

*In 2008, the AMA and other organizations staved off a major reduction in the Medicare conversion factor. This year the fight will be much harder.*

## 2009 Medicare changes

By BOB PERNA, Director, WSMA Practice Resource Center

**T**HE MEDICARE PART B program has new provisions, effective January 1, driven by the 2008 Medicare Improvements for Patients and Providers Act and the annual rulemaking process. Here's a brief summary of those changes; see the Noridian website for more details ([www.noridian.com](http://www.noridian.com)).

### Conversion factors

The 2009 conversion factor increased 1.1% to \$36.0666; the anesthesia CF is \$20.9150. The 2008 CF was actually higher, \$38.0870. The 2009 reduction in the CF is the result of a scheduled five-year review of Medicare work RVUs and budget neutrality adjustment. But it could have been much worse. Before the AMA and other medical organizations persuaded Congress to step in, the annual reductions to Medicare CF would have been as follows:

2008: - 10.1%  
 2009: - 15.5%  
 2010: - 21.0%  
 2011 and beyond: - 5.0%.

### Physician enrollment and past claims

Medicare's enrollment process for physicians has changed. In the past, providers could submit past claims, prior to becoming an enrolled Medicare provider, for up to 23 months retrospectively. The new process limits claims of providers before enrollment to a 30-day period. Billing privileges can begin on the date the contractor accepts a completed enrollment form.

Practices should allow ample time for new practitioners joining their group to complete and submit the enrollment application. Good news: the provider application can now be completed online via the Noridian website, with 15 days to submit the signed and dated certification statement.

### Ambulatory surgery centers

Medicare payments to ASCs are in a four-year transition, aligning payment rates for ASC services with similar services paid under the outpatient prospective payment system. In 2009, the payment rate is a 50/50 blend of the 2008 revised ASC rate and the 2007 ASC rate. The transition to full OPPS rates occurs in 2011.

### CPAP therapy

In 2008, CMS published a national coverage determina-

tion that significantly expanded coverage of CPAP devices to beneficiaries whose obstructive sleep apnea was diagnosed by certain unattended sleep studies. Only the physician treating the beneficiary can order a home sleep test and prescribe CPAP therapy.

### Nurse practitioners, clinical nurse specialists

CMS already allows master's degree nursing practitioners and advanced registered nurse practitioners to enroll in Medicare if they are graduates of doctor of nursing practice programs. Pursuant to the latest final rule, CMS will continue to study and monitor the DNP programs and reconsider educational requirements as deemed necessary.

### "Welcome to Medicare" visit

In 2009, the eligibility for the Initial Physician Preventive Examination is extended from 6 months to 12 months, meaning that the service is covered up to one year after the date of the patient's Medicare eligibility. Body mass index and end-of-life planning (if requested) are now part of the examination; the screening EKG is no longer mandatory. The Part B deductible does not apply to the examination, but coinsurance does.

### Advance beneficiary notice

A new advance beneficiary notice replaces three existing versions: the NEMB, ABN-G, and ABN-L. As of March 1, the ABN-G and ABN-L will no longer be valid. The modifiers GA, GY and GZ will still be valid for use when submitting claims. For more details, see the CMS website: [www.cms.hhs.gov/BNI/02\\_ABNGABNL.asp](http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp).

Next issue: Medicare e-prescribing, the budget neutrality adjustment and PQRI.

For questions, contact me at (206) 441-9762, 1 (800) 552-0612 or [rjp@wsma.org](mailto:rjp@wsma.org). ♣

*PQRI remains Medicare's broadest initiative to improve care.*

## Medicare changes: PQRI and budget neutrality adjustment

By BOB PERNA, FACMPE, WSMA Practice Resource Center

**T**HIS ARTICLE FOCUSES on two aspects of the Medicare program in 2009: PQRI and the budget neutrality adjustment.

### Small raise for Physician Quality Reporting Initiative

For 2009, Medicare's Physician Quality Reporting Initiative (PQRI) is offering a small raise to participants, additional options for reporting data on quality, and more quality measures. PQRI remains Medicare's broadest initiative to improve care to Medicare Part B patients in physicians' practices. Medicare paid out \$36 million in incentives payments in 2007, the most recent year for which data are available.

For 2009, physicians submitting quality data to the Centers for Medicare and Medicaid Services (CMS) can earn an incentive payment of 2.0% of their total allowed Medicare Part B charges, up from 1.5% in 2008. A cap on the dollar amount physicians could receive was removed in 2007.

Physicians report those data by including quality data codes on the Medicare claims associated with those medical services.

CMS has expanded the options for reporting quality data to nine, including the use of clinical registries and reporting on either individual measures or one of seven "measures groups"—broader clinical conditions such as diabetes, preventive

care, and back pain. CMS is also testing the use of electronic health records for reporting.

In 2008 there were 119 quality measures; now there are 153 quality measures and 7 measures groups.

For a list of measures, go to [www.cms.hhs.gov/PQRI/15\\_MeasuresCodes.asp](http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp).

For registry options, go to [www.cms.hhs.gov/PQRI/20\\_Reporting.asp](http://www.cms.hhs.gov/PQRI/20_Reporting.asp).

### Budget neutrality adjustment

Under the Medicare relative value system, CMS must apply a "budget neutrality adjustment" (BNA) when a

policy change may result in an increased net payment amount of \$20 million or more and where Congress has not allocated separate funding. The budget adjustment serves to curb overall Medicare spending.

CMS must also review the Medicare work relative value units every five years and propose revisions as needed. In the last review, conducted during 2007-2008, CMS estimated that the proposed RVU revisions would exceed the \$20 million threshold and applied the neutrality adjustment. In doing so, CMS reduced the overall amounts paid out through the Medicare Part B physician fee schedule.

However, physicians disputed CMS's approach in implementing the budget adjustment. For the 2007 Medicare physician fee schedule, CMS applied a -10.6% BNA to the overall amounts of the work RVUs rather than to the conversion factor, as many physician organizations expected.

In 2008, due to subsequent changes from the five-year review, CMS applied a separate BNA for work RVUs of -11.94%.

The AMA and other organizations objected, arguing that CMS's approach disrupted the relativity of the RVUs.

As a result of organized medicine's advocacy and passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), effective January 1, CMS was required to apply the budget adjustment to the conversion factor rather than to work RVUs. CMS therefore shifted the -11.94% separate work adjustment to that 2009 conversion factor, resulting in a reduction to that CF of -6.41%.

The work RVUs represent slightly more than half of the Medicare Part B physician fee schedule payments. So while the values for the work RVUs will increase as a result of this change, those increases are offset in the aggregate by the decrease to the CF.

In the Final Rule for 2009, CMS published a chart illustrating the impact of these Medicare changes across specialties. That chart is posted at the WSMA's Practice Resource Center website, under Health Insurers, Medicare.

### Commercial health insurers

In a related note, physicians' practices should be vigilant in their dealings with commercial health insurers on their non-Medicare products.

Most health insurers use some version of Medicare's RBRVS methodology as the basis for their own payment mechanisms. The potential exists for a commercial insurer to exploit the recent complexities of work RVUs and conversion factor changes to lower their overall reimbursements to physicians.

At its 2008 interim meeting, the AMA considered a resolution that the AMA support federal legislation requiring that commercial health insurers disclose their use of any "adjustment factors."

*continued on page 10*

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**What to do**

While an understanding of insurers' systems is advisable for physicians and managers, WSMA recommends that practices focus on an insurer's *net payments* as a basis for negotiating payment rates.

Practice leadership should also have a clear picture of what it costs the practice to actually deliver each service. The amount charged for a service, and then collected from an insurer, should be higher than that true cost. The WSMA offers practice management seminars and

webinars on how to perform these calculations.

Also, when assessing a contract offer from a health insurer, insist on first receiving a list of the actual payment amounts, not merely their proposed CF or the base year of the Medicare RVUs being used. Absent that level of detail, the practice is poorly informed about what payments to expect.

If an insurer refuses to provide that list, please contact me at [rjp@wsma.org](mailto:rjp@wsma.org). The WSMA will contact the insurer on your behalf. ♣