

2012 Medicare Physician Fee Schedule Proposed Rule Summary

On Friday July 1, 2011, the Centers for Medicare and Medicaid Services (CMS) posted a display copy of the proposed Medicare Physician Fee Schedule (PFS) for 2012. The proposed rule in its entirety can be found [here](#). The addenda to the rule, including Addendum B, which lists the proposed RVUs for each CPT code, can be found [here](#). (Please note: once this notice is published in the Federal Register the link will change). The provisions of the rule will be effective January 1, 2012 unless stated otherwise. Comments on the rule are due by COB August 30, 2011.

Highlights of the rule include:

- **Conversion Factor:** The current CF, which expires on December 31, 2012, is \$33.9764. Without congressional action, the CF will be reduced by 29.5% in 2012, due to the SGR formula. Assuming that Congress acts to prevent this reduction, as it has in previous years, we estimate a 2012 CF identical to the 2011 CF in the prepared charts.
- **Specialty Impact:** Most hematology/oncology procedural codes will see reductions of 1-3 percent, while bone marrow biopsy and bone marrow aspiration codes will see modest increases. The total impact of the proposed changes in the rule is estimated to be 0%, and total allowed charges for hematology/oncology is \$1,912,000,000.
- **Bone Marrow Biopsy and Aspiration Tray:** CMS accepted the ASH recommendation to adjust the pricing for the tray used for bone marrow biopsy and aspiration from \$24.27 to \$34.47.
- **RUC Review of Potentially Misvalued Codes:** CMS is proposing that the AMA's Relative Value Update Committee (RUC) review E/M codes as well as a few high-volume chemotherapy codes which have not been reviewed in the last 6 years. These codes include 96365, 96367 and 96413.
- **Physician Quality Reporting System (PQRS):** CMS proposes to redefine a group practice for the group practice reporting option as 25 or more eligible professionals. CMS also proposes to reduce the number of options for 6-month registry-based measures reporting.
- **PQRS Maintenance of Certification Program Incentive:** CMS is proposing to significantly modify this program and require more frequent participation for CY 2012 through 2014.
- **The Electronic Prescribing Incentive Program:** This program is transitioning into its penalty phase in 2012. Participation will be required in 2012 to avoid a 1.5 percent payment reduction in 2013.
- **Medicare Electronic Health Records Incentive Program:** CMS proposes to harmonize the EHR incentive program with PQRS.

SGR and Conversion Factor (CF) Impact

The current CF, which expires on December 31, 2012, is \$33.9764. Without congressional action, the CF will be reduced by 29.5%, due to the SGR formula. The President's budget calls for an extension of the 2011 CF through December 31, 2013, but legislation is needed enact this proposal or to maintain the current CF. Congress has prevented reductions in the CF due to the SGR formula for numerous years and it is anticipated that it will once again take similar action. Assuming that the SGR reductions are prevented by legislation, we are estimating a 2012 CF of \$33.9764 for purposes of the payment projections in the prepared charts.

Background information on SGR

While Medicare annually updates payment rates for inflation for most provider services, physician services are updated by a formula mandated in legislation known as the Sustainable Growth Rate (SGR). The conversion factor (CF) for a year is based on the prior year’s CF adjusted for inflation by the Medicare Economic Index (MEI) and performance under the SGR. The SGR is a cumulative target whereby actual expenditures for all physician services are compared to a target rate of spending. The target is based on a statutory formula and includes an allowance for changes in the Medicare population, statutory and regulatory changes, and an allowance for volume and intensity growth based on GDP growth. If the SGR target is exceeded, the update to the CF is reduced and, conversely, if actual spending is less than the target, the CF is increased. For a number of years the actual expenditures for all physician services exceeded the target suggesting a need for a substantial reduction in the CF. Most observers believe that the statutory formula using GDP as a proxy for appropriate volume and intensity growth is flawed by not providing adequately for changes due to new technology, medical improvements, transfer of services from the hospital and other reasons. Congress has acted each year since 2003 to prevent reductions in the CF from occurring. Since the SGR is a cumulative target, the potential reductions have reached massive proportions.

Specialty Impact

Table 64 (see Attachment 1), extracted from the rule, provides a summary of the impact of the proposed changes in the rule by specialty. The impact, positive or negative, is due to a number of factors highlighted in the table, particularly the continued transition to the new practice expense (PE) values (2012 is the third year of the 4-year transition), the change in the weights assigned to physician work, PE and professional liability insurance (PLI) components, and other changes in the proposed rule.

The overall impact of the 2012 proposed rule on hematology services is shown below.

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges (mil)	Impact of Work & MP RVU Changes	Impact of PE RVU Changes		Combined Impact	
			2013	2012	2013	2012
TOTAL	\$83,014	0%	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	\$1,912	0%	-1%	0%	-2%	0%

*Table 64 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.

Attached to this summary are several charts comparing payment for evaluation and management services (E/M) and hematology/oncology procedural services from 2011 to 2012. Overall, E/M services will either show no change or a change in the range of + or – 1 percent. Most procedural codes including infusion and injection codes and apheresis in the hospital will see reductions of 1-3 percent. Bone marrow biopsy and bone marrow aspiration codes in the office setting will see modest increases. Most chemotherapy codes are seeing reductions of about 3 percent. Most of the reductions in payment can be explained by the phase-in of the practice expense changes begun in 2010. The increased pricing in the bone marrow biopsy/aspiration tray discussed below may explain why these two procedures had modest increases in payment.

Bone Marrow Biopsy and Aspiration Tray

ASH had requested CMS to adjust the pricing for the tray used for bone marrow biopsy (Code 38221) and aspiration (Code 38221) procedures from \$24.27 to \$34.47. CMS accepted this recommendation and included the price of the higher cost tray in calculating the practice expense values for the code.

RUC Review of Potentially Mis-valued Codes

At the direction of CMS, the AMA's Relative Value Update Committee (RUC) has reviewed the relative values assigned to various categories of services. CMS has typically identified for review, codes with substantial growth in utilization, codes billed in multiple units, and codes for which the site of service had changed. In the proposed rule, CMS is proposing that RUC review the physician work and practice expense values for all of the evaluation and management codes including new and established office visits, hospital care services, emergency department visits, critical care, and nursing home care. CMS notes that while many of these codes were reviewed in 2006, during the intervening years there have been significant changes in the delivery system such as the development of the patient-centered medical home and the increased prevalence of chronic health conditions affecting the Medicare population (heart disease, diabetes, Alzheimer's disease, etc.) has increased the work of primary care physicians. CMS is asking the RUC to give priority to the review of E/M codes and to have half the codes reviewed by July 2012 in time for next year's MPFS proposed rule.

CMS is also asking the RUC to review high volume procedural codes which have not been reviewed in the last 6 years. CMS has asked that the following chemo therapy codes be reviewed:

- 96365 – Intravenous infusion, for therapy, prophylaxis, or diagnosis up to 1 hour
- 96367 – Tx/Proph/Diag, additional sequential infusion up to 1 hour
- 96413 – Chemotherapy admin, IV infusion, up to 1 hour

Given the frequency of the listed procedural and E/M codes that CMS has asked be reviewed, any substantial changes to the values could have substantial redistributive impact on the values of services since all changes are implemented in a budget neutral manner. The E/M codes alone represent approximately 30 percent of Medicare spending.

Multiple Procedure Payment Reductions

Currently a 50% multiple procedure payment reduction (MPPR) is applied to the technical component of (TC) of advanced imaging codes provided in the same session. This policy is based on the assumption that there are efficiencies in labor, supplies and equipment when more than one imaging procedure is performed. The policy was extended to the Practice Expense (PE) of therapy services (PT, speech therapy and occupational therapy). A 20 percent reduction is applied to the PE of the second and additional therapy codes billed the same day.

In the rule, CMS is proposing to apply the MPPR to the Professional Component of advanced imaging services based on the rationale that there are efficiencies, especially in the pre- and post- service periods, when multiple images are interpreted.

CMS is also considering three options to further apply the MPPR on physician services, but none of these options are being proposed in this rule. The options, which are subject for comment, are:

- Apply the MPPR to the TC of all imaging codes, not just advanced imaging
- Apply the MPPR to the PC of all imaging codes
- Apply the MPPR to the TC of all diagnostic codes including radiology, audiology, cardiology, neurology, etc.

Geographic Practice Expense Index (GPCI)

The GPCI is an adjustment CMS calculates and applies to both the work and practice expense relative value units for each code to reflect differences in labor, rent and other cost elements. CMS is proposing several changes to the GPCI and how it is applied to payment for physician services:

- CMS is proposing a technical change in how the GPCI applies to office rents, purchased services and employee compensation.
- CMS is proposing to implement a provision of the Affordable Care Act establishing a PE index of 1.0 in several so-called frontier states. These are Montana, Wyoming, North Dakota, South Dakota and Nevada. A PE index of 1.0 would be equivalent to the national average. The actual GPCI in these states would be less than 1.0 so this change raises payments in these states.
- CMS is proposing to eliminate the floor on the GPCI which was legislated by Congress to protect lower cost and rural areas. While the overall impact of this change will be modest (in the range of +/- 1 or 2 percent), removing the floor in some areas will lead to substantial reductions in payment. For instance, payments in Puerto Rico will be reduced by 15 percent and in West Virginia, Oklahoma, Mississippi, Iowa, Kentucky and Arkansas will be reduced by -5 to -6 percent. Table 66 in the rule has a complete listing of the estimated changes in the weighted geographic adjustment factor by locality.

Telehealth Services

CMS is proposing to add smoking cessation counseling to the list of approved telehealth services. CMS is also changing the criteria it uses to approve additional telehealth services. CMS is proposing to evaluate whether to approve telehealth services based on the clinical benefit to the patient rather than the current requirement that a telehealth service must be equivalent to an in-person service to be approved.

Annual Wellness Visit

As of January 1, 2011, Medicare has covered an annual wellness visit for beneficiaries as mandated in the Affordable Care Act (ACA). The law also provided coverage for a personalized prevention plan which is to include a health risk assessment (HRA) that meets guidelines established by the Secretary. CMS is proposing the following elements be included in the HRA:

- Collects self-reported information about the beneficiary.
- Can be administered independently by the beneficiary or administered by a health professional prior to or as part of the AWV encounter.
- Takes into account the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs,
- Takes no more than 20 minutes to complete.
- Addresses, at a minimum, demographic data, including but not limited to age, gender, race, and ethnicity; self-assessment of health status, frailty, and physical functioning, psychosocial risks, including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, or fatigue; behavioral risks, including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual practices, motor vehicle safety (seat belt use), and home safety and activities of daily living (ADLs), including but not limited to dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing.

CMS is seeking public comment on the overall impact and burden of the annual wellness visit and personalized prevention plan on practitioners, including the impact the incorporation of the health risk assessment will have on health professionals and their practices

Payment for Part B Drugs

Currently, Medicare pays for drugs provided by a physician based on 106 percent of ASP. While the authority has never been used, current law permits CMS to substitute AMP in determining payment if it is lower than ASP. If ASP exceeds the AMP by 5 percent or more for several quarters (to eliminate a short

term anomaly) CMS is proposing to base payment on 103 percent of AMP rather than 106 percent of ASP. The impact analysis in the rule indicates that CMS expects very modest savings from this authority.

Bundling of Payments in Wholly-Owned Physician Practices

Virtually from the inception of the hospital PPS program, services in hospital outpatient departments in the 3 days prior to a hospital admission were bundled into the DRG payment. This was true for all diagnostic services and for non-diagnostic services related to the reason for admission. In 1998, CMS issued a rule that would extend this policy to entities, including physician practices, wholly owned or controlled by the hospital. However, for preadmission non-diagnostic services to be considered related to the admission there needed to be an exact match on the ICD-diagnosis code. This greatly complicated the application of this policy. The law was changed in 2010 to broaden the definition of non-diagnostic codes subject to the 3 day window by providing that there did not need to be an exact match of the diagnosis code for the services to be considered related to the reason for admission

For physicians that are in a practice which is wholly owned or wholly operated by a hospital, CMS is proposing that payment for all diagnostic services and any non-diagnostic services clinically related to the hospital admission and provided within three days of the admission be bundled into the DRG payment. Essentially what this means is that for services with both a professional (PC) and technical component (TC), only the PC will be paid by under Medicare Part B by the carrier and the TC will be considered bundled into the hospital's payment. For codes without a PC/TC breakdown, the physician would only get paid at the facility rate for the practice expenses. A new HCPCS modifier will be established effective January 1, 2012, which when reported would alert the system of the preadmission services rendered in the 3-day payment window. Hospitals will also need to notify the practice of the hospital admission since the practice might not always know this when the service would otherwise be billed.

2012 Physician Quality Reporting System (PQRS)

Since its initial implementation in 2007, PQRS has continued to evolve largely as a result of statutory updates enacted by Congress. Under the current program, those who successfully report quality measures in CY 2012 will receive a bonus payment of 0.5 percent of total allowed charges for services provided during the reporting period. Like last year, an additional 0.5 percent will be available for those who participate in a maintenance of certification (MOC) program required for board certification by a recognized physician specialty organization.

Eligible professionals who choose not to participate in CY 2012 should note that beginning in 2015 penalties will be assessed for those who do not satisfactorily submit quality data. The initial penalty will be 1.5 percent and rise to 2.0 percent in CY 2016. The reporting period for the 2015 payment adjustment will be the reporting period of January 1, 2013 through December 31, 2013.

Measures Selection. Measures included in the PQRS are endorsed by the NQF or adopted by the AQA except in limited circumstances as determined by the agency. The initial set of core measures for hematology/oncology is as follows:

- 67: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
- 68: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
- 69: Multiple Myeloma: Treatment with Bisphosphonates
- 70: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry

CMS is proposing to retain all of the measures included in the 2011 PQRS, including the hematology/oncology measures. Of the 199 measures that would be retained, 55 are registry-only

measures and 144 are reportable either by claims or registry. CMS is proposing to add 26 new measures to the PQRS, 13 of which would be registry only measures and the other 13 would be reportable by claims or registry.

To further align the PQRS and the EHR Incentive Program, CMS is proposing the inclusion of all clinical quality measures available for reporting under the Medicare EHR Incentive Program in the EHR-based reporting option in the 2012 PQRS.

CMS is proposing to retain 14 of last year's measures groups: diabetes mellitus; CKD; preventive care; CABG; rheumatoid arthritis; perioperative care; back pain; CAD; heart failure; IVD; hepatitis C; HIV/AIDS; CAP; and asthma. In addition, CMS is proposing to add 10 new measures groups: COPD; inflammatory bowel disease; sleep apnea; epilepsy; dementia; Parkinson's; elevated blood pressure; radiology; cardiovascular prevention; and cataracts. All measures included in measures groups would be reportable as part of a group or individually, except for the measures in the back pain measures group.

For the group practices participating in the PQRS, CMS is proposing that they be required to report on 40 measures listed in Table 56 of the proposed rule.

Maintenance of Certification Program Incentive. The Affordable Care Act authorized this additional incentive. There are four parts to the program that physicians must satisfy:

1. Maintain a valid and unrestricted license in the United States;
2. Participate in educational and self-assessment programs;
3. Demonstrate through a formalized secure examination that the physician has fundamental diagnostic skills, medical knowledge and clinical judgment to provide care in his specialty; and
4. Successfully complete a qualified maintenance of certification program practice assessment.

In CY 2011, those wishing to qualify for the bonus had to meet these 4 requirements more frequently than required. CMS is revising this requirement for CY 2012 through 2014, by requiring an eligible professional to participate more frequently than is required in at least one of the four parts of the MOC program, not all four. CMS will look to the specific requirements of Board certification to determine if the "more frequently" requirement is met. However, CMS will interpret the statute to require the participation and successful completion in at least one MOC program practice assessment for each year the physician participates in the MOC Program Incentive.

Participation Options. Eligible professionals will be able to participate either individually or as part of a group practice through the group practice reporting option (GPRO). CMS is proposing to redefine a group practice to be 25 or more eligible professionals who have reassigned their billing rights to a TIN. Those wishing to participate under GPRO would be required to self-nominate by January 31, 2012. For practices wishing to participate in the PQRS and the e-Prescribing (eRx) program must indicate that in the self-nomination statement. The group practice option for groups with between 2 and 24 eligible professions are being eliminated. However, group practices regardless of size who are participating in a Medicare approved demonstration project would be deemed eligible for the PQRS. CMS is considering further redefining of what constitutes a group practice in future rulemaking to better align all of the agency's quality reporting programs.

Reporting Period Options. CMS is statutorily required to have multiple reporting periods. To remain in compliance, CMS is proposing to have a 6-month reporting period option for reporting measures groups via registry. However, CMS is proposing to eliminate the 6-month reporting period for claims and registries previously available. All other reporting options, claims, registry, EHR-based, and GPRO, will require a 12-month reporting period.

Reporting Mechanisms. CMS proposes to retain the claims-based, registry-based and EHR-based reporting mechanisms for 2012 and future years. Eligible professionals can report through multiple mechanisms, but must satisfy the reporting criteria for a single reporting mechanism to be eligible for the bonus payment.

- *Claims-based reporting:* Eligible professionals are required to submit the appropriate PQRS data codes on their Medicare Part B claims for the measures of their choosing.
- *Registry-based reporting:* Those electing to report via registry must maintain an appropriate legal arrangement with a qualified registry to submit individual measures or measures groups. Registries must self-nominate to become qualified.
- *EHR-based reporting:* Eligible professionals can submit quality data either directly from a qualified EHR or indirectly from a qualified EHR data submission vendor. Those choosing the indirect method must maintain an appropriate legal arrangement with a qualified 2012 EHR data submission vendor. EHR technology that was purchased to meet the specifications of the Medicare and Medicaid EHR Incentive programs; these products may not be qualified for the PQRS. CMS is exploring ways to align these programs' requirements moving forward.

Criteria to Satisfactorily Report. This year CMS is proposing to alter the criteria for satisfactory reporting by specialty. Those eligible professionals with specialties designated as internal medicine, family medicine, general practice and cardiology will be required to report on core measures as specified by CMS. (Those core measures will be listed below.) They anticipate developing core measures for other specialties in future years.

CMS is required to integrate the PQRS and EHR reporting. The agency is proposing that integration will consist of the following: the selection of measures that reporting would demonstrate meaningful use of an EHR and the quality of care furnished to an individual as well as other activities to be specified by the Secretary. This year CMS is taking the first step towards integration and providers can report can choose an option that reflects this integration. This is detailed in the chart under the heading "EHR – Aligning with the Medicare Incentive Program."

The reporting requirements are below.

Individual Measures – Eligible Professionals

Claims-Based Reporting	
<p>Reporting Criteria:</p> <ul style="list-style-type: none"> - Report at least three Physician Quality Reporting System measures; OR - If less than three measures apply to the eligible professional, 1-2 measures; AND - Report each measure for at least 50% of the eligible professional’s Medicare Part B FFS patients seen during the reporting period - Measures with 0% performance rate will not be counted. 	<p>Reporting Period: January 1, 2012 – December 31, 2012</p>
Registry-Based Reporting	
<p>Reporting Criteria:</p> <ul style="list-style-type: none"> - Report at least three Physician Quality Reporting System measures; AND - Report each measure for at least 80% of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to which these measures apply - Measures with 0% performance rate will not be counted. 	<p>Reporting Period: January 1, 2012 – December 31, 2012</p>
EHR – Aligning with the Medicare EHR Incentive Program	
<p>Reporting Criteria:</p> <ul style="list-style-type: none"> - Reports on ALL three Medicare EHR Incentive Program core measures (as identified in Table 31 of this proposed rule) - If the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to three Medicare EHR Incentive Program alternate core measures (as identified in Table 31 of this proposed rule); AND - Report on three (of the 38) additional measures available for the Medicare EHR Incentive Program. 	<p>Reporting Period: January 1, 2012 – December 31, 2012</p>
EHR	
<p>Reporting Criteria:</p> <ul style="list-style-type: none"> - Report at least three Physician Quality Reporting System measures; AND - Report each measure for at least 80% of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to which the measure applies - Measures with 0% performance rate will not be counted. 	<p>Reporting Period: January 1, 2012 – December 31, 2012</p>

Measures Groups – Eligible Professionals

Claims-Based Reporting – Two Options		
<i>Option 1</i>	Reporting Criteria: <ul style="list-style-type: none"> - Report at least 1 Physician Quality Reporting System measures group; AND - Report each measure group for at least 30 Medicare Part B FFS patients. - Measures groups containing a measure with a 0% performance rate will not be counted 	Reporting Period: January 1, 2012 – December 31, 2012
<i>Option 2</i>	Reporting Criteria: <ul style="list-style-type: none"> - Report at least 1 Physician Quality Reporting System measures group; - Report each measures group for at least 50% of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT - Report each measures group on no less than 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies. - Measures groups containing a measure the 0% performance rate will not be counted. 	Reporting Period: January 1, 2012 – December 31, 2012
Registry-Based Reporting – Three Options		
<i>Option 1</i>	Reporting Criteria: <ul style="list-style-type: none"> - Report at least 1 Physician Quality Reporting System measures group; AND - Report each measures group for at least 30 Medicare Part B FFS patients. - Measures groups containing a measure with a 0% performance rate will not be counted 	Reporting Period: January 1, 2012 – December 31, 2012
<i>Option 2</i>	Reporting Criteria: <ul style="list-style-type: none"> - Report at least 1 Physician Quality Reporting System measures group; - Report each measures group for at least 80% of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT - Report each measures group on no less than 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies. - Measures groups containing a measure with a 0% performance rate will not be counted. 	Reporting Period: January 1, 2012 – December 31, 2012
<i>Option 3</i>	Reporting Criteria: <ul style="list-style-type: none"> - Report at least 1 Physician Quality Reporting System measures group; AND - Report each measures group for at least 80% of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT - Report each measures group on no less than 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies. - Measures groups containing a measure with a 0% performance rate will not be counted. 	Reporting Period: July 1, 2012 – December 31, 2012

For group practices with 25-99 eligible professionals, CMS is proposing that the group practice report on all the GPRO measures specified in the rulemaking for up to 218 beneficiaries for each disease module and preventive care measure. If the pool of beneficiaries is less than 218, CMS would require that reporting be completed for 100 percent of eligible assigned beneficiaries for the disease module or preventive care measure. For group practices with 100 or more eligible professionals, they will need to report on 411 beneficiaries. Regardless of size, the group practices will be required to report on consecutive patients; “skipping” will be allowed in limited circumstances.

Feedback Reports. CMS is statutorily required to provide feedback reports to eligible professionals. These reports will be provided on or about the time of issuance of the incentive payments. CMS is proposing to provide interim feedback reports for those reporting individual measures and measures groups through the claims-based reporting mechanism. These reports would be a simplified version of the annual feedback reports currently provided.

The Electronic Prescribing Incentive Program

Electronic prescribing is the transmission using electronic media of prescription or prescription-related information between the prescriber, dispenser, pharmacy benefit manager or health plan, using an electronic prescribing network. The program provides for a combination of incentives and payment adjustments through 2014. Bonus payments and adjustments will be based on a percentage of the prescriber's total estimated Medicare Part B PFS allowed charges. CMS believes that those who earn an incentive should not be subject to a payment adjustment in future years, having demonstrated their adoption and use of electronic prescribing technology.

Eligibility. For the 2012 and 2013 incentive payments and the 2013 and 2014 payment adjustments, eligible professionals can report individually or as part of a group practice. Determinations of success for individuals will be based on NPI/TIN combinations with payments being made to the holder of the TIN. Like in the PQRS, CMS is proposing that group practices in this program be composed of 25 or more eligible professionals; these group practices must indicate that they are participating under the GPRO for each calendar year.

Reporting Period. For the 2012 and 2013 incentive payments, CMS is proposing that the reporting period be the entire calendar year. For the 2013 payment adjustment, CMS finalized a full year period of January 1, 2011 through December 31, 2011 and is proposing an additional 6-month reporting period of January 1, 2012 through June 30, 2012. Similarly, CMS is proposing reporting periods of January 1, 2012 through December 31, 2012 and January 1, 2013 through June 30, 2013 for the 2014 payment adjustment.

Successful Electronic Prescribing. CMS is proposing to continue the same criteria for the electronic prescribing incentive program, requiring eligible professionals to report on the electronic prescribing measure to determine success. The measure has a denominator that defines the patient population on which the eligible professional's performance is measured and a numerator which identifies whether or not a clinical quality action was performed. The NQF measure is #0486: Adoption of Medication e-Prescribing. Eligible professionals can report via claims, qualified registry or qualified EHR; however, the requirement must be met by reporting through a single mechanism.

For individuals to earn the 2012 and 2013 incentive payments, they must report the measure a minimum of 25 times during the 12-month reporting period. For group practices of 25-99 and of 100 or more, they must report 625 and 2,500 unique visits respectively.

Payment Adjustment. A payment reduction of 1.5 percent in 2013 and 2 percent in 2014 will apply to eligible professionals who do not meet certain criteria. The payment adjustment will not apply in the following circumstances:

- If an eligible professional is not a MD, DO, podiatrist, nurse practitioner or physician assistant as of June 30, 2012 for the 2013 payment adjustment or as of June 30, 2013 for the 2014 payment adjustment.
- If the eligible professional's Medicare Part B allowed charges for covered professional services to which the electronic prescribing measure applies are less than 10 percent of their total allowed Medicare Part B PFS allowed charges for the reporting period, he will not be subject to the payment adjustment.

- If the eligible professional does not have at least 100 cases with an encounter code that falls within the denominator of the electronic prescribing measure for the 6-month reporting periods for the 2013 and 2014 payment adjustment.

To avoid the 2013 payment adjustment:

- Individual professionals must report the electronic prescribing measure 10 times between January 1, 2012 and June 30, 2012.
- Group practices of 25-99 must report the electronic prescribing measure 625 times between January 1, 2012 and June 30, 2012.
- Group practice of 100 or more must report the electronic prescribing measure 2,500 times between January 1, 2012 and June 30, 2012.

To avoid the 2014 payment adjustment:

- Individual must report the electronic prescribing measure 25 times between January 1, 2012 and December 31, 2012 or 10 times between January 1, 2013 and June 30, 2013.
- Group practices of 25-99 must report the electronic prescribing measure 625 times between January 1, 2012 and December 31, 2012 or 625 times between January 1, 2013 and June 30, 2013.
- Group practices of 100 or more must report the electronic prescribing measure 2,500 times between January 1, 2012 and December 31, 2012 or 2,500 times between January 1, 2013 and June 30, 2013.

Significant Hardship Exemptions. The Secretary may exempt eligible professionals from the payment adjustment on a case-by-case basis if complying with the requirement would result in a significant hardship. CMS is proposing to retain the two existing exemptions for the 2013 and 2014 payment adjustments:

- The eligible professional or eRx GPRO practices in a rural area with limited high speed internet access.
- The eligible professional or eRx GPRO practices in an area with limited available pharmacies for electronic prescribing.

CMS proposed two additional exemptions in its proposed rule entitled “Proposed Changes to the Electronic Prescribing Incentive” that they would retain for 2013 and 2014:

- Inability to prescribe due to local, state or federal law or regulation.
- Eligible professionals who prescribe fewer than 100 prescriptions during a 6-month payment adjustment reporting period.

Those who believe they qualify under one of the exemptions must provide the following information to CMS by June 30, 2012 for the 2013 payment adjustment and June 30, 2013 for the 2014 payment adjustment:

- The name of the practice and other identifying information.
- The proposed exemption that applies.
- A justification statement describing how compliance would create a significant hardship.
- An attestation of the accuracy of the information provided.

Medicare EHR Incentive Program

CMS is proposing that eligible professionals participating in the Medicare EHR Incentive Program can meet the clinical quality measures (CQMs) reporting requirements in 2012 by participating in the voluntary PQRS-Medicare EHR Incentive Pilot. Those who elect not to participate will continue to attest to the results of the CQMs as calculated by certified EHRs. CMS is proposing that measures could be submitted either through the infrastructure used for the PQRS EHR data submission vendor reporting mechanism or for the PQRS EHR reporting mechanism.

Under the first option, the data submission vendor would receive data from the participant's EHR, reformat the data and then submit it to CMS. A list of the qualified vendors will be available in summer 2012. The data submitted would be limited to Medicare patients and be based on a CQM reporting period of 1-calendar year regardless of which year of participation in the Medicare EHR Incentive Program the participant is in.

Those electing for the second option would submit CQM data directly from their certified HER to CMS. The certified EHR must be a 2012 PQRS qualified EHR; those will be listed on the CMS website prior to January 1, 2012. CMS will conduct an additional vetting process for EHRs wishing to participate in this pilot. The data submitted would be limited to Medicare patients, be patient-level data from which CQM results could be calculated, and be based on a CQM reporting period of 1-calendar year regardless of which year of participation the participant is in.

Participants would continue to have the same measures submission requirements outlined in the July 28, 2010 final rule for the Medicare EHR Incentive Program and would be required to report the CQMs for the full year.

APPENDIX 1 – TABLE 64: CY2012 PFS PROPOSED RULE TOTAL ALLOWED CHARGE ESTIMATED IMPACT FOR RVU AND MPPR CHANGES*

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges (mil)	Impact of Work & MP RVU Changes	Impact of PE RVU Changes		Combined Impact	
			2013	2012	2013	2012
TOTAL	\$83,014	0%	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	\$194	0%	1%	1%	1%	1%
ANESTHESIOLOGY	\$1,847	0%	4%	2%	4%	2%
CARDIAC SURGERY	\$384	0%	-2%	-1%	-2%	-1%
CARDIOLOGY	\$6,778	0%	-3%	-1%	-3%	-1%
COLON AND RECTAL SURGERY	\$146	0%	2%	1%	2%	1%
CRITICAL CARE	\$252	0%	1%	0%	1%	0%
DERMATOLOGY	\$2,931	0%	0%	0%	0%	0%
EMERGENCY MEDICINE	\$2,658	0%	-1%	-1%	-1%	-1%
ENDOCRINOLOGY	\$415	0%	1%	0%	1%	0%
FAMILY PRACTICE	\$5,640	0%	2%	1%	2%	1%
GASTROENTEROLOGY	\$1,837	0%	1%	0%	0%	0%
GENERAL PRACTICE	\$656	0%	2%	1%	2%	1%
GENERAL SURGERY	\$2,277	0%	1%	0%	1%	0%
GERIATRICS	\$200	0%	2%	1%	2%	1%
HAND SURGERY	\$121	0%	3%	1%	2%	1%
HEMATOLOGY/ONCOLOGY	\$1,912	0%	-1%	0%	-2%	0%
INFECTIOUS DISEASE	\$597	0%	1%	1%	1%	0%
INTERNAL MEDICINE	\$10,737	0%	1%	1%	1%	1%
INTERVENTIONAL PAIN MGMT	\$448	0%	3%	2%	2%	1%
INTERVENTIONAL RADIOLOGY	\$211	-1%	-3%	-1%	-4%	-2%
MULTISPECIALTY CLINIC/OTHER	\$84	1%	1%	1%	2%	1%
NEPHROLOGY	\$2,011	0%	0%	0%	0%	0%
NEUROLOGY	\$1,520	0%	4%	2%	4%	2%
NEUROSURGERY	\$669	0%	1%	0%	1%	0%
NUCLEAR MEDICINE	\$53	0%	-4%	-2%	-5%	-3%
OBSTETRICS/GYNECOLOGY	\$678	0%	0%	0%	0%	0%
OPHTHALMOLOGY	\$5,316	0%	3%	2%	3%	2%
ORTHOPEDIC SURGERY	\$3,572	0%	2%	1%	2%	1%
OTOLARNGOLOGY	\$1,001	0%	2%	1%	1%	1%
PATHOLOGY	\$1,122	0%	-2%	-1%	-2%	-1%
PEDIATRICS	\$68	0%	1%	1%	1%	1%
PHYSICAL MEDICINE	\$928	0%	3%	2%	3%	2%
PLASTIC SURGERY	\$339	0%	2%	1%	1%	0%
PSYCHIATRY	\$1,134	0%	0%	0%	0%	0%
PULMONARY DISEASE	\$1,758	0%	1%	0%	1%	0%
RADIATION ONCOLOGY	\$1,968	0%	-8%	-4%	-8%	-4%
RADIOLOGY	\$4,722	-1%	-5%	-2%	-6%	-4%
RHEUMATOLOGY	\$530	0%	0%	0%	0%	0%
THORACIC SURGERY	\$371	0%	-2%	-1%	-1%	-1%

UROLOGY	\$1,919	0%	-3%	-2%	-3%	-2%
VASCULAR SURGERY	\$749	0%	-2%	-1%	-2%	-1%
AUDIOLOGIST	\$56	0%	-6%	-3%	-6%	-3%
CHIROPRACTOR	\$743	0%	2%	1%	2%	1%
CLINICAL PSYCHOLOGIST	\$559	0%	-5%	-3%	-5%	-3%
CLINICAL SOCIAL WORKER	\$386	0%	-6%	-3%	-6%	-3%
DIAGNOSTIC TESTING FACILITY	\$833	0%	-8%	-2%	-8%	-3%
INDEPENDENT LABORATORY	\$1,047	0%	-3%	-1%	-3%	-1%
NURSE ANES / ANES ASST	\$769	0%	5%	2%	5%	2%
NURSE PRACTITIONER	\$1,376	0%	2%	1%	2%	1%
OPTOMETRY	\$980	0%	4%	2%	4%	2%
ORAL/MAXILLOFACIAL SURGERY	\$43	0%	2%	1%	2%	1%
PHYSICAL/OCCUPATIONAL THERAPY	\$2,324	0%	5%	3%	5%	3%
PHYSICIAN ASSISTANT	\$1,055	0%	1%	0%	1%	0%
PODIATRY	\$1,902	0%	3%	2%	3%	2%
PORTABLE X-RAY	\$97	0%	4%	3%	4%	3%
RADIATION THERAPY CENTERS	\$73	0%	-9%	-5%	-9%	-5%
OTHER	\$17	0%	5%	4%	5%	4%

* Table 64 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.