Proposed 2011 Medicare Physician Fee Schedule Analysis
Exclusively for MGMA Members

The Centers for Medicare & Medicaid Services (CMS) published the proposed 2011 Medicare fee schedule for physician services in the Federal Register on July 13. The proposed regulation discusses polices that, if included in the 2011 Medicare final physician fee schedule, would affect Part B payment policies for services furnished on or after Jan.1, 2011. It also implements several provisions from the recently enacted Patient Protection and Affordable Care Act (PPACA) as well as the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. CMS also published an impact chart detailing the effects of the rule on each medical specialty and a table showing the effect of the proposed rule on selected HCPCS* codes. Below is the Medical Group Management Association's (MGMA's) analysis of the proposed fee schedule. We will submit extensive comments to CMS by Aug. 24, which will then be made available to members.

Medicare physician reimbursement

In addition to the approximate 23 percent Medicare physician payment cut scheduled to occur Dec. 1, 2010, the proposed regulation includes provisions that would reduce 2011 Medicare payments by approximately 6.1 percent as a result of the sustainable growth rate (SGR) formula.

The regulation forecasts the 2011 Medicare Economic Index (MEI) to be 0.3. The MEI is a measurement of medical practice cost increases originally based on 1973 data. In the 2011 proposed regulation, CMS discusses the need to *rebase* (moving the base year for the structure of costs of an input price index) and *revise* (change in data source and cost categories) the MEI. CMS last rebased the MEI in 2004 to include 2000 data. In the 2011 regulation, CMS proposes to again rebase the MEI, this time to include 2006 data from the national Physician Practice Information Survey (PPIS) conducted by the American Medical Association (AMA) and more than 70 other medical specialty societies. Furthermore, CMS proposes revising the cost categories used to determine the MEI by expanding the office expense category into nine detailed categories. Finally, CMS discusses convening a technical advisory panel later this year to review all aspects of the MEI, including the inputs, input weights, price measurement proxies, and productivity adjustment.

As part of the proposed rebasing, CMS would establish new relative weights for physician work, PE, and malpractice under the MEI. The agency proposes to increase PE RVUs by an adjustment factor of 1.168 and malpractice RVUs by an adjustment factor of 1.413. Citing the need for stability in work RVUs (for example for use in physician compensation systems), CMS proposes to no adjustments to work RVUs. Instead, to offset the increased weights to PE and malpractice, CMS proposes to reduce the 2011 conversion factor by approximately 8 percent to achieve budget neutrality as required by law. The practical effect of this change would be increases to payments for services with higher relative practice expense values and decreases to services with higher relative work values.

As a result of the SGR cuts as well as the rebased and revised MEI, CMS estimates that, unless Congress enacts legislation to address it, the CY 2011 Medicare conversion factor will be $26.6574. MGMA members should refer to the impact chart in Table 73, to determine how these proposed changes would affect specific medical specialties.

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Practice Expense (PE) Relative Value Units (RVUs)

For the 2010 Medicare Physician Fee Schedule, CMS began using different PE/hour data to calculate the PE RVUs for most specialties. The new data, from the Physician Practice Information Survey (PPIS), resulted in significant increases and decreases to the PE values for many codes. Due to these considerable changes, CMS decided to use a four-year transition to implement the values from the new data source. 2011 is the second year of this transition, and represents a 50/50 blend of the PPIS data, data from the Socioeconomic Monitoring Survey (SMS) and supplemental survey data. The four-year data source transition will be complete in 2013. Although the overall impact is budget neutral, this change results in a payment shift among medical specialties.

CMS proposes changes related to direct PE inputs for biohazard bags, certain diagnostic tests, Cobalt-57 flood source, venom immunology, and electrocardiograms (ECGs). CMS proposes to accept five recommendations, one with slight modification, made by the American Medical Association (AMA) Specialty Society Relative (Value) Update Committee (RUC) for changes related to direct PE inputs for certain codes. In order to confirm that certain high-cost supplies are currently used in the typical cases described by two CPT codes, CMS requests that the AMA RUC review the inclusion of these supplies as inputs for the PE of these services.

CMS proposes to establish a more transparent and regular process for considering public requests to change PE database price inputs for equipment and supplies used in existing codes. The agency proposes to use the Medicare Physician Fee Schedule as the vehicle for considering and making these changes. Requests would be accepted on an ongoing basis throughout the year, and would be reviewed in the next proposed fee schedule following the year of submission. For example, all requests collected no later than December 31, 2010 would be included in the proposed and final 2012 fee schedules. CMS requests feedback on determining the specific information the requesting-party should be required to furnish for the review.

Geographic practice cost indices

CMS is required by law to develop separate geographic practice cost indices (GPCIs) to measure resource cost differences among geographic localities compared to the national average for the work, practice expense, and malpractice components of the fee schedule. The Agency must update GPCIs every three years. The 2011 proposed and updated GPCI values reflect CMS' sixth review of the GPCIs.

Since PPACA only extended the GPCI work floor through the end of 2010, the 2011 proposed fee schedule does not reflect the 1.0 GPCI work floor. However, as a result of MIPPA, the GPCI work floor for Alaska is permanently set to 1.5.

PPACA established a permanent, non-budget neutral practice expense GPCI floor of 1.0 for “frontier states”, which are defined as having at least 50 percent of the state's counties' population density of less than six people per square mile. In the 2011 proposed regulation, CMS calculates that this provision applies to Montana, Wyoming, North Dakota, Nevada and South Dakota.

The proposed regulation also discusses implementation of the PPACA provision requiring that the employee wage and rent portions of the practice expense GPCI reflect only one-half of the

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relative cost differences for each locality compared to the national average for 2010 and 2011, with a “hold harmless” exception for localities that otherwise would receive a reduction to its practice expense GPCI as a result.

PPACA required the Department of Health and Human Services (HHS) to analyze current methods of establishing practice expense GPCIs and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in different localities. Though this analysis and its revisions are due in 2012, CMS instead incorporates this analysis into the proposed 2011 GPCI figures.

Addendum D on page 605 contains the proposed 2011 Geographic Adjustment Factors and addendum E on page 608 contains the proposed 2011 GPCIs by state and Medicare locality.

Equipment utilization rate

CMS proposes to implement a provision of PPACA requiring the equipment utilization rate for expensive diagnostic equipment to be set at 75 percent. The utilization assumption is used to calculate the practice expense RVUs in the technical component payment. Through 2009, the utilization assumption for MRI and CT was set at 50 percent. In 2010, CMS increased the assumption to 90 percent, to be phased in over four years. Beginning Jan. 1, 2011, CMS will set the equipment utilization assumption for these same services (spelled out by CPT code) at 75 percent and proposes to also apply the higher utilization rate to 24 additional codes, which are predominantly diagnostic computed tomographic angiography (CTA) and magnetic resonance angiography (MRA) procedures that include a CT or MRI room in their direct practice expense inputs. As mandated by PPACA, this change is not budget neutral, meaning that the savings associated with this change will not remain in the Medicare Part B payment pool.

Malpractice Relative Value Units (RVUs)

Malpractice RVUs, a component of payment under the physician fee schedule, are reviewed every five years. The first review occurred in the CY 2005 proposed physician fee schedule and the second occurred in the CY 2010 proposed physician fee schedule. For new and revised codes that become effective before the next five-year review, malpractice RVUs are determined based on a direct or modified (adjusting for differences in work) crosswalk to “source” codes. CMS proposes to now publish a list of new/revised codes and the analytic crosswalk(s) used for determining their malpractice RVUs in the final rule. The malpractice RVUs would be implemented as interim final values, subject to public comment and finalized in the next year’ s final rule. CMS also proposes to update the risk factor used to assign malpractice RVUs for selected disc arthroplasty services.

Codes with site-of-service-anomalies

CMS previously requested that the AMA RUC address changes to 40 codes to account for changes in the typical site of service since the original valuation of the code. CMS has ongoing concerns about the methodology used by the AMA RUC, preferring instead a “reverse building block methodology” for these codes. In general, the reverse building block methodology produces a lower value than the AMA RUC-recommended value. For CY 2011, CMS requests that the AMA RUC review the 40 codes and recommend an appropriate RVU value wherever the application of the reverse building block methodology produces an aberrant result. If the reverse building block methodology produces a result consistent with physician work, CMS asks

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the AMA RUC to confirm the values and recommend them for CY 2011. Instances in which the AMA RUC recommends values that are not consistent with the reverse building block methodology and not appropriate relative to other services, CMS proposes to adopt the reverse building block methodology for CY 2011.

Codes with "23-hour" stays

CMS proposes to modify its approach for addressing services that are typically performed in the outpatient setting and that require a hospital stay of less than 24 hours. CMS suggests a new method for the AMA RUC to review new and potentially misvalued codes that are identified as 23-hour stay services, and encourages the AMA RUC to apply the recommended methodology, assessing the RVUs to ensure appropriate relativity to other codes in the system.

Expanding the multiple procedure payment reduction policy to additional nonsurgical Services

Beginning on July 1, PPACA required CMS to increase the multiple procedure payment reduction for the technical component (TC) of imaging procedures from 25 percent to 50 percent. Previous CMS policy has reduced the TC payment by 25 percent for the second and subsequent imaging procedures performed on the same patient on contiguous body parts within 11 families of codes based on modality and body region. CMS proposes to increase the reduction to 50 percent, as mandated by PPACA, and to expand the services subject to the reduction. Under the proposal, CMS would reduce the TC payment on the second and subsequent procedures for all CT and CTA, MRI and MRA, and ultrasound services regardless of modality or body part. Increased savings due to the expansion of services affected would remain in the general Part B physician payment pool, however savings resulting from the increased reduction in the TC payment from 25 percent to 50 percent would not.

Therapy Services

CMS proposes extending the multiple procedure payment reduction policy to therapy services. Effective Jan. 1, 2011, CMS proposes to implement a 50% payment reduction to the PE component of second and subsequent therapy services for multiple "always therapy" services furnished to a single patient on the same day. The proposal defines "always therapy" services as services that are only paid by Medicare when furnished under a therapy plan of care. If enacted, this proposal would authorize a full payment for the service with the highest PE and then reduce the payment for the second and subsequent service by 50%. This proposal applies to services paid under the 2011 Physician Fee Schedule that are furnished in the office setting, outpatient hospital, home health agencies, comprehensive outpatient rehabilitation facilities (CORFs) and other entities paid by Medicare for outpatient therapy services.

End Stage Renal Disease (ESRD)

Under the Medicare Modernization Act (MMA), a drug payment add-on to the composite rate is required for changes in the drug payment method. CMS must update this add-on every year to reflect estimated growth in expenditures for these drugs and biologicals. For 2011, CMS proposes the drug add-on payment of $20.33, which is the same rate that was established in 2008.

In 2004, CMS developed Level II HCPCS G-codes for ESRD monthly capitation payment (MCP) services. Beginning Jan. 1, 2011, CMS proposes to require at least one in-person patient visit

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by an MCP physician for home dialysis MCP services.

Telehealth Services

For CY2011, CMS proposes to add the following services to the list of Medicare telehealth services:

- Individual and group Kidney Disease Patient Education (KDE) Services;
- Individual and group Diabetes Self-Management Training (DSMT) services, with a minimum of one hour of in-person instruction to be furnished in the year following the initial DSMT service;
- Group Medical Nutrition Therapy (MNT) and health and behavioral assessment and intervention (HBAI) services
- Subsequent hospital care services, with the limitation for the patient's admitting practitioner of one telehealth visit every three days; and
- Subsequent nursing facility care services, with the limitation for the patien's admitting practitioner of one telehealth visit every 30 days.

Value-Based Payment Modifier and the Physician Resource Use and Measurement Reporting Program

PPACA required CMS to develop a value-based payment (VBP) modifier under the physician fee schedule. This modifier will provide differential payments to physicians or groups of physicians based on the quality of care furnished compared to the cost of care during a performance period. Before 2012, the Department of Health and Human Services (HHS) must publish the quality and cost measures, the implementation dates and the initial performance period associated with a new Part B VBP payment modifier. This modifier will affect payments in 2015 based off 2014 performance data.

In the 2011 proposed physician fee schedule, CMS proposes to build upon the existing Physician Resource Use and Measurement Reporting Program to eventually implement the VBP modifier. The goal of the Physician Resource Use Measurement and Reporting Program is to assess efficiency and furnish providers with a confidential feedback report comparing their resource use with that of their peers.

Phase II of the resource use program is slated to begin in the fall of 2010 and will initially focus on five common chronic diseases: diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and prostate cancer. CMS will provide confidential feedback reports to approximately 40 medical groups and 2000 individual physicians.

In previous fee schedules, CMS discussed incorporating PQRI data into the resource use reports however in this proposal, CMS discusses the use of claims-based measures it developed concerning the Generating Medicare Physician Quality Performance Measurement Results (GEM) project, which is a set of 12 process measures calculated using only administrative claims data. However, CMS discusses the possibility of linking this program to the HITECH incentive program for meaningful use of electronic health records and/or to the group practice reporting option in PQRI.

As suggested by MGMA, CMS proposes to discontinue utilizing commercially available proprietary episode grouping software since it is not designed for Medicare beneficiaries with multiple chronic conditions.

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Payment for bone density tests

PPACA requires that payment amounts for dual-energy x-ray absorptiometry services (identified as HCPCS codes 76075 and 76077 and any succeeding codes) for CY 2010 and CY 2011 be based on a formula that takes into account the 2006 RVUs and conversion factor. CMS proposes a method for imputing RVUs to effectuate this change.

Annual Wellness Visits

CMS proposes to implement provisions of PPACA, which entitle all Medicare beneficiaries to an initial wellness visit and subsequent wellness visits annually, beginning Jan. 1, 2011. These visits would involve a health risk assessment and development of a personalized prevention plan (PPA). The proposed PPA includes:

- Establishment of the individual's medical and family history;
- Establishment of a list of current providers and suppliers that are regularly providing medical care to the individual;
- Measurement of the individual's height, weight, body mass index, blood pressure, and other routine measurements as deemed appropriate;
- Detection of any cognitive impairment that the individual may have;
- Review of the individual's potential for depression;
- Review of the individual's functional ability and level of safety;
- Establishment of a written screening schedule, a list of risk factors for interventions, furnishing of personalized health advice, and any other elements determined appropriate by the Secretary of the Department of Health and Human Services through the National Coverage Determination process.

The agency also proposes definitions for each of the components to the PPA. CMS proposes the development of two new HCPCS codes, one for the initial and one for subsequent wellness visits, to provide for proper Medicare reporting and payment. Providers would continue to bill for the Initial Preventive Physical Exam (IPPE), which Medicare beneficiaries receive with in the first 12 months of Part B coverage. Beneficiaries would be eligible for this benefit if they have received Medicare benefits for 12 months and have not received an IPPE or annual wellness visit within the past 12 months.

Primary Care Incentives and General surgery in HPSA incentives

The 2011 proposed physician fee schedule implements provisions in PPACA that require incentive payments for certain primary care providers and general surgeons for 2011 through 2016.

Largely following the legislative language, the proposed regulation establishes a 10 percent payment incentive for primary care services furnished by physicians enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics or 38-geriatrics; or, in the case for non-physician practitioners, enrolled as 50-nurse practitioner, 89-certified clinical nurse specialist, or 97-physician assistant. Congress instructed the agency to make incentive payments on a monthly or quarterly basis and CMS will use historical claims data to satisfy the statutory requirement that the incentive payments are only for qualifying

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practices that charge at least 60 percent of their total annual allowed Medicare charges as office, nursing facility, or home visits.

CMS discusses its intent to monitor potential changes in the primary specialty designation of enrolled practitioners over time to detect anyone deceptively attempting to take advantage of these incentive payments. The proposed regulation would also implement a 10 percent payment incentive for general surgeons enrolled in Medicare with a primary specialty designation of 02-general surgery, furnishing major procedures (10-day or 90-day global service period) in a Health Professional Shortage Areas (HPSAs). The agency cites 489 surgical procedures in a 10-day global period and 3,796 surgical procedures in the 90-day global period that are eligible for this bonus and also clarifies that providers are eligible for both the HPSA incentive as well as the general surgery HPSA incentive.

Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services

In implementing a provision in PPACA, CMS proposes the details of the requirement that physicians who perform MRI, CT and PET services in their offices relying on the in-office ancillary services exception to the physician self-referral law disclose certain information to patients. Physicians must notify patients in writing at the time of referral that they have the right to receive these services from an entity other than the physician or his/her group practice and must also provide a list of alternative “suppliers” in the area.

CMS proposes to require that the list of alternative suppliers include 10 alternative suppliers within 25 miles of the physician's office at the time of the referral (an exception would apply to areas with fewer than 10 alternative suppliers within 25 miles). The term “suppliers” would be defined to mean “a physician or other practitioner, a facility, or other entity (other than a “provider” of services) that furnishes items or services under this title.” In other words, CMS proposes not to permit or require that the list include hospitals and critical access hospitals, among other facilities that have a “provider” designation under Medicare.

The new requirement would be limited to MRI, CT and PET services. CMS does not propose to expand this requirement to other radiology services, which it is empowered to do under PPACA, but solicits comments on whether it should do so. As documentation of compliance, the disclosure notification must include the patient's signature and be kept in the patient’s medical record as documentation of compliance.

The relevant section of PPACA included an effective date of Jan. 1, 2010, though it was unclear whether the government could enforce this requirement without first issuing a regulation implementing it. CMS indicates that it will not enforce the provision until a regulation has been finalized. Based on its proposal, the effective date of this provision is Jan. 1, 2011.

Maximum period for submission of Medicare claims reduced to not more than 12 months

CMS proposes to implement a provision of PPACA restricting the period of time in which providers can submit claims to Medicare for payment. PPACA required that Medicare claims be filed within one calendar year after the date of service. For services furnished in the last 3 months of 2009, claims must be filed before Dec. 31, 2010. The changes made by PPACA do not affect the law governing services before 2010. As a result, the following filing deadlines apply:

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- Services furnished in the first 9 months of calendar years before 2010 must be billed by Dec. 31 of the following year.
- Services furnished in the last 3 months of calendar years before 2010 (except 2009) must be billed by Dec. 31 of the second following year.

The statute gives CMS the authority to make exceptions to this requirement. CMS proposes to maintain the existing exception for claims where failure to meet the deadline was the result of an error or misrepresentation made by an employee or agent of HHS performing a Medicare function. It also proposes two new exceptions when a beneficiary receives notification that he/she is retroactively eligible for Medicare.

Physician Quality Reporting Initiative

The proposed rule makes two significant improvements to the 2011 Physician Quality Reporting Initiative (PQRI) that were specifically advocated for by MGMA. First, the agency proposes to reduce the PQRI reporting threshold for claims-based reporting from 80 percent to 50 percent. Second, CMS proposes creating an additional Group Practice Reporting Option (GPRO) for medical practices with two to 199 eligible professionals working together. Further details of this new option for medical groups, which CMS refers to as "GPRO II", will be released by Nov. 15, 2010. Medical groups that chose to participate through this new method must send a self-nominating letter to CMS with the name of their group, the tax identification number, an email address of the contact person, and the names and NPIs of all of the eligible professionals. Groups selected by CMS for the GPRO II must submit quality measure information for three to six individual 2011 PQRI measures, depending on the size of the group as outlined in Table 50.

With the exception of the above two improvements, the agency proposes few changes to the 2011 PQRI and proposes to offer the same 2010 PQRI reporting options in the 2011 PQRI citing the need to "move in the direction of maintaining program stability and continuing program flexibility," according to the agency.

As stipulated in PPACA, successful participants in the 2011 PQRI will be eligible for an incentive payment equaling one percent of their total allowed charges for all covered professional services furnished during the reporting period.

For the 2011 PQRI, the agency proposes to:

- Include a total of 198 measures, counting both individual measures and measures that are part of a proposed 2011 measures group;
- Introduce 20 new measures not included in the 2010 PQRI, as outlined in Table 54;
- Retire five PQRI measures that were a part of the 2010 PQRI, as outlined in Table 51;
- Retain 170 measures from the 2010 PQRI;
- Include 45 measures exclusively for reporting via a qualified 2011 registry, as outlined in Table 53.
- Include 22 measures (targeting preventive care, common chronic and high-cost conditions) exclusively for reporting via a qualified 2011 PQRI electronic health record vendor, as outlined in Tables 55 and 56.
- Include 14 PQRI measure groups (defined as containing at least 4 individual PQRI measures that share a common denominator definition), as identified in Tables 57 through 70.

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- Include 26 measures for the PQRI GPRO I (for selected practices with 200 or more eligible professionals) as outlined in Table 71.

It is important to note that CMS retains the ability to update and/or modify PQRI measure specifications from year to year. The final 2011 PQRI measure specifications, which will include the specific codes required for successful reporting, will be available in late 2010.

As detailed in the final 2010 physician fee schedule, CMS intends to post the names of 2010 PQRI participating providers and group practices regardless of whether the participant was successful (i.e. earned the 2010 PQRI incentive payment) on a Physician Compare website. However, in the proposed 2011 fee schedule, CMS outlines their intention to post the names of 2011 PQRI participating providers and group practices that both attempted the 2011 PQRI as well as those that were successful in the 2011 PQRI. While only names of PQRI participants will be listed on the Physician Compare website in 2011, PPACA required that CMS add information to the Physician Compare website on physician performance, including measures collected under the PQRI, no later than 2013.

E-prescribing Incentive Program

MIPPA, passed in July 2008, contained several new authorities and requirements for electronic prescribing for 2009 and beyond. The program established both financial incentives for prescribing electronically in physician practices and penalties for those practices that do not adopt this capability by a certain threshold date. To participate, prescribers must use a “qualified e-prescribing system,” whether it is a standalone software system or integrated into an electronic health record (EHR). The MIPAA E-Prescribing incentives are not available if the eligible medical professional earns an incentive payment under the HITECH provisions for those qualifying as “meaningful EHR users.”

MIPPA outlined that successful e-prescribers can receive incentive payments as follows:
Increase amount of total estimated allowed charges for covered professional services (Part B charges)

- 2009 2.0%
- 2010 2.0%
- 2011 1.0%
- 2012 1.0%
- 2013 0.5%

For prescribers that do not adopt e-prescribing, penalties begin to apply in 2012 as follows:
Decrease in amount of total estimated allowed charges for covered professional services (Part B charges)

- 2012 1.0%
- 2013 1.5%
- 2014 (and beyond) 2.0%

Participation

Any medical professional defined as "eligible" by CMS may participate. Eligibility is further restricted by scope of practice to those professionals who have prescribing authority. Similar to last year, CMS proposes that for the incentive program in 2011 the success of an eligible profession prescribing electronically will be determined at the individual professional level,

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based on the NPI. In general, an eligible professional is one of the following:

- Physician
- Physical or occupational therapist
- Qualified speech-language pathologist
- Nurse practitioner
- Physician assistant
- Clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse midwife
- Clinical social worker
- Clinical psychologist
- Registered dietitian
- Nutrition professional
- Qualified audiologist (as of 2009)

Defining Qualified E-prescribing Systems

To participate, prescribers must use a "qualified e-prescribing system." A qualified system must be able to do all of the following using the standards currently in effect for the Part D program, if applicable:

1. Generate a complete active medication list (with information from PBMs or pharmacies if available);
2. Select medications, print prescriptions, transmit prescriptions electronically using the applicable standards, and warn the prescriber of possible undesirable or unsafe situations;
3. Provide information on lower-cost, therapeutically-appropriate alternatives (if any). The ability to receive tiered formulary information, if available, would again suffice for this requirement for 2011 and until this function is more widely available in the marketplace; and
4. Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

Reporting Requirements

An eligible prescriber will be considered a "successful e-prescriber" based on a count of the number of times the professional reports that at least one prescription created during a patient encounter was generated using a qualified e-prescribing system. The minimum threshold for this reporting is 25 electronic prescribing events during the 2011 calendar year. The prescriber must identify whether the encounter is an applicable case using the following denominator codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109.

The numerator includes the applicable G Code: G8553 – at least one prescription created during the encounter must be generated and transmitted electronically using a qualified electronic prescribing system.

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Note - At least 10% of the prescriber's total Medicare allowed charges must be for services in the measure denominator.

Reporting period

CMS proposes to keep the 2011 program reporting period consistent with the 2009 and 2010 Programs – the entire calendar year (Jan. 1, 2011 through Dec. 31, 2011). In order to be eligible for the incentive payment, 2011 claims must be submitted no later than Feb. 28, 2012.

Reporting methods

Similar to the PQRI program, CMS proposes to retain the 2010 reporting mechanisms available to individual professionals. These include claims-based and registry approaches. In addition, CMS proposes that an EHR-based reporting mechanism be available for this program. Again similar to the PQRI program, the e-prescribing program has two basic elements: (1) a reporting denominator that defines the circumstances when the measure is reportable and (2) a reporting numerator.

Group practice reporting option

Identical to the PQRI program, CMS proposes to define a "group practice" as a single Taxpayer Identification Number (TIN) with two or more eligible professionals, as identified by their individual NPI, who have reassigned their Medicare billing rights to the TIN. If a group practice wishes to participate in the 2011 e-prescribing incentive program utilizing this group practice reporting option, it must indicate its desire to do so at the time that the group self-nominates to participate in the 2011 PQRI group practice reporting option. CMS proposes to allow groups to report using any of the three reporting options outlined above.

The most significant modification to the 2010 program is the reduction in the required size of the group. In fact, CMS proposes to allow groups as small as two eligible professionals to utilize the group practice reporting option. The minimum number of prescriptions that would need to be generated electronically using the group practice reporting option is the following:

- Group of 2-10 NPIs would need to report a minimum of 75 denominator eligible patient encounters
- Group of 11-25 NPIs: 225 encounters
- Group of 26-50 NPIs: 475 encounters
- Group of 51-100 NPIs: 925 encounters
- Groups of 101-199 NPIs: 1,875 encounters

In determining whether a group practice will receive the incentive bonus, CMS will gauge whether the ten percent threshold is met based on the claims submitted by the group practice.

2012 penalties

For purposes of the 2012 e-prescribing penalties, CMS proposes to make a determination of whether an eligible professional or a group practice is a successful e-prescriber based on the reporting period that begins Jan. 1, 2011 through June 30, 2011.

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Questions about the proposed 2011 Medicare fee schedule?
Contact the MGMA Government Affairs department. Call toll-free 877.ASK.MGMA (275.6462), ext. 1300 or e-mail govaff@mgma.com.

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