MEDICARE PROGRAM: PAYMENT POLICIES UNDER THE PHYSICIAN FEE SCHEDULE AND FIVE-YEAR REVIEW OF WORK RELATIVE VALUE UNITS FOR CY 2012

The final rule for the 2012 Medicare Physician Fee Schedule (PFS) was released on November 1. The structural changes in the program, mandated in the Affordable Care Act, were outlined in the proposed rule released July 1 and were discussed in the September and October Watchlines. This final rule includes comments and responses on details of the proposed program changes to Medicare Part B payment policies, the Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, the Physician Resource-Use Feedback Program, as well as specific changes to the value of certain CPT codes under the five year review program.

The Multiple Procedure Payment Reduction Policy

In July 2009 the Government Accountability Office released a report entitled, "Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved when Services are Provided Together". The report recommended that CMS take steps to ensure that fees for services paid under the PFS reflect efficiencies that could occur when services were furnished by the same physician to the same beneficiary on the same day. As discussed in the July 2011 Watchline, the Medicare Payment Advisory Commission (Med PAC) has consistently raised concerns about the increasing inequities in the RBRVS system due to misvalued CPT codes. Research findings and personal experience led Commission members to conclude that the current physician time data, obtained from specialty society surveys, are flawed. Their recommendations included a focus on bundling of physician services to reduce overpayment. In its March 2010 report to Congress, Med PAC reiterated its concerns about mispricing of services under the PFS. Med PAC encouraged CMS to consider expansion of the existing Multiple Procedure Payment Reduction (MPPR) Policy to including other diagnostic procedures. Med PAC indicated that the AMA and CMS should explore bundling of services to improve payment accuracy.

The Washington Watchline is published monthly and provides timely information to NAMDRC members on pending legislative and regulatory issues that impact directly on the practice of pulmonary medicine.

NAMDRC’s primary mission is to improve access to quality care for patients with respiratory disease by removing regulatory and legislative barriers to appropriate treatment.

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Email: ExecOffice@namdrc.org

NAMDR will directly affect your practice more than any other organization to which you belong."
New Pulmonary Procedures Codes

For CY 2012, the American Medical Association Specialty Society Relative Value Scale Update Committee (RUC) submitted a codes change proposal to the CPT Editorial Panel to bundle services commonly reported together. The AMA RUC Relativity Assessment Workgroup identified CPT codes 94240 (functional residual capacity or residual volume), 94260 (thoracic gas volume), 94350 (multiple breath nitrogen washout), 94360 (airway resistance), 94370 (airway closing volume), and 94725 (membrane diffusing capacity with two DLCO measurements) are reported together 75 percent or more of the time. They find these codes are commonly billed together with CPT code 94720 (monoxide diffusing capacity), 94360 (airway resistance), 94240 (residual lung capacity), and 94350 (multiple breath nitrogen washout). CMS identified CPT code 94060 (Bronchodilation responsiveness, spirometry) through the AMA RUC’s multi-specialty points of comparison list screen. These are codes that have been designated as reference codes for the valuation of other codes. As a result of the reviews, the CPT Editorial Panel created new pulmonary procedure codes codes:

- **94726** Plethysmography for determination of lung volumes and when performed, airway resistance (Do not report 94726 in conjunction with 94727, 94728)
- **94727** Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes (Do not report 94727 in conjunction with 94726)
- **94728** Airway resistance by impulse oscillometry (Do not report 94728 in conjunction with 94010, 94060, 94070, 94375, 94726)
- **+94729** Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure) (Report 94729 in conjunction with 94010, 94060, 94070, 94375, 94726-94728)

CPT code 94240 (Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method) is being deleted for CY 2012 and the utilization associated with that service is expected to be captured under new CPT codes 94726 and 9272.

The AMA RUC recommended a work RVU of 0.31 for CPT codes 94060, 94726, 94727, and 94728, which corresponded to each surveys 25th percentile work RVU. Supported by CPT code 97012 (work RVU=0.25), CMS believes that a work RVU of 0.26 appropriately reflects the work associated with CPT codes 94060, 94726, 94727, and 94728 and is assigning a work RVU of 0.26 to CPT codes 94060, 94726, 94727, and 94728 on an interim final basis for CY 2012.

The AMA RUC recommended a work RVU of 0.19 for CPT code 94729. After clinical review of CPT code 94729, CMS believes that a work RVU of 0.17 reflects the work associated with this service. CMS also believes that CPT code 94010 (spirometry) is similar in time and intensity to CPT code 94729, and that the codes should have the same work RVU. CMS is assigning a work RVU of 0.17 to CPT code 94729 on an interim final basis for CY 2012.

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>94060</td>
<td>Evaluation of wheezing</td>
<td>0.31</td>
<td>0.31</td>
<td>0.26</td>
<td>Disagree</td>
<td>No</td>
</tr>
<tr>
<td>94726</td>
<td>Pulm funct tst plethysmograp</td>
<td>New</td>
<td>0.31</td>
<td>0.26</td>
<td>Disagree</td>
<td>No</td>
</tr>
<tr>
<td>94727</td>
<td>Pulm function test by gas</td>
<td>New</td>
<td>0.31</td>
<td>0.26</td>
<td>Disagree</td>
<td>No</td>
</tr>
<tr>
<td>94728</td>
<td>Pulm funct test oscillometry</td>
<td>New</td>
<td>0.31</td>
<td>0.26</td>
<td>Disagree</td>
<td>No</td>
</tr>
<tr>
<td>94729</td>
<td>O22/membrane diffuse capacity</td>
<td>New</td>
<td>0.19</td>
<td>0.17</td>
<td>Disagree</td>
<td>No</td>
</tr>
</tbody>
</table>
2012 PQRS; Individual Quality Measures and Measures Groups:

For 2012, CMS will retain all measures currently used in the 2011 Physician Quality Reporting System and have added 33 new measures to the program. New Measures that could pertain to a pulmonary practice for the 2012 PQRI program are:

- NQF endorsed; Anticoagulation for Acute Pulmonary Embolus Patients NQF 0503
- Endorsement pending; Hypertension: Blood Pressure Control

The 2012 Physician Quality Reporting System (Physician Quality Reporting) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures can be found:

http://www.cms.gov/PQRS/15_MeasuresCodes.asp

Measures Groups

Introduced in 2008, Measures Groups are a subset of four or more Physician Quality Reporting measures that have a particular clinical condition or focus in common. Twenty-two measures groups have been established for 2012 Physician Quality Reporting. Included are measures groups for Asthma, Chronic Obstructive Pulmonary Disease, Sleep Apnea and Community-Acquired Pneumonia.

2012 Asthma Measures Group

<table>
<thead>
<tr>
<th>Physician Quality Reporting System Number</th>
<th>Measure Title</th>
<th>NQF Measure Number</th>
<th>Measure Developer</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>Asthma: Pharmacologic Therapy for Persistent Asthma</td>
<td>0047</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>64</td>
<td>Asthma: Asthma Assessment</td>
<td>0001</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>231</td>
<td>Asthma: Tobacco Use: Screening – Ambulatory Setting</td>
<td>N/A</td>
<td>AMA-PCPI/NCQA</td>
</tr>
<tr>
<td>232</td>
<td>Asthma: Tobacco Use: Intervention – Ambulatory Screening</td>
<td>N/A</td>
<td>AMA-PCPI/NCQA</td>
</tr>
</tbody>
</table>

2012 COPD Measures Group

<table>
<thead>
<tr>
<th>Physician Quality Reporting System Number</th>
<th>Measure Title</th>
<th>NQF Measure Number</th>
<th>Measure Developer</th>
</tr>
</thead>
<tbody>
<tr>
<td>110</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>0041</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>111</td>
<td>Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older</td>
<td>0043</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>51</td>
<td>Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation</td>
<td>0091</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>52</td>
<td>Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy</td>
<td>0102</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>226</td>
<td>Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention</td>
<td>0028</td>
<td>AMA-PCPI</td>
</tr>
</tbody>
</table>
2012 Sleep Apnea Measures Group

<table>
<thead>
<tr>
<th>Physician Quality Reporting System Number</th>
<th>Measure Title</th>
<th>NQF Measure Number</th>
<th>Measure Developer</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBD</td>
<td>Assessment of Sleep Symptoms</td>
<td>N/A</td>
<td>AMA/PCPI/AASM</td>
</tr>
<tr>
<td>TBD</td>
<td>Severity Assessment at Initial Diagnosis</td>
<td>N/A</td>
<td>AMA/PCPI/AASM</td>
</tr>
<tr>
<td>TBD</td>
<td>Positive Airway Pressure Therapy Prescribed</td>
<td>N/A</td>
<td>AMA/PCPI/AASM</td>
</tr>
<tr>
<td>TBD</td>
<td>Assessment of Adherence to Positive Airway Pressure Therapy</td>
<td>N/A</td>
<td>AMA/PCPI/AASM</td>
</tr>
</tbody>
</table>

* This measures group is reportable through registry-based reporting only.

2012 Community Acquired Pneumonia Measures Group

<table>
<thead>
<tr>
<th>Physician Quality Reporting System Number</th>
<th>Measure Title</th>
<th>NQF Measure Number</th>
<th>Measure Developer</th>
</tr>
</thead>
<tbody>
<tr>
<td>56</td>
<td>Community-Acquired Pneumonia (CAP): Vital Signs</td>
<td>0232</td>
<td>AMA-PCPI/NCQA</td>
</tr>
<tr>
<td>57</td>
<td>Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation</td>
<td>0094</td>
<td>AMA-PCPI/NCQA</td>
</tr>
<tr>
<td>58</td>
<td>Community-Acquired Pneumonia (CAP): Assessment of Mental Status</td>
<td>0234</td>
<td>AMA-PCPI/NCQA</td>
</tr>
<tr>
<td>59</td>
<td>Community-Acquired Pneumonia (CAP): Empiric Antibiotic</td>
<td>0096</td>
<td>AMA-PCPI/NCQA</td>
</tr>
</tbody>
</table>

During the comment period, a pulmonary rehabilitation measures group was submitted for possible inclusion in the 2012 Physician Quality Reporting System. Upon review of the measures and feedback received from the NQF, 2 of the 5 proposed measures contained within the Pulmonary Rehabilitation measures group did not pass review, leaving only 3 measures. Since a Physician Quality Reporting System measures group must consist of at least 4 measures, the Pulmonary Rehabilitation measures group no longer contained enough measures to be classified as a measures group. CMS is interested in including a pulmonary rehabilitation measures group and they encourage professional organizations to submit a revised measures group for inclusion in future program years.
The Electronic Prescribing Program (eRx)

In the 2012 PFS, CMS finalized the comprehensive requirements for the 2012 and 2013 eRx incentive payments, additional requirements for the 2013 payment adjustment, and requirements for the 2014 payment adjustment. Individuals do not have to participate in the Physician Quality Reporting System in order to participate in the eRx Incentive Program and vice versa. For the 2012 and 2013 incentive payments CMS proposed two ways to participate in the program: (1) as an individual eligible professional; or (2) as part of a group practice participating in the group practice reporting option. The determination of whether an eligible professional is a successful electronic prescriber will continue to be made for each unique TIN/NPI combination. The incentive payments will be made to the applicable holder of the TIN. CMS requires that all group practices wishing to participate as a group under the eRx also participate in the Physician Quality Reporting System. This does not preclude individuals within group practices from participating in the eRx Incentive Program as individuals.

CRITERIA FOR BEING A SUCCESSFUL ELECTRONIC PRESCRIBER FOR THE 2012 INCENTIVE – INDIVIDUAL ELIGIBLE PROFESSIONALS

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Reporting Mechanism</th>
<th>Criteria for Being a Successful Electronic Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1, 2012 – Dec 31, 2012</td>
<td>Registry</td>
<td>Report the electronic prescribing measure's numerator for at least 25 unique denominator-eligible visits</td>
</tr>
</tbody>
</table>

CRITERIA FOR BEING A SUCCESSFUL ELECTRONIC PRESCRIBER FOR THE 2013 INCENTIVE – INDIVIDUAL ELIGIBLE PROFESSIONALS

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Additional information on the eRx Incentive Program including the final electronic prescribing measure specifications and list of qualified registries is available:

http://www.cms.gov/ERXIncentive
Physician Resource-Use Feedback Program

CMS continues to work toward resolving the methodological issues surrounding the Physician Resource Use and the Value Modifier Programs. Comments regarding this effort and the responses of CMS staff were included in the PFS. Comments strongly supported the development of quality of care measures that assess patient outcomes. As a first step in that direction CMS is finalizing outcome measures that assess the rate of potentially preventable hospital admission at the group practice level for heart failure and chronic obstructive pulmonary disease. CMS will be proposing outcome measures that assess the rate of potentially preventable hospital admissions for other ambulatory care sensitive conditions at the group practice level in next year’s rulemaking. In the next several months, CMS plans to host public events to further gather input on the value modifier and explain the price standardization and risk adjustment methodologies.

The Centers for Medicare & Medicaid Services Leadership

Now that Republicans have successfully blocked his Senate confirmation, CMS Administrator Dr. Donald Berwick steps down on December second. Deputy Administrator Marilyn Tavenner has been nominated by the White House to be his replacement and will serve as Acting Administrator pending the confirmation hearings. Tavenner began her career as an ICU nurse in a community hospital and rapidly rose through the Healthcare Corporation of America administration as a result of her hard work and common sense approach to problems. She was appointed Virginia’s Secretary of Health by the Democrat administration of Governor Tim Kane. As CMS Administrator, she would be an experienced friend of clinical medicine. Unfortunately, in the current political climate, Senate confirmation of any individual will be a challenge.

NAMDR C’S 2012 ELECTION TIME IS JUST AROUND THE CORNER!!!!!!

The Nominations Committee is seeking nominees for the NAMDRC Board of Directors.

Board Terms are for 3 years and you may nominate yourself.

Submit Nominations by Friday, January 27, 2012 directly to
Steve Peters, MD at Peters.Steve@mayo.edu or to
the NAMDRC Executive Office at vickie@namdrc.org

PRODUCT AND TECHNOLOGY NEWS!

NAMDRC is providing this space to our benefactors and patrons who provide us with information about new products and innovations related to pulmonary medicine. NAMDRC reserves the right to edit this copy as appropriate.
AFTER NAMDRC:
Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

NAMDRC members, all physicians, work in close to 2,000 hospitals nationwide, primarily in respiratory care departments and critical/intensive care units. They also have responsibilities for sleep labs, management of blood gas laboratories, pulmonary rehabilitation services, and other respiratory related services.

NAMDRC MEMBERSHIP BENEFITS AT A GLANCE...

- Monthly publication of the Washington Watchline, providing timely information for practicing physicians;
- Publication of Current Controversies focusing on one specific Pulmonary/Critical Care Issue in each publication;
- Regulatory updates;
- Discounted Annual Meeting registration fees;
- The Executive Office Staff as a resource on a wide range of clinical and management issues; and
- The knowledge that NAMDRC is an advocate for you and your profession.

http://www.namdrc.org/coding.html

One of NAMDRC’s primary reasons for existence is to provide both clinicians and patients with the most up-to-date information regarding pulmonary medicine. Bookmark this page!

The complexity of our nation’s health care system in general, and Medicare in particular, create a true challenge for physicians and their office staffs. One of NAMDRC’s key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, NAMDRC members indicate that their #1 reason for belonging to and continuing membership in the Association is its voice before regulatory agencies and legislators. That effective voice is translated into providing members with timely information, identifying important Federal Register announcements, pertinent statements and notices by the Centers for Medicare and Medicaid Services, the Durable Medical Equipment Regional Carriers, and local medical review policies.

ABOUT NAMDRC:

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NAMDRC MEMBERSHIP APPLICATION

Two Easy Ways to become a NAMDRC member

1. Go to www.namrdc.org and register for membership online.
2. Mail this application to:
   NAMDRC
   8618 Westwood Center Drive, Suite 210
   Vienna, VA 22182-2222

Please print clearly or type:

Name (Last) (First) (MI)

Degree

Address

City State Zip

Telephone Fax

E-mail

Facilities with which you are affiliated

Please indicate ALL the areas that apply to your practice:

☐ Respiratory Care Management
☐ Anesthesiology
☐ Sleep Disorders
☐ Pulmonary Rehabilitation
☐ Skilled Nursing Facility
☐ Hyperbaric Oxygen Therapy
☐ Critical Care
☐ Home Health Services
☐ Physiology Assessments

Membership Dues Schedule

(Dues for the first year includes $75.00 Initiation Fee*)

Individual and Small Group Membership Dues $350.00
Can include groups of up to 6. Please include contact information for additional members.

Group Membership Dues

(For larger groups, please attach a list of names. If a group member wishes to receive mailings at an address other than that indicated above, please attach appropriate information.)

Groups of 7-10 $1,100.00
Groups of 11-20 $1,460.00
Groups of 21-30 $1,805.00

TOTAL PAYMENT DUE

Payment

☐ Enclosed is a check payable to NAMDRC (US Dollars)
☐ Charge my credit card for total payment due
   ☐ VISA
   ☐ MasterCard

Credit Card Number Expiration Date

Name as it appears on Credit Card

Billing Address (If different from registration)

E-mail

Signature

*The $75.00 Initiation Fee is waived if your membership application and an Annual Meeting Registration form are submitted at the same time.

In accordance with IRS Regulations, 95% of your 2012 Annual Dues are tax deductible. NAMDRC’s Federal TAX ID # is 74-2020988.

For More Information, Contact NAMDRC

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Fax: 703-752-4360
E-mail: ExecOffice@namrdc.org
Web Site: www.namrdc.org

NAMDRC’s primary mission is to improve access to quality care for patients with respiratory disease by removing regulatory and legislative barriers to appropriate treatment.

NAMDRC 36th Annual Meeting and Educational Conference
will be held March 21-23, 2013
U.S. Grant Hotel San Diego, CA

National Association for Medical Directors of Respiratory Care
Physician Advocacy for Excellence in the Delivery of Pulmonary, Critical Care and Sleep Medicine