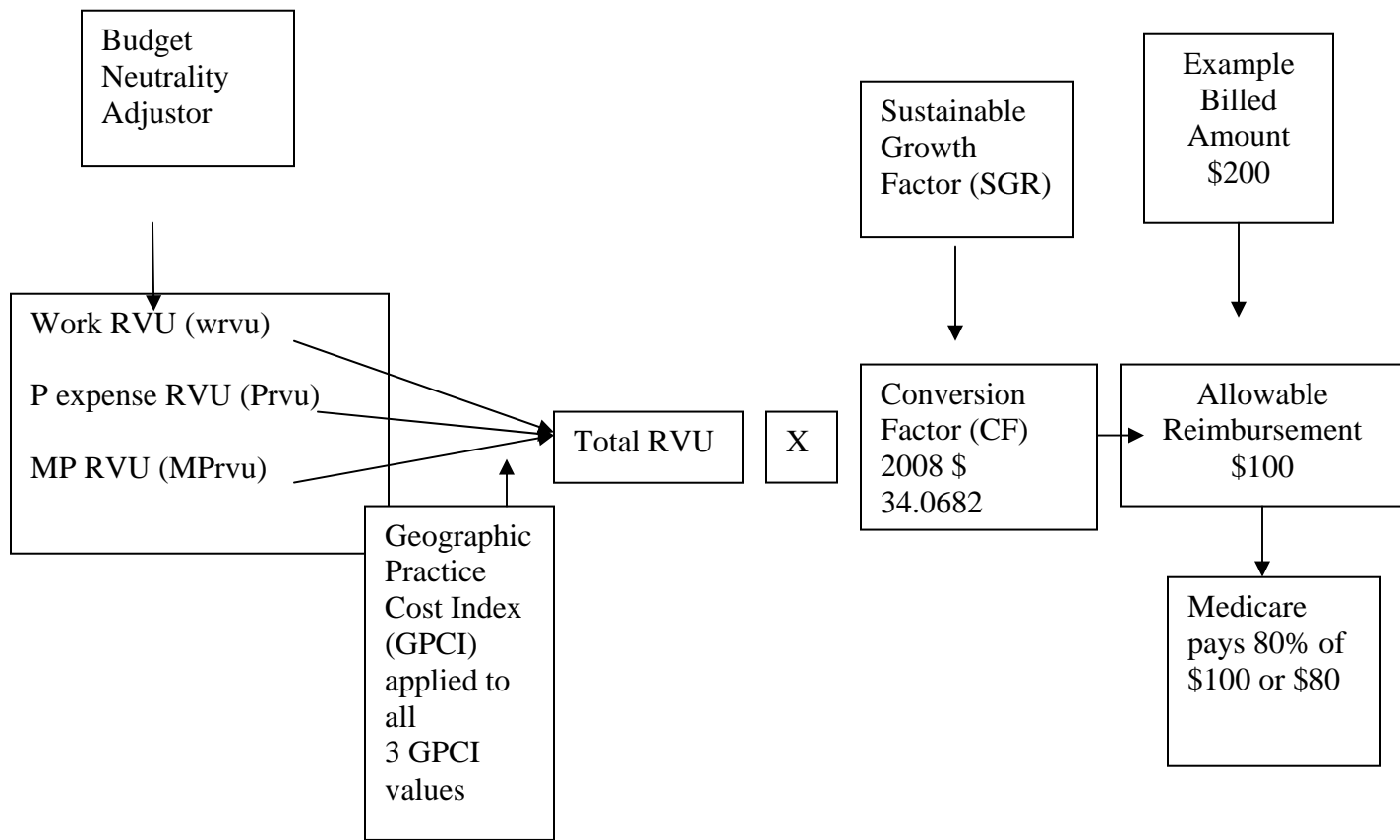


The final 2008 Medicare physician fee schedule was announced by CMS and cuts to physician payment of 10.1% are slated to occur on January 1, 2008 unless Congress acts. This will be accomplished by a decrease in the conversion factor from the current \$37.8975 to \$34.0682 and for anesthesia from \$17.7594 to \$16.3307.

A flow chart illustrating how the methodology works is:



The formula for calculating 2008 physician fee schedule payment amount is as follows:

***2008 Non-Facility Pricing Amount =***

((Work RVU \* Budget Neutrality Adjustor (0.8806)) (round product to two decimal places) \* Work GPCI) +

(Transitioned Non-Facility PE RVU \* PE GPCI) +

(MP RVU \* MP GPCI)] \* Conversion Factor

***2008 Facility Pricing Amount =***

((Work RVU \* Budget Neutrality Adjustor (0.8806)) (round product to two decimal places) \* Work GPCI) +

(Transitioned Facility PE RVU \* PE GPCI) + (MP RVU \* MP GPCI)] \* Conversion Factor

It is clear that operating costs have risen an average of almost 5% per year over the past 10 years (MGMA data) and a significant percentage of physicians will be forced to decline Medicare patients, lay off staff and possibly do with fewer physicians in their group practices. As indicated in the flow diagram above there are specific issues related to each of the items listed.

**RVU**

CMS has stated that they will change methodology with respect to determining practice expense RVU's (PERVU). In a four year transition CMS will determine the direct costs of practice expenses by combining the costs associated with typical resources.

**Malpractice RVUs**

Originally CMS had proposed some changes in radiology codes since MPRVU's expenses were calculated a being greater for technical compared to professional components. However, for now CMS has decided to postpone changes till a future time.

**Budget neutrality adjuster**

Congress has mandated that any changes in RVU's have to be essentially budget neutral and Medicare cannot spend over \$20 million over what it

would have been without any changes. Anesthesia has received a significant bump upwards so that CMS has reduced the BNA to 0.8806.

### **Telehealth**

CMS also decided to add a neurobehavioral status exam to the list of Medicare Telehealth Services and a facility fee of \$23.35 has been set for the originating site.

**Payments** for physician scarcity areas. The three year Physician Scarcity Area bonus program which provided a 5% bonus to practices is set to expire on December 31, 2007.

### **Self-referral / Stark changes**

CMS ended up not finalizing most of the previously announced proposals floated for the time being. However, it did go ahead and make changes to the 'anti-markup' rule which will limit payment for diagnostic services purchased from contractors. As it currently stands, the limitation applies only to the technical component of diagnostic tests. In other words, if a physician purchases a diagnostic test from an outside service and bills Medicare for both technical and professional services, there are rules limiting how much the technical component can be 'marked up.' This limits the payment to the lesser of: The supplier's net charge to the physician; the physician's actual charge; or the fee schedule amount for the test that would be allowed if the supplier billed directly. However, these rules did not apply to the professional component of the purchased service. Now, the limitation will apply BOTH to the technical and professional components of a diagnostic service ordered by and billed for by a physician or other supplier if they were purchased from an outside supplier or performed at a site other than the office of the billing physician or other supplier. So, essentially if any service (purchased or not) is performed at a location where the physician or group does not provide full range of patient care services, the anti-markup rule is in place for the professional component of the diagnostic service.

### **Pathology services to hospital patients**

Starting next year an independent laboratory may not bill the carrier for the technical component of physician pathology services furnished to a hospital inpatient or outpatient.

**PQRI 2008.** The 2008 PQRI will contain 119 measures including 59 measures endorsed by the National Quality Forum (NQF); 38 new measures

developed through the AMA Physician Consortium for Performance Improvement; 7 new measures for non-physician eligible professionals; and 13 other measures for preventive, pharmacologic and podiatric areas. Congress allocated \$1.35 billion in 2007 and CMS is going to make those funds available for 2008 PQRI bonus payments. In brief, the 2007 PQRI contains 74 approved quality measures to be reported by physicians between July 1, 2007, and Dec. 31, 2007. At least three quality measures are to be reported at least 80 percent of the applicable time through existing Part B claims-processing systems. It is anticipated that successful participants in the 2007 program will receive a bonus equal to 1.5 percent of their entire Part B payments around June 2008 in addition to a confidential 2007 PQRI feedback report.