



AMERICAN SOCIETY *of* HEMATOLOGY

2011 Medicare Physician Fee Schedule Proposed Rule Summary

On June 25, 2010, the Centers for Medicare and Medicaid Services (CMS) posted a copy of the proposed Medicare physician fee schedule (PFS) for 2011. The proposed rule in its entirety can be found at: http://www.federalregister.gov/OFRUpload/OFRData/2010-15900_PI.pdf. The rule includes the standard annual fee schedule update, as well as implementation of provisions included in the Affordable Care Act (ACA) the recently passed health reform legislation. Comments may be submitted on the proposed rule through August 24, 2010 and a final rule is expected to be published around November 1, 2010. The provisions of the rule are effective January 1, 2011 unless stated otherwise.

A number of significant changes are contained in the proposed rule, including the following:

- A rescaling of the relative proportions of the components of the fee schedule between work, practice expense and physician liability insurance
- A change in the utilization assumption used in the calculation of practice expenses for costly imaging equipment
- An increase in the multiple procedure reduction for imaging services and an extension of this policy to certain therapy services
- Pricing of high cost disposable supplies
- Geographic practice cost indices
- Identification of potentially misvalued codes
- Disclosure to patients for certain services subject to the in-office ancillary exception under the Stark law
- Expansion of the PQRI, eRx and Physician Feedback Programs
- Physician signature for ordering clinical diagnostic laboratory tests
- Expansion of Medicare preventive services
- Improvement of access to primary care

Those changes that have greatest impact on hematology are explained further in this document.

Physician Fee Schedule Update

SGR Impact

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).

CMS proposes a negative 6.1 percent update to the conversion factor for 2011 based on the SGR formula. This reduction would be in addition to the 23 percent reduction that will occur on December 1, 2010 if not prevented by new legislation. Congress has enacted legislation repeatedly to prevent such reductions from occurring. Most recently, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 provided for a 2.2 percent update to the 2010 PFS, effective for services provided from June 2, 2010 through November 30, 2010. The conversion factor for services furnished during this time period is \$36.8729. It is assumed that Congress will act to prevent the SGR reductions for 2011, but if new legislation is not enacted, this means there will be a 29 percent reduction in Medicare physician fees in 2011.

Impact on Hematology

Table 73 (see Attachment 1), extracted from the proposed rule, provides a summary of the impact of the changes in the proposed 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, the change in the weights assigned to physician work, PE and professional liability insurance (PLI) components, the reduction in imaging equipment payments, and the multiple procedure reduction.

The impact of the 2011 proposed rule on hematology/oncology services is shown below.

Specialty	Allowed Charges (mil)	Impact of Work and MPRVU Changes	Impact of PE RVU and MPPR Changes		Impact of MEI Rebasing	Combined Impact	
			Fully Implemented	2011		Fully Implemented	2011
TOTAL	\$79,731	0%	0%	0%	0%	0%	0%
16-HEMATOLOGY/ONCOLOGY	\$1,870	0%	-5%	-2%	1%	-4%	-1%

NOTE: In the 2010 Final Rule, the calculation for the practice expense was changed. CMS decided to implement this change over a period of 4 years. The column header “2011” reflects the year 2 transition. The column header “Fully implemented” reflects the change after 4 years.

Practice Expense Changes

Rebasing of Fee Schedule Weights

Over the years, CMS has periodically rebased the elements of the Medicare Economic Index which is used to measure changes in the costs of operating a medical practice. When this is done, CMS adjusts the proportion of the relative value units (RVUs) assigned to physician work, practice expenses and professional liability insurance. This change in the relative weights must be done in a budget neutral manner and can be accomplished by a change in the conversion factor (CF) or a change in the physician work RVUs.

CMS proposes to increase the PE RVUs by 16.8 percent and PLI by 41.3 percent in recognition of the increased share of physician expenses associated with these costs. However, in lieu of reducing the work RVUs, CMS proposes to adjust the conversion factor (CF) by .921 (a 7.9 percent reduction) in order to maintain budget neutrality. According to CMS, the decision to adjust the CF as opposed to reducing the work RVUs was made to maintain stability in the work RVUs, which are used by other insurers. In addition, when the last 5-year review of work RVUs took place, the medical professional societies clearly preferred that any rescaling needed to preserve budget neutrality be achieved through the CF as opposed to a reduction in the work RVUs.

The change in the relative weights assigned to work, PE and PLI while budget neutral in the aggregate, does have differential impacts by specialty. Consequently, the change is positive for specialties for which PE represents a larger share of their payments (e.g., dermatology, allergy) and negative for those specialties with a higher proportion of their payments based on work RVUs (e.g. anesthesiology, psychiatry).

Assuming Congress pass legislation to prevent the SGR cut from occurring and preserves the current CF in 2011, the rebasing proposal would result in a 2011 CF of \$33.96 (i.e., \$36.87 adjusted by .921). This assumption was made in preparing the attached payment charts.

Misvalued Codes Under the Physician Fee Schedule

Identification of Misvalued Codes

Section 3134 of the Affordable Care Act directed CMS to identify misvalued codes. Seven categories of services were identified in the ACA for review:

- Codes and code families for which there has been the fastest growth
- Codes or families that have experienced substantial changes in practice expenses
- Recently established codes for new technologies or services
- Multiple codes that are frequently billed in conjunction with furnishing a single service
- Codes with low relative values, particularly those that are billed multiple times in a single treatment
- Codes that have not been subject to review since implementation of RBRVS (i.e., so-called Harvard valued codes)
- Other codes determined to be appropriate by the Secretary

The ACA also directed the Secretary to establish a process to validate RVUs within the PFS including validating the elements of physician work (time, mental effort, skill, risk, etc.). CMS is soliciting public comments on possible approaches to consider for a validation process including the use of time and motion studies to validate estimates of physician time and intensity.

CMS identified codes that may be misvalued which are being referred to the RUC for review during 2011. It is not clear what process the RUC will be asked to use to review these codes; i.e., to go through a complete survey process or to have some short cut process as has been used the last couple of years with codes that experienced substantial volume increases. The identified misvalued codes include the following:

Codes on the Multi-Specialty Points of Comparison (MPC) List

CMS notes that it is critical that the 316 codes that serve as reference points for evaluating new, revised, or other codes under RUC review be appropriately valued. CMS identified 33 MPC codes for initial RUC review based on their volume of services and allowed charges. This includes some of the most commonly billed codes across all specialties.

Codes with Low Work RVUs Commonly Performed in Multiple Units

CMS identified 12 codes with low work values billed in multiple units for RUC review. It is unclear why CMS considers the valuation of these codes to be problematic.

Codes with High Volume and Low Work RVUs

CMS identified 23 codes with low work RVUs (less than 0.25) which have very high volume of services. Fifteen of these codes are high volume x-ray codes. CMS does not indicate why a low work RVU should suggest potential misevaluation, although the volume involved suggests that substantial expenditures are incurred.

Codes with Site of Service Anomalies

CMS is asking the RUC to reassess 40 codes for a site of service anomaly over the past several years. The RUC has been reexamining a number of codes where the typical site of service has shifted from the inpatient to the outpatient or office setting. This shift may indicate that the current valuation is inaccurate since some of the services previously provided—inpatient visits and critical care—might no longer apply to the setting where the code is now provided. CMS,

however, has questioned the methodology used by the RUC and suggests that an alternative building block technique would yield very different values.

Codes with 23-Hour Stays

CMS is proposing that the RUC change its valuation methodology when reviewing codes which typically involve a 23 hour stay (i.e., where the patient remains overnight but is not classified as an inpatient).

Physician Quality Reporting Initiative (PQRI)

The Physician Quality Reporting Initiative (PQRI) was first implemented as a voluntary program in 2007. The program provides incentive payments to eligible physicians and other practitioners who satisfactorily report data on quality measures for covered services furnished during a reporting period, which is typically one year. In 2010, participating professionals reporting measures were eligible for an incentive payment equal to 2.0 percent of the estimated total allowed charges for all covered professional services furnished during the reporting period. In 2010, eligible practitioners (EPs) could report individual measures or measure groups through one of three reporting mechanisms: claims-based reporting, registry-based reporting, and electronic health record (EHR)-based reporting. In addition to reporting individual measures, participants could also report a limited number of preselected measure groups.

CMS is proposing a 1 percent incentive payment in 2011 and 0.5 percent incentive payments in 2012 – 2014 for successfully reporting PQRI measures. Penalties will begin in 2015 for those who do not satisfactorily submit quality data. The major changes to the PQRI program for 2011 are as follows:

Reporting of individual measures and measure groups - Eligible practitioners (EPs) participating in the program reporting claims-based individual or measure groups must report at least 3 measures that apply to the services furnished by the professional and report each measure for at least 50% of the practitioner's Medicare Part B fee-for-service (FFS) patients receiving services to which the measure applies. This is a reduction from the current requirement of 80%. For eligible practitioners that have less than 3 measures to report they can report one or two measures as well as meet the 50% threshold.

Eligible practitioners reporting individual measures through qualified registries or electronic health records (EHRs) must report at least 3 measures (or one or two if three measures are not applicable to their services) and report each measure for at least 80% of the FFS patients receiving services where the measure applies. These criteria also apply for reporting group measures through registries, but not for EHR-based reporting.

Reporting by a Group Practice - CMS proposes to continue to allow reporting by group practices as a whole and incentive payments are provided to the group rather than the individual EP. CMS is proposing to change the definition of a group practice to include any group with 2 or more EPs (currently only groups of 200 or more practitioners can participate as a group practice). The smaller groups' participation in PQRI will be piloted with the first 500 groups to sign up. Smaller group practices (with between 2 and 200 EPs) must report 3 to 6 individual measures and one or more measure groups. For groups of more than 200 – all 26 of the current NQF-endorsed quality measures for coronary artery disease, diabetes, heart failure and preventive care services must be reported

Proposed Quality Measures for CY 2011 - CMS proposes to include 198 measures individual EPs can report in 2011. Measures are listed in the rule in four categories: 1) claims-based and

registry-based reporting measures; 2) registry-based reporting measures only; 3) new individual measures, including several related to care transitions from hospital to home/self care; 4) EHR-based reporting measures.

Maintenance of Certification Program (MOCP) – ACA provided for an additional mechanism for reporting quality measures through a MOCP operated by a specialty board of the ABMS. An additional bonus payment of 0.5 percent for years 2011 through 2014 is provided if the EP participates in the MOCP for at least one year and completes a MOCP practice assessment. MOCPs must qualify as a PQRI registry for 2011 in order to submit quality measures on behalf of EPs.

Physician Compare web site ACA required CMS to establish a website by January 1, 2011, where the names of physicians and groups that successfully participate in PQRI will be posted. CMS is proposing not to publicly report any individual or group performance information for the 2011 PQRI program, although such reporting is required by law in future years.

Feedback mechanism and appeals process- The ACA required the Secretary to provide timely feedback to EPs on their performance under PQRI. CMS proposes to provide the 2011 feedback reports on or about the time that the PQRI incentive payments are issued, which is consistent with current practice. The ACA also required that an informal review process be established for EPs to seek review of a determination that the practitioner did not satisfactorily submit quality data under PQRI. The law did not require a formal appeals process. CMS proposes a process where an EP can seek an informal review and CMS will provide a written response within 60 days of receiving the original request.

E-Prescribing Incentive Program

The E-prescribing (eRx) incentive program will enter its third year in 2011. The program continues to use a mix of carrots and sticks to encourage participation. Eligible practitioners and group practices who are successful e-prescribers for 2011 may earn an incentive payment based on the estimated total allowed charges for PFS services under Medicare Part B provided during the reporting period. To qualify for the program, eligible practitioners will need to submit e-prescribing measures for at least 25 visits in 2011. Successful participants will be eligible for the following bonus payments: 1% in 2011; 1% in 2012; and, 0.5% in 2013. In 2012, eligible participants who are not successful or do not participate will encounter reductions to their Medicare payments: – 1% in 2012; – 1.5% in 2013; and -2.0% in 2014.

CMS is proposing to:

- Prohibit eligible practitioners participating in the Electronic Health Records (EHR) Incentive Program from receiving an eRx Incentive Program payment
- Impose penalties in 2012 on eligible practitioners participating in the EHR Incentive Program in 2011 but not participating in the eRx Incentive Program
- Allow group practices with less than 200 members to participate in the eRx Incentive Program as a group practice
- Establish criteria for applying penalties in 2012 or 2013, including a proposed process for hardship exemptions

Improvements to the Physician Feedback Program

In 2009, CMS established and implemented the Physician Feedback Program. This pilot program uses Medicare claims data and other data to provide confidential feedback to individual physicians comparing the cost and quality of care provided to Medicare beneficiaries with other participating physicians in the program. Although the program currently involves a limited number of providers, CMS intends to continue the program and eventually provide every Medicare practitioner a feedback report.

The ACA contains two provisions relevant to the Physician Feedback Program. First, the Secretary is required beginning in 2012, to provide reports that compare patterns of resource use of individual physicians to other physicians. Second, the ACA requires the Secretary to apply a separate, budget-neutral payment modifier to the physician fee schedule payment formula which will be phased in beginning January 1, 2015 through January 1, 2017. The modifier will provide for differential payment under the fee schedule to a physician or groups of physicians, and later, possibly to other eligible professionals, based upon the relative quality and cost of care of their Medicare beneficiaries.

CMS is proceeding with Phase II of the program, which will include quality measures and will expand reporting to group practices. The quality measures would be derived from the Generating Medicare Physician Quality Performance Measurement Results Project (referred to as GEM), which are claims-based measures calculated from administrative claims data. PQRI data was discussed as a potential data source, however CMS determined that PQRI data is not the best source of quality measurements at this time because of the low participation in the current available data year (2007). CMS will also produce reports containing per capita cost information instead of the episode specific cost information, for the following conditions: congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, prostate cancer, and diabetes.

Signature Requirements for Clinical Laboratory

Currently Medicare does not require a physician's signature on a requisition for clinical diagnostic laboratory tests paid on the basis of the clinical laboratory fee schedule (CLFS). However, it must be evident, that the physician ordered the tests. A "requisition" is the actual paperwork provided to the laboratory showing the specific tests to be performed for the patient. An "order" on the other hand is not as well defined and frequently just consists of an annotation on the patient's medical record signed or initialed by the physician indicating the tests to be performed.

CMS is now proposing to require a physician's or non-physician provider's (NPP's) signature on requisitions for clinical diagnostic laboratory tests paid on the basis of the CLFS. According to CMS, this policy would make it easier for the reference laboratory technicians to know whether a test is appropriately requested, and potential compliance problems would be minimized for laboratories during the course of a subsequent Medicare audit because a signature would be consistently required.

Payment for Part B Drugs

CMS proposed several changes in payment for Part B drugs:

- Payment Amount when Drugs are Intentionally Overfilled - CMS has become aware of situations where manufacturers include a small amount of "intentional overfill" in containers of drugs to compensate for the potential loss of product when a drug is prepared and administered. CMS indicates that any overfill provided "free" should not be billed by physicians (e.g., if they "harvest" the overfill from more than one container) since it does not represent a cost to the physician. Also, such overfill is not to be included in the calculation of the ASP in excess of the amount of the product reflected on the FDA label.

- Carry over ASP Pricing – Manufacturers of pharmaceuticals must submit ASP data on a timely basis. On occasion this does not occur. When this is the case, CMS proposes to “carry over” data for a prior quarter for which ASP data is available. In the case of multi source data, they will do this only if the data for the missing manufacturer is likely to result in an ASP rate that is 10 percent or more too high or too low.
- WAMP/AMP - The law provides that the Secretary can disregard the reported ASP data when the OIG finds that through studies that it exceeds the widely available market price (WAMP) or average manufacturer’s price (AMP) by a threshold percentage which is currently set at 5 percent. CMS proposes to maintain the 5 percent standard in 2011 for the comparison of WAMP to ASP. However, where CMS finds for a given drug that the AMP is consistently lower than 106 percent of ASP for several quarters, they propose to substitute 103 percent of AMP as the payment standard.

Primary Care and Preventive Services

Payment for Annual Wellness Visits

Currently Medicare pays for one welcome to Medicare visit, but does not pay for routine physical examinations. Based on a provision in the ACA, CMS proposes to cover an annual wellness visit which would include the establishment of a personalized prevention plan service (PPPS) which is payable in addition to the “Welcome to Medicare” initial preventive physical examination (IPPE, Code G0402).

Removal of Deductibles and Coinsurance for Preventive Services in Medicare

The ACA waives the deductible and coinsurance for most preventive services provided to Medicare beneficiaries, which will include the new annual wellness visits. The provision applies to preventive services “strongly recommended (grade A)” or “recommended (grade B)” from the U.S. Preventive Services Task Force (USPDTF) as well as the initial preventive physician examination (IPPE) and annual wellness exam.

Proposed Primary Care Incentive Payment Program (PCIP)

The ACA established the PCIP to provide incentive payments to qualified providers and practitioners for primary care services furnished between January 1, 2011 and January 1, 2016.

CMS is proposing to:

- Provide a 10 percent incentive payment to primary care practitioners defined as: 1) a physician who has a primary specialty designation of family practice (08), internal medicine (11), geriatrics (38), or pediatrics (37); or 2) a nurse practitioner (50), clinical nurse specialist (89), or physician assistant (97).
- Use the most current claims data (2009) to determine eligible primary care practitioners. Primary care services (defined as office, house calls and nursing home visits) must meet or exceed 60 percent of the allowed charges under Part B for the practitioner.
- Calculate and disperse payments quarterly by Medicare contractors

Since new providers would not meet the 60 percent threshold, CMS is seeking comments on alternative methods to determine PCIP eligibility for new providers. Also, CMS will monitor practitioners who change their specialty designation to take advantage of the PCIP payments. They use the example of cardiologists who designate their specialty as internal medicine although they practice cardiology

Other Miscellaneous Issues

Payment for Biosimilar Biological Products

The ACA specifies that Medicare payment for biosimilar biological products will be determined using the average sales price (ASP) methodology effective July 1, 2010. Specifically, the payment amount for the products will be the sum of two amounts: 1) the ASP of all national drug codes (NDC) assigned to the biosimilar biological drug product, and 2) six percent of the payment amount for the corresponding reference biological product.

Telehealth Services

Medicare policy allows for coverage and reimbursement for telehealth services for an eligible telehealth beneficiary which include consultation, office visits, individual psychotherapy, pharmacologic management, and additional services specified by the Secretary delivered via a telecommunications system to an approved originating site. CMS maintains a list of eligible services.

CMS is proposing to add the following services to its list of approved telehealth services:

- Subsequent hospital care services- patient's admitting practitioner has a limit of one telehealth visit every three days (99231, 99232, 99233)
- Subsequent nursing facility care services- patient's admitting practitioner has a limit of one telehealth visit every 30 days (99307, 99308, 99309, 99310)
- Individual and group kidney disease education; diabetes self-management training; group medical nutrition therapy; and health behavior assessment and intervention services

CMS received several other requests for additions to the list of approved telehealth services including home wound care services, speech-language pathology services, and neuropsychological testing, which were rejected.

Payment for Bone Density

A provision in the ACA increases payment for two dual-energy x-ray absorptiometry (DXA) codes furnished in 2011 and 2012. Payment for CPT codes 77080, *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)* and 77082 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment* will be paid at 70 percent of the 2006 Medicare payment rate.

ATTACHMENT 1

**TABLE 73: CY 2011 PFS Proposed Rule Total Allowed Charge
Estimated Impact for RVU, MPPR, and MEI Rebasing Changes***

NOTE: In the 2010 Final Rule, the calculation for the practice expense was changed. CMS decided to implement this change over a period of 4 years. The column header “2011” reflects the year 2 transition. The column header “Fully implemented” reflects the change after 4 years.

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Specialty	Allowed Charges (mil)	Impact of Work and MPRVU Changes	Impact of PE RVU and MPPR Changes		Impact of MEI Rebasing	Combined Impact	
			Full	Tran		Full	Tran
TOTAL	\$79,731	0%	0%	0%	0%	0%	0%
01 -ALLERGY/IMMUNOLOGY	\$176	0%	0%	0%	4%	4%	4%
02-ANESTHESIOLOGY	\$1,729	0%	3%	1%	-3%	0%	-2%
03-CARDIAC SURGERY	\$373	0%	-1%	0%	0%	-1%	0%
04-CARDIOLOGY	\$6,801	0%	-5%	-2%	0%	-5%	-2%
05-COLON AND RECTAL SURGERY	\$134	0%	4%	1%	0%	4%	1%
06-CRITICAL CARE	\$233	0%	2%	1%	-2%	0%	-1%
07-DERMATOLOGY	\$2,678	0%	1%	1%	2%	3%	3%
08-EMERGENCY MEDICINE	\$2,527	0%	1%	1%	-3%	-2%	-2%
09-ENDOCRINOLOGY	\$382	0%	3%	1%	-1%	2%	0%
10-FAMILY PRACTICE	\$5,351	0%	3%	1%	0%	3%	1%
11-GASTROENTEROLOGY	\$1,752	0%	2%	1%	-1%	1%	0%
12-GENERAL PRACTICE	\$704	0%	2%	1%	0%	2%	1%
13-GENERAL SURGERY	\$2,221	0%	3%	1%	0%	3%	1%
14-GERIATRICS	\$182	0%	5%	2%	-2%	3%	0%
15-HAND SURGERY	\$100	0%	3%	1%	2%	5%	3%
16-HEMATOLOGY/ONCOLOGY	\$1,870	0%	-5%	-2%	1%	-4%	-1%
17-INFECTIOUS DISEASE	\$567	0%	4%	2%	-2%	2%	0%
18-INTERNAL MEDICINE	\$10,381	0%	3%	1%	-1%	2%	0%
19-INTERVENTIONAL PAIN MGMT	\$379	0%	4%	2%	1%	5%	3%
20-INTERVENTIONAL RADIOLOGY	\$222	0%	-9%	-4%	0%	-9%	-4%
21-MULTISPECIALTY CLINIC/OTHER	\$44	0%	-5%	-4%	1%	-4%	-3%

22-NEPHROLOGY	\$1,891	0%	0%	0%	-1%	-1%	-1%
23-NEUROLOGY	\$1,415	0%	4%	1%	0%	4%	1%
24-NEUROSURGERY	\$622	0%	2%	1%	1%	3%	2%
25-NUCLEAR MEDICINE	\$57	0%	-7%	-4%	1%	-6%	-3%
27-OBSTETRICS/GYNECOLOGY	\$649	0%	1%	0%	1%	2%	1%
28-OPHTHALMOLOGY	\$5,154	0%	7%	3%	1%	8%	4%
29-ORTHOPEDIC SURGERY	\$3,339	0%	2%	1%	1%	3%	2%
30-OTOLARNGOLOGY	\$915	0%	3%	1%	1%	4%	2%
31-PATHOLOGY	\$1,040	0%	-1%	0%	-1%	-2%	-1%
32-PEDIATRICS	\$65	0%	2%	1%	0%	2%	1%
33-PHYSICAL MEDICINE	\$868	0%	4%	1%	-1%	3%	0%
34-PLASTIC SURGERY	\$306	0%	4%	2%	1%	5%	3%
35-PSYCHIATRY	\$1,105	0%	1%	1%	-3%	-2%	-2%
36-PULMONARY DISEASE	\$1,736	0%	2%	1%	-1%	1%	0%
37-RADIATION ONCOLOGY	\$1,889	0%	-5%	-2%	4%	-1%	2%
38-RADIOLOGY	\$4,975	0%	-12%	-6%	0%	-12%	-6%
39-RHEUMATOLOGY	\$496	0%	0%	0%	1%	1%	1%
40-THORACIC SURGERY	\$388	0%	-1%	0%	0%	-1%	0%
41-UROLOGY	\$1,909	0%	-6%	-2%	1%	-5%	-1%
42-VASCULAR SURGERY	\$702	0%	-2%	-1%	2%	0%	1%
43-AUDIOLOGIST	\$52	0%	-7%	-2%	1%	-6%	-1%
44-CHIROPRACTOR	\$732	0%	3%	1%	-2%	1%	-1%
45-CLINICAL PSYCHOLOGIST	\$557	0%	-6%	-2%	-5%	-11%	-7%
46-CLINICAL SOCIAL WORKER	\$376	0%	-5%	-2%	-5%	-10%	-7%
47-DIAGNOSTIC TESTING FACILITY	\$851	0%	-26%	-13%	6%	-20%	-7%
48-INDEPENDENT LABORATORY	\$1,009	0%	-6%	-2%	4%	-2%	2%
49-NURSE ANES / ANES ASST	\$706	0%	2%	2%	-3%	-1%	-1%
50-NURSE PRACTITIONER	\$1,175	0%	4%	1%	-1%	3%	0%
51-OPTOMETRY	\$937	0%	7%	3%	1%	8%	4%
52-ORAL/MAXILLOFACIAL SURGERY	\$38	0%	3%	2%	2%	5%	4%
53-PHYSICAL/OCCUPATIONAL THERA	\$2,138	0%	-7%	-11%	-1%	-8%	-12%
54-PHYSICIAN ASSISTANT	\$868	0%	3%	1%	0%	3%	1%
55-PODIATRY	\$1,738	0%	4%	2%	1%	5%	3%
56-PORTABLE X-RAY SUPPLIER	\$91	0%	3%	2%	6%	9%	8%
57-RADIATION THERAPY CENTERS	\$69	0%	-9%	-3%	8%	-1%	5%
OTHER	\$67	0%	2%	1%	-1%	2%	2%

Does not include the impact of the current law -6.1 percent CY 2011 update.

2011 Proposed Physician Fee Schedule (CMS 1503-P)								
Payment Rates for Medicare Physician Services - Hematology-Oncology								
* The 2010 CF includes the 2.2% increase enacted by Congress for June-November 2010								
** The 2011 CF is based on the 2010 CF for June-November reduced by 7.9%								
***These codes are considered bundled by Medicare and are not separately paid. However, CMS published the RVUs for informational purposes and for use by other payers.								
CPT Code	Mod	Descriptor	NON-FACILITY (OFFICE)			FACILITY (HOSPITAL)		
			2010*	2011**	% CHANGE 2010-2011	2010*	2011**	% CHANGE 2010-2011
			CF= \$36.8729	CF = \$33.9598		CF= \$36.8729	CF = \$33.9598	
36430		Blood transfusion service	\$33.91	\$34.30	1.14%	NA	NA	NA
36511		Apheresis wbc	NA	NA	NA	\$95.47	\$95.77	0.31%
36512		Apheresis rbc	NA	NA	NA	\$93.62	\$92.71	-0.98%
36513		Apheresis platelets	NA	NA	NA	\$99.15	\$101.20	2.02%
36514		Apheresis plasma	\$502.76	\$510.08	1.43%	\$93.99	\$93.73	-0.28%
36515		Apheresis, adsorp/reinfuse	\$1,874.65	\$1,901.41	1.41%	\$92.15	\$93.39	1.33%
36516		Apheresis, selective	\$2,080.70	\$2,104.15	1.11%	\$70.03	\$71.66	2.26%
36522		Photopheresis	\$1,312.18	\$1,337.68	1.91%	\$102.47	\$101.88	-0.58%
38205		Harvest allogenic stem cells	NA	NA	NA	\$81.09	\$79.13	-2.48%
38206		Harvest auto stem cells	NA	NA	NA	\$81.09	\$80.15	-1.18%
38220		Bone marrow aspiration	\$148.54	\$149.08	0.36%	\$61.92	\$61.13	-1.30%
38221		Bone marrow biopsy	\$162.55	\$160.97	-0.98%	\$76.30	\$75.05	-1.66%
38230		Bone marrow collection	NA	NA	NA	\$329.89	\$341.64	3.44%
38240		Bone marrow/stem transplant	NA	NA	NA	\$125.32	\$124.97	-0.28%
38241		Bone marrow/stem transplant	NA	NA	NA	\$125.69	\$123.95	-1.40%
38242		Lymphocyte infuse transplant	NA	NA	NA	\$95.47	\$94.75	-0.76%
88184		Flowcytometry/ tc, 1 marker	\$79.25	\$82.18	3.57%	NA	NA	NA
88185		Flowcytometry/ tc, add-on	\$47.18	\$49.58	4.84%	NA	NA	NA
88187		Flowcytometry/read, 2-8	\$68.19	\$66.90	-1.93%	\$68.19	\$66.90	-1.93%
88188		Flowcytometry/read, 9-15	\$84.41	\$83.20	-1.45%	\$84.41	\$83.20	-1.45%
88189		Flowcytometry/read, 16 & <	\$106.52	\$102.90	-3.52%	\$106.52	\$102.90	-3.52%
96360		Hydration iv infusion, init	\$54.92	\$56.03	1.99%	NA	NA	NA
96361		Hydrate iv infusion, add- on	\$15.48	\$15.28	-1.30%	NA	NA	NA
96365		Ther/ proph/ diag iv inf, init	\$68.19	\$69.62	2.05%	NA	NA	NA
96366		Ther/ proph/ dg iv inf, add- on	\$21.01	\$21.39	1.80%	NA	NA	NA
96367		Tx/ proph/ dg addl seq iv inf	\$33.17	\$32.60	-1.75%	NA	NA	NA
96368		Ther/ diag concurrent inf	\$19.54	\$19.36	-0.92%	NA	NA	NA
96372		Ther/ proph/ diag inj, sc/ im	\$21.75	\$22.75	4.42%	NA	NA	NA
96373		Ther/ proph/ diag inj, ia	\$18.43	\$18.68	1.33%	NA	NA	NA
96374		Ther/ proph/ diag inj, iv push	\$53.81	\$54.68	1.57%	NA	NA	NA
96375		Ther/ proph/ diag inj add- on	\$22.48	\$22.41	-0.31%	NA	NA	NA
96401		Chemotherapy, sc/im	\$68.19	\$71.32	4.38%	NA	NA	NA
96402		Chemo hormon antineopl sq/ im	\$35.75	\$34.64	-3.22%	NA	NA	NA
96405		Intralesional chemo admin	\$84.04	\$84.90	1.01%	\$29.49	\$29.88	1.31%
96406		Intralesional chemo admin	\$116.84	\$116.48	-0.31%	\$43.49	\$43.47	-0.05%
96409		Chemo, iv push, sngl drug	\$109.84	\$111.05	1.09%	NA	NA	NA
96411		Chemo, iv push, addl drug	\$61.55	\$62.15	0.95%	NA	NA	NA
96413		Chemo, iv infusion, 1 hr	\$143.75	\$144.33	0.40%	NA	NA	NA
96415		Chemo, iv infusion, addl hr	\$30.96	\$30.56	-1.30%	NA	NA	NA
96416		Chemo prolong infuse w/ pump	\$157.02	\$158.25	0.78%	NA	NA	NA
96417		Chemo iv infus each addl seq	\$70.77	\$70.98	0.29%	NA	NA	NA
96420		Chemotherapy, push technique	\$106.15	\$106.97	0.77%	NA	NA	NA
96422		Chemotherapy,infusion method	\$170.29	\$172.18	1.10%	NA	NA	NA
96423		Chemo, infuse method add-on	\$77.40	\$78.45	1.33%	NA	NA	NA
96425		Chemotherapy,infusion method	\$171.39	\$176.25	2.76%	NA	NA	NA
96440		Chemotherapy, intracavitary	\$668.26	\$716.21	6.70%	\$143.75	\$148.06	2.91%
96445		Chemotherapy, intracavitary	\$283.45	\$282.21	-0.44%	\$120.53	\$119.20	-1.12%
96450		Chemotherapy, into CNS	\$203.09	\$195.61	-3.83%	\$88.46	\$84.56	-4.61%
96521		Port pump refill & main	\$126.43	\$131.08	3.55%	NA	NA	NA
96522		Refill/ maint pump/ resvr syst	\$107.26	\$109.35	1.91%	NA	NA	NA
96523		Irrig drug delivery device	\$25.06	\$25.13	0.26%	NA	NA	NA
96542		Chemotherapy injection	\$129.38	\$125.31	-3.24%	\$44.97	\$43.47	-3.45%
99363***		Anticoag mgmt, init	\$122.37	\$122.93	0.46%	\$84.78	\$83.20	-1.89%
99364***		Anticoag mgmt, subseq	\$42.02	\$41.77	-0.60%	\$32.44	\$31.58	-2.70%
G0364		Bone marrow aspirate & biopsy	\$12.16	\$12.23	0.51%	\$8.85	\$8.83	-0.19%