Highlights of the 2011 Medicare Physician Fee Schedule Final Rule

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- **Pay Cut:** The 2.2% update expires on December 1, 2010. CMS estimates that using the SGR formula, the 2011 reduction will be close to -30% without Congressional intervention. The conversion factor in December will be $28.40, down from $36.87. As if January 1, 2011, the CF will be $25.52.

- **New Adjustments/MEI**: The Medicare Economic Index (MEI) is used in conjunction with the SGR formula to update the physician fee schedule. For 2011, CMS will "rebase" the MEI, i.e. update the base year to from 2000 to 2006 (the most recent year with complete information) to reflect changes in prices of goods and services physicians purchase to run their practices. Further, some of the components or categories that comprise the MEI were revised.
    - The impact of the proposed MEI changes varies by specialty. Data from the PCPI survey (that ACEP supported and participated in) showed that practice expense (PE) and medical liability costs grew at a faster rate than physician "work". Therefore, CMS increased the PE RVUs used in the MEI to 47.44%, malpractice RVUs from 3 to 4%, and reduced work from 52.46% to 48.27% of total RVUs.
    - Because these changes must be budget neutral in overall impact, CMS made the reduction to the Conversion Factor rather than reduce Work values. Therefore, the proposed payment levels for high practice expense specialties will increase, while payment to low practice expense specialties, such as emergency medicine may decrease slightly.
    - CMS will also appoint a Technical Advisory Panel to review MEI components and recommend changes for future rulemaking proposals.

- **Primary Care Incentive Program:** The health reform law passed in March 2010 created a 10% bonus payment for primary care services performed by specific specialties of family practice, internal medicine, pediatrics, or geriatrics (but not emergency medicine). General surgeons are also eligible for a 10% bonus if they practice in designated shortage areas. Bonus funds are not budget neutral so money will not be taken from other specialties to pay for the bonuses.

- **Physician Quality Reporting Initiative:** CMS has changed the name to "Physician Quality Reporting System (PQRS)" and is proposing to add 20 new measures to the program. CMS will make 12 additional measures reportable through electronic health records. A list of measures will be provided in the web update. The new law extends the program through 2014. Payments to eligible professionals will equal 1% of estimated total allowed fee schedule services for 2011 and .05% for 2012-2014. In 2015 the payment is replaced by a penalty of 1.5% for non-reporting. This increases to 2% for 2016 and thereafter. To achieve an additional 0.5 percent incentive for participating in a qualified Maintenance of Certification Program practice assessment, CMS will allow individual boards to verify that their eligible professionals have met the program requirements. CMS will proceed with developing a "Physician Compare Web site," which will provide data on providers who satisfactorily participate in the 2011 program. CMS retained the nine (9) ED individual measures and the ED pneumonia measures group from 2010. Measure specifications may have changed; CMS expects to publish these before December 31st.

Physician Quality Reporting System (PQRS) – 2011

Nine (9) individual measures may be reported as "emergency medicine" measures:*

#28	Aspirin at Arrival for Acute Myocardial Infarction (AMI) †
#31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage†
#54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain†
#55	12-Lead Electrocardiogram (ECG) Performed for Syncope†
#56	Community-Acquired Pneumonia (CAP): Vital Signs*
#57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation*
#58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status*

#59 Community-Acquired Pneumonia (CAP): Empiric Antibiotic*
#76 Prevention of Catheter-Related Bloodstream Infections (CRBSI): CVC Insertion Protocol.

Emergency physicians may also report the four CAP measures as a measure group:

#56 Community-Acquired Pneumonia (CAP): Vital Signs*
#57 Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation*
#58 Community-Acquired Pneumonia (CAP): Assessment of Mental Status*
#59 Community-Acquired Pneumonia (CAP): Empiric Antibiotic*

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†The Part B claim form place of service field must indicate emergency department
* Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.

- **Physician Resource Use Reporting (RUR) Program:** CMS is in Phase II of this program started in 2009 with a limited number of conditions and mostly primary care physicians designated to participate. CMS dropped its use of the proprietary episode groupers (Ingenix and Thomson Reuters) and is only measuring beneficiary per capita costs and "quality measures" using claims data and "GEMS" – a list of clinical process measures developed by CMS that don't include any EM or PQRI measures. PPACA requires CMS to develop episode groupers by 2012, which it is in the process of doing via 5 preliminary contracts. The new law also requires using resource use feedback as basis for creating payment modifiers for all physicians by 2017. CMS is seeking our ideas on how emergency physicians and other hospital-based or sub specialty physicians should be treated for resource use attribution and ultimately, payment purposes.

- **Maximum Claim Submission time reduced from 27 months to 12 as per PPACA.**

- **Imaging**: As mandated by PPACA, CMS finalized the factor at 75% for the amount of time that complex diagnostic imaging machines (valued at > $1m) are used in practices. This will affect the **technical component** only but will reduce practice expenses for many physicians who perform complex imaging services in their offices. The policy will not be phased in and is not budget neutral, meaning that savings will not be redistributed within the fee schedule.

Emergency E/M RVUs in the 2011 FINAL rule

Code	Description	2010 Work RVUs	2011 Work RVUs	2010 Facility PE RVUs	2011 Facility PE RVUs *	2010 Total RVUs	2011 Total RVUs
99281	ED visit	0.45	0.45	0.10	0.14	0.58	0.61
99282	ED visit	0.88	0.88	0.17	0.24	1.12	1.19
99283	ED visit	1.34	1.34	0.29	0.36	1.71	1.80
99284	ED visit	2.56	2.56	0.50	0.62	3.21	3.40
99285	ED visit	3.80	3.80	0.72	0.88	4.74	4.98
99291	Crit care 1st hr	4.50	4.50	1.24	1.56	5.99	6.40

Medical Liability component is approximately .043 and included when configuring total amounts.

Conversion Factor for 2011is listed at $25.52, a nearly 30% reduction.

*2011 PE Values are Year 2 (50:50) of a 4-year phase-in to total use of the PPIS survey data (that ACEP participated in) from historical rates.

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