Tran	Full	Tran
THORACIC SURGERY	\$369	-1%	-2%	-1%	-3%	-2%
UROLOGY	\$1,925	0%	-3%	-2%	-3%	-2%
VASCULAR SURGERY	\$745	0%	-2%	-1%	-2%	-1%
AUDIOLOGIST	\$57	1%	-8%	-5%	-7%	-4%
CHIROPRACTOR	\$752	0%	2%	2%	2%	2%
CLINICAL PSYCHOLOGIST	\$567	0%	-5%	-3%	-5%	-3%
CLINICAL SOCIAL WORKER	\$394	0%	-6%	-3%	-6%	-3%
DIAGNOSTIC TESTING FACILITY	\$839	0%	-8%	-3%	-8%	-3%
INDEPENDENT LABORATORY	\$1,057	0%	-3%	-1%	-3%	-1%
NURSE ANES / ANES ASST	\$738	0%	3%	2%	3%	2%
NURSE PRACTITIONER	\$1,385	0%	2%	1%	2%	1%
OPTOMETRY	\$990	0%	4%	2%	4%	2%
ORAL/MAXILLOFACIAL SURGERY	\$44	0%	3%	2%	3%	2%
PHYSICAL/OCCUPATIONAL THERA	\$2,349	0%	6%	4%	6%	4%
PHYSICIAN ASSISTANT	\$1,021	0%	1%	0%	1%	0%
PODIATRY	\$1,921	0%	4%	2%	4%	2%
PORTABLE X-RAY SUPPLIER	\$99	0%	5%	4%	5%	4%
RADIATION THERAPY CENTERS	\$74	0%	-11%	-6%	-11%	-6%
OTHER	\$18	0%	3%	3%	3%	3%

* Table 84 shows only the payment impact on PFS services. We note that these impacts do not include the effects of the January 2012 conversion factor change under current law.