2010 Medicare Physician Fee Schedule Proposed Rule Summary

The Centers for Medicare and Medicaid Services (CMS) has proposed the Medicare physician fee schedule (MPFS) for 2010. The rule in its entirety can be found at: http://edocket.access.gpo.gov/2009/pdf/E9-15835.pdf. CMS will accept comments on the proposed rule until August 31, and will respond to all comments in a final rule to be issued by November 1, 2009. Unless otherwise specified, the new payment rates and policies will apply to services furnished to Medicare beneficiaries on or after January 1, 2010.

Physician Fee Schedule Update

While Medicare updates most of their payment rates each year for inflation, physician services are updated by a formula mandated in legislation known as the Sustainable Growth Rate (SGR). SGR establishes a spending target for physician services. CMS projects a negative update of -21.5 percent for the 2010 Medicare Physician Fee Schedule due to the application of the SGR formula. This will result in a **CY 2010 conversion factor (CF) of $28.3208.** This represents a decrease from the 2009 CF of $36.0666. Negative updates have been expected every year since 2002, although Congressional action has averted payment reductions since 2003. Congressional action will be needed again in order to avoid a payment reduction in 2010.

Proposal to Remove Physician Administered Drugs from SGR Formula

√PROPOSAL: CMS is proposing to remove physician administered drugs from the calculation of allowed and actual expenditures. While this proposal would not change the update for 2010 it would reduce the past discrepancy between actual and targeted expenditures and would reduce the number of years in which physicians are projected to experience a negative update.

Specialty Impact

Included in the rule, is a chart showing the impact of the proposed work, practice expense (PE), and malpractice (MP) relative value units (RVU) changes on the various Medicare recognized specialties. The analysis does not include the effect of any conversion factor change which is the same for all specialties. For the most part, the projected impact on specialties is a function of the proposed changes to practice expense and malpractice. Based on this analysis, hematology/oncology is estimated to experience an impact of -5 percent from the practice expense changes and – 1 percent from malpractice RVU changes in the 2010 proposed rule. An excerpt from the chart is below and the full chart is attached.

Table 39: CY 2010 Total Allowed Charge Impact for Work, Practice Expense and Malpractice (MP) Changes

Specialty	Allowed Charges (mill)	Impact of Work RVU Changes	Impact of PE RVU Changes*	Impact of MP RVU Changes	Combined Impact
Total	$77,744	0%	1%	0%	1%
Hematology/Oncology	$1,888	0%	-5%	-1%	-6%

* Note: The law caps the MFS imaging payment amount at the comparable payment amount in the hospital outpatient payment system (OPPS cap). In the absence of the negative current law CY 2010 MFS update, the proposed PE change to the equipment utilization rate for expensive equipment from 50 percent to 90 percent would increase expenditures by approximately 1 percent due to a loss of savings from the OPPS cap.

Practice Expense Changes

Practice Expense Relative Value Units (RVUs) represent the resources used in furnishing supplies, office rent/lease, equipment and personnel wages (excluding malpractice expense) when providing physician services.

AMA Physician Practice Information Survey (PPIS)

Currently PE per hour (PE/HR) data is obtained from the American Medical Association's (AMA's) Socioeconomic Monitoring Survey (SMS) surveys from 1995-1999. For several specialties more current supplemental survey data was accepted and is being used by the Agency to calculate PE RVUs. These specialties include cardiology, dermatology, gastroenterology, radiology, cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, independent diagnostic testing facilities (IDTFs), radiation oncology, medical oncology, and urology. Because the SMS data and the supplemental survey data are from different time periods, CMS has historically inflated them by the Medical Economic Index (MEI) to help make the data comparable.

The AMA in collaboration with numerous medical specialty societies recently conducted a new survey, the Physician Practice Information Survey (PPIS) to update the specialty-specific PE per hour (PE/HR) data used to develop PE RVUs. The PPIS survey was administered in 2007 and 2008 and unlike previous surveys included nonphysician practitioners (NPP).

√**PROPOSAL**: CMS is proposing to update the PE/HR data based on the new PPIS survey for all Medicare recognized specialties that participated in the PPIS for payments effective January 1, 2010. The PPIS gathered information from 3,656 respondents across 51 physician specialty and health care professional groups. Since IDTFs and independent labs did not participate in the PPIS survey, CMS is proposing to continue using the existing survey data for these providers. Although reproductive endocrinology, sleep medicine, and spine surgery participated in the PPIS survey since these specialties are not separately recognized by Medicare, CMS is not using this data and is seeking comment on how to blend this specialty data.

Impact on Medical Oncology Services: While hematology did not participate in the survey, medical oncology did participate. Regardless of specialty designation the medical oncology data would impact all oncology services. PE RVUs are based on direct practice expense inputs (clinical labor, medical supplies and medical equipment) and indirect costs (clerical payroll, office expense, and other expense). Key to the determination of indirect costs is the ratio of a specialty's indirect costs to that of all physicians. The chart below provides the results of the new survey for medical oncology.

	Indirect				Direct	
Specialty	**Current Indirect PE/HR**	**PPIS Indirect PE/HR**	**Current Indirect %**	**PPIS Indirect %**	**2009 PE/HR**	**PPIS PE/HR**
All Physicians	$59.04	$86.36	67%	74%	$88.23	$116.96
Medical Oncology	$141.84	$129.94	59%	56%	240.91	$230.06

The survey final report and other details is available on the CMS website: http://www.cms.gov/PhysicianFeeSched/

Equipment Utilization Rate Assumption

In allocating equipment costs for calculating PE RVUs, CMS assumes equipment is in use 25 hours per week or 50 percent of the time a facility/office is open (a 50 hour week is assumed). A 2006 survey sponsored by the Medicare Payment Advisory Commission (MedPAC) of CT and MRI machines indicates that the current usage rate is understated. According to the data from the survey MRI scanners

are used an average of 52 hours per week and CT machines are operated an average of 42 hours per week. An increase in the equipment use assumption would decrease the equipment costs allocated to these services and reduce PE RVUs for CT, MRI and other services associated with equipment priced at $1 million or above.

√**PROPOSAL**: Although MedPAC has concluded that their survey was not nationally representative but representative of the imaging providers in the six markets included in the survey, CMS is proposing a change in the equipment utilization assumption based on this new data. CMS is proposing to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over $1 million. The threshold of a million is proposed since all of the equipment cited in the MedPAC study is priced at $1 million or more. CMS will continue to explore data sources regarding the utilization rates of equipment priced at less than $1 million but no policy changes are being proposed at this time for this less expensive equipment.

Miscellaneous PE Issues

The proposed rule mentioned other miscellaneous PE issues including:

- CMS will continue to analyze PE methodology for services which are utilized 24 hours a day/7 days a week
- CMS requested AMA RUC to review PE direct inputs for several high dose radiation therapy (HDRT) and placement CPT codes

CPT Code Changes

Consultation Services

A consultation service is an evaluation and management (E/M) service furnished by a physician or qualified NPP at the request of another physician or appropriate source. The payment for a consultation has been set higher than for an initial visit because a written report must be made to the requesting professional.

For the past several years the appropriate reporting of consultation services has been an issue of some interest to CMS. Since 2006 CMS has had an ongoing discussion with the AMA CPT Editorial Panel for potential changes to the consultation definition and guidance in CPT. A 2006 report published by the Office of the Inspector General (OIG) indicated that Medicare allowed approximately $1.1 billion more in 2001 than it should have for services that were billed as consultations.

CMS cited two areas of disagreement that have remained unresolved with the physician community regarding consultation codes: documentation requirements and ambiguity regarding transfer of care policies. EM guidelines require both the requesting physician and the consulting physician to document the request. CMS has heard from representatives from national physician organizations that are dissatisfied with this policy. CMS has also found that interpretation differs from one physician to another as whether a transfer of care should be reported as an initial E/M service or as a consultation service.

√**PROPOSAL**: CMS proposes to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for the telehealth consultation G-codes) by increasing the work RVUs for the new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE and malpractice RVU calculations. CMS believes the rationale for differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services.

While specific crosswalks were not provided in the rule, CMS stated that providers will bill initial visit codes in lieu of the consultation codes. While there are five office/outpatient consultation codes and five office/outpatient new patient EM codes, the crosswalk for inpatient consultation codes is less clear since there are only three initial inpatient visit codes while there are five inpatient consultation codes.

Because Medicare policy only allows one admitting patient of record for a particular patient, CMS will create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. This will help distinguish the admitting physician who oversees the patient's care from other physicians who may be furnishing specialty care.

Potentially Misvalued Services Under the Physician Fee Schedule
CMS is considering several different approaches to address the issue of potentially misvalued services.

AMA RUC Process – To address concerns voiced by different stakeholders, the AMA RUC reviewed a number of potentially misvalued codes through their Five Year Review Workgroup at their February and April 2009 meetings. Subsequently recommendations were submitted to CMS by the RUC. CMS plans to address these recommendations in the 2010 final rule.

High Cost Supplies – In the CY 2009 proposed physician rule CMS proposed a process to update the prices associated with high cost supplies over $150 every two years. The Agency requested documentation from the medical community. The Agency did receive input but is continuing to consider alternatives to obtain pricing information and will propose a revised process in future rulemaking.

Nonsurgical Services Often Billed Together – CMS plans to analyze codes furnished together more than 75 percent of the time, excluding E/M codes. Both physician work and PE inputs will be examined. If duplications or overlap in work or PE are found, CMS will consider whether a multiple procedure payment reduction (MPPR) or bundling of service is most appropriate. Any proposed changes will be made through rulemaking and open for public comment.

Site of Services Anomalies – The AMA RUC Five Year Identification Workgroup reviewed a number of codes where there had been a shift in the site of service (site of service anomaly). These are generally services that historically were provided in the inpatient setting and are now typically provided in the outpatient setting. The AMA submitted revisions to the values of these codes. After further review, CMS is proposing additional changes to several of these codes. CMS does not believe the AMA RUC-recommended values reflect the extraction of the RVUs associated with deleted or reallocated pre-service and post-service time, hospital days, office visits, and discharge day management services.

MedPAC Recommendation– MedPAC in the past has recommended the establishment of a group of panel of experts separate from the AMA RUC to review RVUs. CMS is seeking public input on the following questions and other aspects of such an approach:

- How could input from a group of experts best be incorporated into existing processes of rulemaking and agency receipt of AMA RUC recommendations?

- What specifically would be the roles of a group of experts (for example, identify potentially misvalued services, provide recommendations on valuation of specified services, review AMA RUC recommendations selected by the Secretary, etc.)?

- What should be the composition of a group of experts? How could such a group provide expertise on services that clinician group members do not furnish?

- How would such a group relate to the AMA RUC and existing Secretarial advisory panels such as the Practicing Physician Advisory Committee?

Also of interest are comments on the resources required to establish and maintain such a group.

Telehealth Services
Medicare policy allows for coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management any additional services specified by the Secretary delivered via a telecommunications system. CMS maintains a list of eligible services.

√**PROPOSAL**: CMS is proposing to specify that G-codes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and SNFs.

CMS received a number of other requests for additions to the list of approved telehealth services including Health Behavior and Assessment Intervention (HBAI) and critical care services which were rejected.

Payment for Initial Preventive Physical Examination (IPPE)
MIPPA changed the initial preventive physical examination (IPPE) benefit by adding the measurement of an individual's body mass index and, upon an individual's consent, end of life planning. MIPPA also removed the screening electrocardiogram (EKG) as a mandatory service of IPPE. The IPPE is reported with code G0402 and is valued at 1.34 work RVUs in 2009.

√**PROPOSAL**: CMS is proposing to increase the work RVUs for code G0402 to 2.30 work RVUs. This value was crosswalked from code 99204, Evaluation and management new patient, office or other outpatient visit. Based on analysis of the work and intensity, CMS concluded the IPPE is most similar to code 99204.

Malpractice Relative Value Units (RVUs)

Revision of Resource-Based Malpractice RVUs
Initial implementation of resource-based malpractice (MP) RVUs occurred in 2000. CMS is required to review these RVUs no less than every five years. The first review of malpractice RVUs were addressed in the CY 2005 final rule.

Hematology/Oncology is estimated to experience a -1% impact in 2010 due to the proposed changes to malpractice relative value units (RVUs).

√**PROPOSAL**: CMS is proposing to implement the second review and update of malpractice RVUs by using specialty-specific malpractice premium data from CY 2006 and 2007. Data was collected from 49 states and the District of Columbia for all physician specialties represented by major insurance providers. Thirteen specialties were crosswalked to similar specialties for which sufficient data was not available. Data for four specialties which were not crosswalked were dropped resulting in data from 44 specialties representing 90 percent of Medicare services.

The data showed that the primary determinants of malpractice liability costs continue to be physician specialty, level of surgical involvement, and the physician's malpractice history.

CMS proposes to use the current methodology of a specialty-weighted approach with minor modifications to accommodate additional data gathered. The specialty-weighted approach bases the malpractice RVUs upon a weighted average of the risk factors of all specialties furnishing a given service. This approach ensures that all specialties furnishing a given service are accounted for in the calculation of the final malpractice RVUs.

Malpractice RVUs for TC Portion of Certain Services
The previous update of the malpractice RVUs did not update the TCs due to the lack of available malpractice premium data for entities providing TC services. In previous regulations CMS has requested information on how technicians employed by these facilities purchase professional liability insurance (PLI) or how their professional liability is covered.

Premium data recently collected by Acumen LLC from a firm that provides liability insurance to imaging companies indicates that medical physicists have very low malpractice premiums relative to physicians. Medical physicists are involved in complex services such as Intensity-Modulated Radiation Therapy (IMRT).

√**PROPOSAL**: CMS is proposing to use the medical physicists' premium data as a proxy for the malpractice premiums paid by entities providing TC services.

Malpractice RVUs for Certain Codes with No Physician Work
Certain codes have no physician work RVUs. The overwhelming majority of these codes are the TC s of the diagnostic tests, such as x-rays and cardiac catheterization which have a distinctly separate TC (the taking of the x-ray) and PC (the interpretation of the x-ray by the physician).

√**PROPOSAL**: CMS proposes to set the TC malpractice RVUs equal to the difference between the global malpractice RVUs and the PC malpractice RVUs.

Impact on the Technical Component (TC) of Services
The impact on the TC of these proposed changes can be dramatic. For example, code 73720, MRI lower extremity, w/out and w/ dye, picked at random went from a 2009 MP RVU of 0.84 down to 0.01 MP RVUs.

Part B Drugs

Statutorily Named Compendia
Medicare has designated compendia that are authoritative sources for use n the determination of "medically-accepted indication" of drugs and biologicals used off-label in an anticancer chemotherapeutic regimen.

√**PROPOSAL:** MIPPA requires that on or after January 1, 2010 no compendia may be included on the list of compendia unless it has a publically transparent process for evaluating therapies and for identifying potential conflicts of interest.

CMS proposes that this standard of publically transparent process could be met by publishing materials used in its evaluation process on its website.

The Agency proposes that assurance of a publicly transparent evaluation process is best achieved by establishing a process that provides for public disclosure of the evidence considered and the review of that evidence leading to the development of compendia recommendations.

CMS proposes that a publicly transparent process for identifying potential conflicts of interest is best demonstrated by a process that requires public transparency regarding the competing financial and nonfinancial interests that may give rise to such conflicts. CMS believes that a compendium should have a process for disclosing by publication on its publicly accessible website certain information regarding potential conflicts of interests associated with individuals who are responsible for the compendium's recommendations as well as their immediate family members. Disclosures should remain available of a period of not less than 5 years.

Other Part B Drug Issues
The rule also reviewed details regarding some technical issues related to the widely available market price (WAMP) and average manufacturer price (AMP).

Physician Quality Reporting Initiative (PQRI)

The Physician Quality Reporting Initiative (PQRI) was authorized by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007. In 2009 participating professionals were eligible for a bonus of 2.0 percent of the estimated total allowed charges for all covered professional services furnished during the reporting period. Providers report either individual measures or a measure group through a variety of reporting mechanisms.

2010 PQRI Program
Incentive Payment - The Secretary is authorized to provide an incentive payment equal to 2.0 percent of the estimated total allowed charges for all covered professional services during the reporting period for 2010.

Reporting Mechanisms – In 2009 providers could submit measures either through claims or via a qualified registry and the Agency proposes to maintain these reporting options. CMS proposes that providers that report measures through a registry will need to enter into and maintain an appropriate legal arrangement with a qualified 2010 PQRI registry. CMS will post on the PQRI section of the CMS website a list of qualified registries for the 2010 PQRI. An initial list will be posted by December 31, 2009 of registries who successfully participated in the 2009 program and a subsequent list will be posted later in 2010 for additional registries who have indicated interest through the self nomination process. CMS is proposing additional criteria for registries to meet in 2011 that are outlined in the rule. The Agency notes that even though a registry is listed as "qualified" CMS cannot guarantee or assume responsibility for the registry's successful submission.

√**PROPOSAL**: For 2010 CMS is proposing to add a third reporting mechanism, electronic health record (EHR) for a limited subset of measures. This proposal is contingent upon the successful completion of the 2009 EHR data submission testing process. This process is scheduled to conclude in 2009. EHR products that meet the requirements will be posted on the CMS section of the PQRI website.

CMS also noted they are considering significantly limiting the claims-based mechanism of reporting clinical quality measures for PQRI after 2010. This would be contingent upon there being an adequate number and variety of registries available and/or an EHR reporting option.

Reporting Periods –CMS proposes to establish the following reporting periods for the various reporting options. The incentive payment is based on the claims submitted for the reporting period.

- 12 month period – January 1 to December 31, 2010
  - Individual measures (claims based, EHR, or registry)
  - Measure groups (claims, registry)

- 6 month period – July 1 to December 31, 2010
  - Individual measures (registry)
  - Measure group (claims based, registry)

Successful Reporting of Individual Measures – In previous years CMS had both a criteria related to the number of measures reported (3 measures or 1-2 measures if less than 3 measures applied) and criteria related to the frequency of reporting (at least 80% of the time the measure applied).

√**PROPOSAL**: For 2010 CMS is proposing an additional requirement. CMS proposes establishing a minimum patient sample size for at least one measure to enhance the scientific validity of the eligible professionals' performance results. For 2010 CMS proposes that regardless of the reporting mechanism that the minimum patient sample size for reporting individual quality measures be 15 Medicare Part B patients for the 12 month reporting period and 8 patients for the 6 month reporting period.

Successful Reporting of Measure Groups – Table 15 in the rule summarizes the six different options and various reporting criteria available to providers when reporting measure groups. Measure groups can be reported either through a claims-based process or a registry for either 12 months or 6 months. The EHR reporting mechanism option is not available for measure groups. Similar to reporting individual measures CMS has proposed criteria related to the number of measures reported (1 measure group) and frequency of reporting and various minimum sample sizes that varies by the reporting option selected.

Group Practice Participation Option – CMS proposes establishing an option for group practices to participate in the PQRI program in 2010.

√**PROPOSAL**: A provider participating in a group practice option would not be eligible to earn a separate individual PQRI incentive payment. A group practice is defined as at least 200 or more individual eligible professionals. Group practices interested in participating would be required to complete a self nomination process and meet certain technical and other requirements and agree to have the performance rates at the group practice level (not individual) for each measure publically reported on posted on the CMS website. However, CMS may identify the individual professionals who were associated with the group during the reporting period. Final participation requirements will be posted on the CMS website by November 15, 2009 and group practices will be required to self nominate by the end of the first quarter in 2010.

Group practices would be required to report for a 12 month period and will be required to submit information on their measures using a data collection tool based on the data collection tool used in CMS' Medicare Care Management Performance (MCMP) demonstration and the Physician Group Practice (PGP) demonstration. Group practices would be required to report on a common set of 26 NQF-endorsed quality measures that are based on measures currently used in the MCMP and/or PGP demonstration. Similar to previous demonstration projects, the group practice will be required to report on beneficiaries assigned by Medicare to the group practice.

Measures Proposed for 2010 - Legislation requires that quality measures be adopted or endorsed by a consensus organization such as the national Quality Forum or the AQA. In January 2009 the AQA announced that it will no longer be adopting measures. CMS proposes that any new quality measures proposed for the 2010 PQRI must be NQF-endorsed by July 1, 2009, while any proposed 2010 PQRI quality measures selected from the 2009 PQRI quality measure set would need to have been adopted by the AQA as of January 31, 2009 if the measure still is not endorsed by the NQF by July 1, 2009.

- All Measures - For the 2010 PQRI program CMS proposes a total of 168 measures of these 22 would be new individual measures.

- Measure Groups - CMS is proposing to retain the 7 measure groups from 2009 and add 6 new measure groups for a total of 13 measure groups for 2010. The six new measure groups proposed for 2010 PQRI are: Coronary and Artery Disease (CAD); Heart Failure (HF); Ischemic Vascular Disease (IVD); Hepatitis C; Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS); and Community Acquired Pneumonia (CAP).

- Registry-only Measures - Due to measure complexity a select number of measures are being proposed to be designated as "registry-only" measures. None of the hematology/oncology measures were selected for this designation.

- EHR Measures - Additionally, a select number of measures have been designated to be reported through an EHR. None of the hematology/oncology measures were selected for this designation.

- Proposed Deletion of Measures for 2010 - CMS is also proposing to delete seven measures from the 2009 PQRI program. None of these measures were of interest to hematology/oncology.

- Hematology/Oncology Measures Proposed for 2010 - CMS is proposing the following measures for 2010 PQRI of potential interest to hematologists/oncologists.

Proposed Measures of Interest to Hematologists/Oncologists for 2010 PQRI Claims-Based and Registry Reporting	
No.	**Measure Title**
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
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)

The 2010 measure specifications document, which provides guidance on the appropriate definition and reporting of the measures, will be posted on the CMS website no later than December 31, 2009.

Physician Resource Use Measurement and Reporting Program

As required by MIPPA, in 2009 CMS established and implemented a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback to physicians that measure the resources involved in furnishing care to Medicare beneficiaries.

CMS is implementing this program in a phased-in approach. Phase I which consisted of the dissemination of an approximately 50-page report on resource use related to specific conditions to a select number of physicians was completed earlier this year. The resource use reports disseminated in phase I of the program defined peer groups of physicians by focusing on one condition, one specialty, and one geographic location. Within each peer group, the resource use reports indicated whether the individual physician fell over the 90th percentile (high cost benchmark), below the 10th percentile (low cost benchmark), or over the 50th percentile (median cost benchmark). CMS also solicited comments on this program in the 2009 final rule with comment period.

2010 Physician Resource Use Measurement Reporting Program

Based on the experiences from phase I and input received from the 2009 final rule with comment CMS is planning on the following changes for the 2010 program.

- Costs – Based on comments received CMS will include all cost of service categories included on the claim for the 2010 program.

- Conditions - Selected conditions for Phase I were: congestive heart failure, chronic obstructive pulmonary disease, prostate cancer, cholecystitis, coronary artery disease with acute myocardial

infarction, hip fracture, community acquired pneumonia, and urinary tract infection. Based on comments received CMS will add diabetes to the list of conditions for the 2010 program.

- Time Period – In 2010 CMS will include three years of Medicare claims data for calculating resource use.

- Specialties – In phase I of the program the following physician specialties were included: general internal medicine, family practice, gastroenterology, cardiology, general surgery, infectious disease, neurology, orthopedic surgery, physical medicine and rehabilitation, pulmonology, and urology. CMS plans on maintaining this list of specialties for the 2010 program.

- Location of physicians – For phase I of the program CMS mailed the report to physicians located in the following sites chosen due to their proximity to a CMS central office: Greenville, SC; Indianapolis, IN; Northern New Jersey; Orange County, CA; Seattle, WA; Syracuse, NY; Boston, MA; Cleveland, OH; East Lansing, MI; Little Rock, AR; Miami, FL; and, Phoenix, AZ. For the 2010 program CMS intends to include the sites listed above and identify a limited number of new locations.

- Benchmarks – CMS intends on continuing the use of the benchmarks used in phase I reports.

CMS is soliciting comments on the design and elements of the sample resource use report used in phase I of the Program. The Agency is particularly interested in receiving comments on the usefulness of the cost of service category drill down analysis. The report is available on-line at: http://rurinfo.mathematica-mpr.com/#content

Phase II of the Program
The Agency is proposing to expand the program in phase II.

√**PROPOSAL:** CMS is proposing the following expansions for phase II.

- Physician Groups – CMS is proposing to add reporting to groups of physicians recognizing that physicians practice in various arrangements. Group level reporting provides a mechanism for addressing sample size issues that arise when individual physicians have too few Medicare beneficiaries with specific conditions to generate statistically significant reports.

- Quality measurements – CMS is proposing to add quality measurement information as context for interpreting comparative resource use. Possible sources of quality measures include PQRI and the Generating Medicare Physician Quality Performance Measurement Results (referred to as GEM) Project.

Physician Value Based Purchasing (PVBP) Program

Currently, Medicare health professional payments are based on the quantity of services or procedures provided, without recognition of quality or efficiency. MIPPA requires the Secretary to develop a value-based purchasing (VBP) program for Medicare payment for professional services paid under the physician fee schedule. By May 1, 2010 the Secretary shall submit a report to Congress containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Examples of VBP initiatives relevant to physicians include: pay for reporting of quality measurement data; resource use reports comparing overall costs, as well as costs for treatment across episodes of care; or, demonstration projects, including the Physician Group Practice demonstration of a shared savings model.

CMS has created an internal VBP Workgroup to lead the development of the plan. Four subgroups were established to address the major sections of the pan: measures; incentives; data strategy and infrastructure; and public reporting. The Agency has reached out to the public and various stakeholders to help inform their work. The goals and objectives of the workgroup were outlined in an issues paper that was released on November 24, 2008. A listening session was held on December 9, 2008 where CMS staff heard various stakeholders.

The workgroup has begun to develop potential recommendations for inclusion in the Report to Congress. The first step is to design various approaches for performance-based payment that will address the planning goal and objectives for different practice arrangements. This design process will include identifying appropriate measures and incentive structures, considering the necessary data infrastructure, and addressing public reporting options. Consideration will be given to approaches that:

- Overlay the current fee schedule such as differential fee schedule payments based on measured performance or for providing a medical home

- Address multiple levels of accountability, including individual health professionals, as well as larger teams or organizations

- Promote more integrated care through shared savings models and bundled payment arrangements.

CMS is soliciting comments particularly in the areas of the appropriate level of accountability (i.e. group, individual, region) and appropriate data submission mechanisms. The workgroup will use public comments to inform its development of the plan and report to Congress.

E-Prescribing Incentive Program

2010 will be the second year of the MIPPA authorized E-prescribing incentive program. The program uses a mix of carrots and sticks to encourage participation. Successful participants will be eligible for the following bonus payments: 2% in 2010; 1% in 2011; 1% in 2012; and, 0.5% in 2013. In order to be eligible for the program, the e-prescribing quality measure must apply to at least 10 percent of the professional's total Part B allowed charges. Eligible participants who are not successful or do not participate will face the following reductions to their Medicare payments: – 1% in 2012; – 1.5% in 2013; and -2.0% in 2014 and each subsequent year. CMS will report publicly the names of eligible professionals who are successful electronic prescribers. The Recovery Act specifies that an individual provider or group providers is not eligible to receive the incentive if, for the EHR reporting period, the eligible professional earns an incentive payment under the new Health Information Technology (HIT) incentive program authorized under the Recovery Act.

2010 E-Prescribing Incentive Program

√PROPOSAL: CMS is proposing the following for the 2010 program:

- Physician group option – CMS will begin making incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber.

- Reporting period – CMS proposes a 12 month reporting period: January 1 – December 31, 2010.

- Reporting Mechanism – CMS proposes to retain the claims-based reporting mechanism that was used in the 2009 program. In addition, CMS proposes to implement a registry-based reporting mechanism. Potentially, an EHR-based reporting mechanism will also be available in 2010. The same registries and EHR products that are qualified to submit PQRI data would be considered qualified to submit e-prescribing data.

- E-prescribing Measure – CMS proposes 1 measure in 2010 (G8443) to indicate that at least 1 prescription in connection with the visit billed was electronically prescribed and proposes to eliminate the other two G-codes used in 2009. CMS proposes to modify the measure so that it would apply to professional services not just in the office and outpatient setting as it had in 2009 but to also include skilled nursing and home care settings.

- Successful reporting - E-prescribers must report the G-codes at least 50% of the time to be considered successful. In 2010 CMS is proposing to add a minimum threshold that the measure was reported at least 25 times during the 2010 reporting period.

In order to be eligible the electronic quality measure must apply to at least 10 percent of the professional's total Part B allowed charges. Final measure specifications for the E-prescribing program will be posted by December 31, 2009 on the CMS website.

Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services

Section 135 of MIPPA requires advanced diagnostic imaging service suppliers to be accredited by an accreditation organization by January 1, 2012. Payment for the technical component (TC) of the service is contingent upon the supplier being accredited by an accreditation organization designated by the Secretary. For the purposes of this policy, advanced diagnostic imaging services include: diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography.

This rule sets forth the criteria for designating organizations to accredit suppliers. CMS expects to publish a notice to solicit applications from entities interested in becoming an accredited organization on or before November 1, 2009.

Request for Comments

CMS indicated that they are interested in obtaining additional information on the role of radiology assistants (RA) and radiology practitioner assistants (RPA), including the level of physician supervision that would be appropriate when RAs and RPAs are involved in the performance of the TC of advanced medical imaging, whether the role varies by state or any other related information.

Geographic Practice Cost Indices (GPCIs)

The Medicare physician fee schedule pricing amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice).

Expiration of MIPPA Provision

The Medicare Improvements For Patients and Providers Act, (MIPPA) extended the 1.000 work GPCI floor from July 1, 2008 through December 31, 2009. MIPPA also established a permanent 1.500 work GPCI floor in Alaska for services furnished beginning January 1, 2009. As required by MIPPA, the 1.000 work GPCI floor will be removed on January 1, 2010 but the 1.500 work GPCI floor for Alaska will remain in place.

Payment Localities

The current locality structure was developed and implemented in 1997. There are currently 89 localities. Any changes to the locality configuration must be made in a budget neutral manner the implication being that any change in localities can lead to significant redistribution in payments. CMS recently contracted with Acumen LLC to conduct a preliminary study of several options for revising the payment localities on

a nationwide basis. Public comments on this interim study were accepted until November 3, 2008. CMS is continuing to review these comments and consider the impact of the proposals in the interim study.

CMS is not proposing changes in the locality structure at this time.

Other Miscellaneous Issues

Outpatient Mental Health Treatment

In this rule CMS also outlined a plan to begin the implementation of the MIPPA provision to phase out the limitation on recognition of expenses incurred for outpatient mental health treatment. The implementation of this provision will result in an increase in the Medicare Part B payment for outpatient and mental health services to 80 percent by CY 2014. At this time CMS is also proposing a number of technical corrections in order to update and clarify the services to which the limitation does not apply.

The rule also addresses policy clarifications of audiology codes, Stark physician self-referral rules, changes to the Medicare anesthesia teaching program, payments and coverage improvements for patients with chronic obstructive pulmonary disease and other conditions, coverage of kidney disease patient educational materials, renal dialysis provisions, chiropractic services demonstration project, comprehensive outpatient rehabilitation facilities (CORF), ambulance fee schedule, and the clinical lab fee schedule.

- Combined Impact of all Proposed Changes. The impact shown is a combined impact that incorporates all proposed changes to Work RVUs, PE RVUs, and MP RVUs, prior to the application of the CY 2010 negative PFS CF update under the current statute.

TABLE 39: CY 2010 Total Allowed Charge Impact for Work, Practice Expense, and Malpractice Changes*

	(A)	(B)		(C)	(D)	(E)
	Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes**	Impact of MP RVU Changes	Combined Impact
1	TOTAL	$ 77,744	0%	1%	0%	1%
2	ALLERGY/IMMUNOLOGY	$ 171	0%	0%	-2%	-3%
3	ANESTHESIOLOGY	$ 1,713	0%	5%	1%	6%
4	CARDIAC SURGERY	$ 371	-1%	-1%	3%	-2%
5	CARDIOLOGY	$ 7,179	0%	-10%	-1%	-11%
6	COLON AND RECTAL SURGERY	$ 129	-1%	5%	1%	5%
7	CRITICAL CARE	$ 221	0%	3%	1%	3%
8	DERMATOLOGY	$ 2,504	0%	2%	0%	3%
9	EMERGENCY MEDICINE	$ 2,395	0%	2%	0%	2%
10	ENDOCRINOLOGY	$ 370	-1%	3%	0%	3%
11	FAMILY PRACTICE	$ 5,055	2%	5%	1%	8%
12	GASTROENTEROLOGY	$ 1,779	-1%	1%	0%	0%
13	GENERAL PRACTICE	$ 719	1%	5%	0%	6%
14	GENERAL SURGERY	$ 2,213	-1%	4%	1%	4%
15	GERIATRICS	$ 167	1%	6%	1%	8%
16	HAND SURGERY	$ 89	-1%	4%	0%	3%

	(A)	(B)		(C)	(D)	(E)
	Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes**	Impact of MP RVU Changes	Combined Impact
17	HEMATOLOGY/ONCOLOGY	$ 1,888	0%	-5%	-1%	-6%
18	INFECTIOUS DISEASE	$ 549	-1%	4%	1%	3%
19	INTERNAL MEDICINE	$ 10,061	1%	4%	1%	6%
20	INTERVENTIONAL PAIN MANAGEMENT.	$ 352	-1%	7%	0%	6%
21	INTERVENTIONAL RADIOLOGY	$ 227	0%	-10%	0%	-10%
22	NEPHROLOGY	$ 1,789	0%	1%	1%	2%
23	NEUROLOGY	$ 1,417	-2%	6%	0%	3%
24	NEUROSURGERY	$ 586	-1%	3%	1%	2%
25	NUCLEAR MEDICINE	$ 72	0%	-12%	-2%	-13%
26	OBSTETRICS/GYNECOLOGY	$ 615	0%	1%	0%	1%
27	OPHTHALMOLOGY	$ 4,736	0%	11%	0%	11%
28	ORTHOPEDIC SURGERY	$ 3,257	0%	4%	0%	3%
29	OTOLARNGOLOGY	$ 926	-1%	3%	-1%	1%
30	PATHOLOGY	$ 985	0%	-1%	0%	0%
31	PEDIATRICS	$ 64	1%	4%	0%	4%
32	PHYSICAL MEDICINE	$ 816	0%	7%	0%	7%
33	PLASTIC SURGERY	$ 278	-1%	5%	1%	5%
34	PSYCHIATRY	$ 1,071	0%	2%	1%	3%
35	PULMONARY DISEASE	$ 1,753	-1%	3%	1%	3%
36	RADIATION ONCOLOGY	$ 1,799	0%	-17%	-1%	-19%
37	RADIOLOGY	$ 5,254	0%	-10%	-1%	-11%
38	RHEUMATOLOGY	$ 494	0%	0%	0%	-1%
39	THORACIC SURGERY	$ 389	-1%	0%	3%	2%
40	UROLOGY	$ 1,989	0%	-6%	0%	-7%
41	VASCULAR SURGERY	$ 685	-1%	-1%	0%	-1%
42	AUDIOLOGIST	$ 35	0%	-4%	-7%	-10%
43	CHIROPRACTOR***	$ 700	0%	4%	1%	5%
44	CLINICAL PSYCHOLOGIST	$ 533	0%	-7%	0%	-7%
45	CLINICAL SOCIAL WORKER	$ 353	0%	-6%	1%	-6%
46	NURSE ANESTHETIST	$ 772	0%	2%	0%	2%
47	NURSE PRACTITIONER	$ 1,004	1%	5%	1%	7%
48	OPTOMETRY	$ 834	1%	11%	0%	12%
49	ORAL/MAXILLOFACIAL SURGERY	$ 35	-1%	3%	-1%	1%
50	PHYSICAL/OCCUPATIONAL THERAPY	$ 1,857	0%	10%	0%	10%
51	PHYSICIAN ASSISTANT	$ 749	0%	4%	0%	5%
52	PODIATRY	$ 1,656	1%	7%	-1%	6%
53	DIAGNOSTIC TESTING FACILITY	$ 1,044	0%	-19%	-5%	-24%
54	INDEPENDENT LABORATORY	$ 960	0%	-4%	-1%	-5%
55	PORTABLE X-RAY SUPPLIER	$ 85	0%	-8%	-2%	-11%

* Does not include the impact of the current law CY 2010 negative update. Rows may not sum to total due to rounding

**Note: The law caps the MFS imaging payment amount at the comparable payment amount in the hospital outpatient payment system (OPPS cap). In the absence of the negative current law CY 2010 MFS update, the proposed PE change to the equipment utilization rate for expensive equipment from 50 percent to 90 percent would increase expenditures by approximately 1 percent due to a loss of savings from the OPPS cap.

***Does not reflect the BN reduction in payments resulting from the chiropractic demonstration

2010 Proposed Physician Fee Schedule (CMS 1413-P)									
Payment Rates for Medicare Physician Services - Hematology-Oncology									
* The 2010 CF assumes a 1.01% update from 2009. This is a proposal currently being considered in Congress.									
** Note: CPT Codes 90760-90775 were deleted in CY 2009. The new codes assigned to these services are 96361-96375.									
CPT Code	**Mod**	**Descriptor**	**2007**	**NON-FACILITY (OFFICE)**			**FACILITY (HOSPITAL)**		
				2009	**2010***		**2009**	**2010***	
			Frequency	**CF= $36.0666**	**CF = $36.4309**	**% CHANGE 2009-2010**	**CF= $36.0666**	**CF = $36.4309**	**% CHANGE 2009-2010**
36430		Blood transfusion service	13,663	$ 36.07	$ 26.96	-25.25%	NA	NA	NA
36511		Apheresis wbc	489	NA	NA	NA	$ 88.00	$ 93.26	5.98%
36512		Apheresis rbc	715	NA	NA	NA	$ 89.45	$ 93.26	4.27%
36513		Apheresis platelets	358	NA	NA	NA	$ 93.41	$ 98.36	5.30%
36514		Apheresis plasma	19,963	$ 495.19	$ 450.65	-9.00%	$ 87.28	$ 91.08	4.35%
36515		Apheresis, adsorp/reinfuse	257	$ 1,845.53	$ 1,719.90	-6.81%	$ 85.48	$ 91.81	7.40%
36516		Apheresis, selective	1,021	$ 2,089.34	$ 1,771.63	-15.21%	$ 61.67	$ 64.12	3.96%
36522		Photopheresis	4,098	$ 1,303.81	$ 1,155.95	-11.34%	$ 99.90	$ 100.18	0.28%
38205		Harvest allogenic stem cells	188	NA	NA	NA	$ 78.26	$ 81.61	4.27%
38206		Harvest auto stem cells	2,305	NA	NA	NA	$ 78.26	$ 80.88	3.34%
38220		Bone marrow aspiration	44,054	$ 147.15	$ 130.06	-11.62%	$ 58.79	$ 60.84	3.49%
38221		Bone marrow biopsy	132,778	$ 163.38	$ 141.35	-13.48%	$ 74.66	$ 75.41	1.01%
38230		Bone marrow collection	384	NA	NA	NA	$ 304.04	$ 330.79	8.80%
38240		Bone marrow/stem transplant	269	NA	NA	NA	$ 121.18	$ 123.50	1.91%
38241		Bone marrow/stem transplant	927	NA	NA	NA	$ 121.91	$ 124.23	1.91%
38242		Lymphocyte infuse transplant	52	NA	NA	NA	$ 92.33	$ 95.08	2.98%
88184		Flowcytometry/ tc, 1 marker	100,366	$ 78.26	$ 72.86	-6.90%	NA	NA	NA
88185		Flowcytometry/ tc, add-on	1,868,752	$ 46.53	$ 44.45	-4.47%	NA	NA	NA
88187		Flowcytometry/read, 2-8	23,544	$ 64.20	$ 68.85	7.25%	$ 64.20	$ 68.85	7.25%
88188		Flowcytometry/read, 9-15	29,031	$ 78.99	$ 86.34	9.31%	$ 78.99	$ 86.34	9.31%
88189		Flowcytometry/read, 16 & <	127,080	$ 100.63	$ 106.01	5.35%	$ 100.63	$ 106.01	5.35%
90760**		Hydration iv infusion, init	258,737	DELETED	DELETED	NA	NA	NA	NA
90761**		Hydrate iv infusion, add- on	639,572	DELETED	DELETED	NA	NA	NA	NA
90765**		Ther/ proph/ diag iv inf, init	1,237,103	DELETED	DELETED	NA	NA	NA	NA
90766**		Ther/ proph/ dg iv inf, add- on	798,381	DELETED	DELETED	NA	NA	NA	NA
90767**		Tx/ proph/ dg addl seq iv inf	2,079,889	DELETED	DELETED	NA	NA	NA	NA
90768**		Ther/ diag concurrent inf	374,116	DELETED	DELETED	NA	NA	NA	NA
90772**		Ther/ proph/ diag inj, sc/ im	8,500,055	DELETED	DELETED	NA	NA	NA	NA
90773**		Ther/ proph/ diag inj, ia	2,414	DELETED	DELETED	NA	NA	NA	NA
90774		Ther/ proph/ diag inj, iv push	346,850	DELETED	DELETED	NA	NA	NA	NA
90775**		Ther/ proph/ diag inj add- on	1,931,941	DELETED	DELETED	NA	NA	NA	NA
96360**		Hydration iv infusion, init	NEW	$ 56.62	$ 47.36	-16.36%	NA	NA	NA
96361**		Hydrate iv infusion, add- on	NEW	$ 16.59	$ 12.75	-23.14%	NA	NA	NA
96365**		Ther/ proph/ diag iv inf, init	NEW	$ 68.89	$ 60.11	-12.74%	NA	NA	NA
96366**		Ther/ proph/ dg iv inf, add- on	NEW	$ 22.00	$ 19.31	-12.24%	NA	NA	NA
96367**		Tx/ proph/ dg addl seq iv inf	NEW	$ 34.62	$ 26.96	-22.14%	NA	NA	NA
96368**		Ther/ diag concurrent inf	NEW	$ 20.56	$ 16.76	-18.48%	NA	NA	NA
96372**		Ther/ proph/ diag inj, sc/ im	NEW	$ 20.92	$ 21.86	4.49%	NA	NA	NA
96373**		Ther/ proph/ diag inj, ia	NEW	$ 18.03	$ 18.58	3.03%	NA	NA	NA
96374**		Ther/ proph/ diag inj, iv push	NEW	$ 54.46	$ 46.63	-14.38%	NA	NA	NA
96375**		Ther/ proph/ diag inj add- on	NEW	$ 23.80	$ 18.22	-23.48%	NA	NA	NA
96401		Chemotherapy, sc/im	415,742	$ 67.44	$ 61.93	-8.17%	NA	NA	NA
96402		Chemo hormon antineopl sq/ im	566,924	$ 36.79	$ 28.05	-23.75%	NA	NA	NA
96405		Intralesional chemo admin	1,415	$ 84.40	$ 73.59	-12.80%	$ 28.85	$ 29.87	3.54%
96406		Intralesional chemo admin	401	$ 116.50	$ 102.01	-12.44%	$ 41.84	$ 44.08	5.36%
96409		Chemo, iv push, sngl drug	224,975	$ 111.81	$ 88.53	-20.82%	NA	NA	NA
96411		Chemo, iv push, addl drug	362,693	$ 63.84	$ 50.27	-21.25%	NA	NA	NA
96413		Chemo, iv infusion, 1 hr	2,314,555	$ 147.51	$ 114.39	-22.45%	NA	NA	NA
96415		Chemo, iv infusion, addl hr	1,652,634	$ 33.54	$ 25.87	-22.88%	NA	NA	NA
96416		Chemo prolong infuse w/ pump	114,079	$ 160.86	$ 124.23	-22.77%	NA	NA	NA
96417		Chemo iv infus each addl seq	716,104	$ 73.58	$ 57.20	-22.26%	NA	NA	NA
96420		Chemotherapy, push technique	177	$ 107.84	$ 87.43	-18.92%	NA	NA	NA
96422		Chemotherapy,infusion method	413	$ 173.84	$ 137.34	-20.99%	NA	NA	NA
96423		Chemo, infuse method add-on	1,301	$ 77.54	$ 64.48	-16.84%	NA	NA	NA
96425		Chemotherapy,infusion method	741	$ 171.32	$ 144.99	-15.36%	NA	NA	NA
96440		Chemotherapy, intracavitary	75	$ 597.98	$ 784.72	31.23%	$ 132.36	$ 140.26	5.96%
96445		Chemotherapy, intracavitary	1,473	$ 285.29	$ 243.36	-14.70%	$ 116.86	$ 118.76	1.63%
96450		Chemotherapy, into CNS	2,667	$ 208.10	$ 163.21	-21.57%	$ 88.00	$ 81.24	-7.68%
96521		Port pump refill & main	87,087	$ 126.95	$ 108.56	-14.49%	NA	NA	NA
96522		Refill/ maint pump/ resvr syst	25,680	$ 107.84	$ 91.08	-15.54%	NA	NA	NA

2010 Proposed Physician Fee Schedule (CMS 1413-P)									
Payment Rates for Medicare Physician Services - Hematology-Oncology									
* The 2010 CF assumes a 1.01% update from 2009. This is a proposal currently being considered in Congress.									
** Note: CPT Codes 90760-90775 were deleted in CY 2009. The new codes assigned to these services are 96361-96375.									
CPT Code	Mod	Descriptor	2007	NON-FACILITY (OFFICE)			FACILITY (HOSPITAL)		
				2009	2010*		2009	2010*	
			Frequency	CF= $36.0666	CF = $36.4309	% CHANGE 2009-2010	CF= $36.0666	CF = $36.4309	% CHANGE 2009-2010
96523		Irrig drug delivery device	261,782	$ 25.25	$ 20.04	-20.63%	NA	NA	NA
96542		Chemotherapy injection	2,015	$ 134.17	$ 101.28	-24.51%	$ 45.44	$ 41.53	-8.61%
99363*		Anticoag mgmt, init	NA	$ 118.30	$ 121.68	2.86%	$ 81.87	$ 85.25	4.12%
99364*		Anticoag mgmt, subseq	NA	$ 41.12	$ 41.53	1.01%	$ 31.74	$ 32.42	2.16%
G0364		Bone marrow aspirate &biopsy	68,441	$ 12.98	$ 11.66	-10.21%	$ 9.74	$ 8.74	-10.21%

2010 Proposed Physician Fee Schedule (CMS 1413-P)									
Payment Rates for Medicare Physician Services - Evaluation & Management Services									
* The 2010 CF assumes a 1.01% update from 2009. This is a proposal currently being considered in Congress.									
** In 2010 CMS proposes to budget neutrally eliminate the use of all consultation codes by increasing work RVUs for the new and established office visits, initial hospital visits and initial nursing facility visits. Providers will bill initial visit codes in lieu of the consultation codes.									
CPT Code	**Descriptor**	**2007**	**NON-FACILITY (OFFICE)**			**FACILITY (HOSPITAL)**			
			2009	**2010***		**2009**	**2010***		
		Frequency	**CF= $36.0666**	**CF = $36.4309**	**% CHANGE 2009-2010**	**CF= $36.0666**	**CF = $36.4309**	**% CHANGE 2009-2010**	
Evaluation and Management Services									
99201	Office/outpatient visit, new	354,658	$ 36.79	$ 41.53	12.89%	$ 23.44	$ 26.59	13.44%	
99202	Office/outpatient visit, new	2,432,664	$ 63.48	$ 71.77	13.06%	$ 45.08	$ 50.64	12.32%	
99203	Office/outpatient visit, new	5,175,289	$ 91.97	$ 104.19	13.29%	$ 68.17	$ 77.23	13.30%	
99204	Office/outpatient visit, new	3,232,644	$ 141.74	$ 160.66	13.35%	$ 113.97	$ 130.79	14.76%	
99205	Office/outpatient visit, new	1,040,042	$ 178.89	$ 200.01	11.80%	$ 148.23	$ 167.95	13.30%	
99211	Office/outpatient visit, est	9,345,985	$ 18.75	$ 18.22	-2.87%	$ 8.66	$ 9.47	9.43%	
99212	Office/outpatient visit, est	21,647,315	$ 37.15	$ 41.17	10.82%	$ 23.08	$ 25.87	12.06%	
99213	Office/outpatient visit, est	104,328,942	$ 61.31	$ 69.58	13.49%	$ 44.72	$ 51.37	14.86%	
99214	Office/outpatient visit, est	65,511,137	$ 92.33	$ 103.10	11.66%	$ 69.25	$ 78.69	13.64%	
99215	Office/outpatient visit, est	8,060,246	$ 124.79	$ 139.53	11.81%	$ 98.46	$ 111.11	12.85%	
99221	Initial hospital care	425,845	NA	NA	NA	$ 89.81	$ 100.91	12.37%	
99222	Initial hospital care	3,035,525	NA	NA	NA	$ 122.63	$ 137.34	12.00%	
99223	Initial hospital care	5,631,298	NA	NA	NA	$ 180.33	$ 200.73	11.31%	
99231	Subsequent hospital care	16,329,791	NA	NA	NA	$ 37.15	$ 39.71	6.89%	
99232	Subsequent hospital care	51,080,310	NA	NA	NA	$ 66.72	$ 72.13	8.11%	
99233	Subsequent hospital care	19,596,436	NA	NA	NA	$ 95.58	$ 103.46	8.25%	
99241	Office consultation**	336,281	$ 48.69	NA	NA	$ 33.18	NA	NA	
99242	Office consultation**	1,503,724	$ 90.89	NA	NA	$ 69.97	NA	NA	
99243	Office consultation**	4,951,902	$ 124.79	NA	NA	$ 97.38	NA	NA	
99244	Office consultation**	6,025,404	$ 184.30	NA	NA	$ 154.00	NA	NA	
99245	Office consultation**	2,256,828	$ 226.50	NA	NA	$ 192.23	NA	NA	
99251	Initial inpatient consult**	267,653	NA	NA	NA	$ 48.69	NA	NA	
99252	Initial inpatient consult**	929,556	NA	NA	NA	$ 75.74	NA	NA	
99253	Initial inpatient consult**	3,093,064	NA	NA	NA	$ 114.69	NA	NA	
99254	Initial inpatient consult**	5,692,509	NA	NA	NA	$ 165.55	NA	NA	
99255	Initial inpatient consult**	2,832,048	NA	NA	NA	$ 201.97	NA	NA	
99291	Critical care, first hour	3,799,317	$ 253.91	$ 265.95	4.74%	$ 212.07	$ 223.69	5.48%	
99292	Critical care, addÏl 30 min	376,489	$ 114.69	$ 120.59	5.14%	$ 106.04	$ 111.84	5.48%	
99471	Ped critical care, initial	65	NA	NA	NA	$ 777.96	$ 800.39	2.88%	
99472	Ped critical care, subseq	198	NA	NA	NA	$ 384.11	$ 405.11	5.47%	