

President signs legislation delaying Medicare cuts for 6 months

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On Saturday, Dec. 29, the president signed the Medicare, Medicaid and SCHIP Extension Act of 2007, which replaces the 10.1 percent reduction in Medicare Part B payments scheduled for 2008 with a six-month, 0.5 percent increase. Physicians will again face a reduction in Part B payments in July 2008 unless Congress once again intervenes.

The Centers for Medicare & Medicaid Services (CMS) announced that it will give physicians an additional 45 days to decide whether to participate in the Medicare program for 2008. Providers now have until Feb. 15, 2008, instead of Dec. 31, 2007.

Besides temporarily averting the cut, the Medicare, Medicaid and SCHIP Extension Act of 2007:

- Extends the SCHIP at current funding through March 31, 2009;
- Continues the Physician Quality Reporting Initiative for all of 2008 (successful participants will still earn a bonus payment of 1.5 percent of all covered professional services provided during the reporting period);
- Extends the 5 percent bonus payment to physician shortage areas through June 30;
- Extends the geographic practice cost index floor of 1.0 through June 30;
- Extends a provision in the Balanced Budget Act of 1997 that allows independent laboratories to bill Medicare directly for the technical component of certain pathology services provided to hospitals through June 30;
- Extends the exceptions process for therapy caps through June 30;
- Extends the current “charges to cost” methodology that provides a separate payment for brachytherapy beginning April 1, including therapeutic radiopharmaceuticals;
- Extends the reasonable costs payments for certain clinical diagnostic laboratory tests in rural areas through June 30;
- Requires the Centers for Medicare & Medicaid Services to adjust the average sales price (ASP) calculation to use volume-weighted ASPs based on actual sales volume and institutes a reimbursement rate for generic albuterol; and
- Allows reimbursement for certain diabetes laboratory tests for home use at the same rate as other glycated hemoglobin tests beginning April 1.

Please note that congressional action to avert the reduction to the conversion factor is not the only change affecting 2008 Medicare payment rates. Adjustments will vary by service, specialty and locale based on the following factors included in the final CMS 2008 Medicare fee schedule rule:

- 2008 will be the second year in a four-year transition to revise practice-expense relative value units.

- A number of services — particularly under anesthesiology, and home-health and eye exams — have revised relative value units for physician work. These values increase significantly.
- CMS has increased the budget-neutrality adjustment created last year to compensate for changes to the five-year review of work values; payments for many services will drop by about 1 percent.
- The geographic adjustment factors (GPCIs) have been updated, as they are every three years. The changes' magnitude is generally small, but affects many payment locales. In addition, the law just passed by Congress continued the floor on the work GPCI and the physician-scarcity area bonuses until June 2008.

The rule adds new services to those subject to imaging payment cuts stemming from the Deficit Reduction Act of 2005, which limits payments to no more than the comparable payment in hospital outpatient departments.

CMS issues limited delay in application of expanded anti-markup rule

CMS issued a delay in the application of the expanded anti-markup rule that it published in the 2008 final physician fee schedule. CMS posted a notice to be published in today's *Federal Register* that postpones implementation of the rule until Jan. 1, 2009, instead of the scheduled effective date of Jan. 1, 2008.

The rule scheduled to take effect on Jan. 1, 2008 would have expanded the Medicare payment rule referred to as the anti-markup rule. In its current form, the anti-markup rule limits the payment a physician can receive for the technical component (TC) of services the physician purchases from an outside supplier. In its expanded form, CMS' new rule would have applied the same payment limitation to the professional component (PC) of purchased diagnostic tests, as well as to the TC and PC of services performed by employees of physicians or group practices if the services are performed outside of the office of the physician or group practice. The new provision defines the office of a group practice as space where the group provides substantially the full range of patient care services that it provides generally.

The delay postpones application of this new rule except in the case of anatomic pathology diagnostic testing services furnished in space used by a physician group practice as a "centralized building" (as defined in the in-office ancillary services exception to the physician self-referral regulations) for purposes of complying with the physician self-referral law if the space does not also meet the "same building" definition (found in the same regulations). CMS has stated its intention to use the one-year delay to clarify the application of the rule, issue an additional proposed rule, or both.

Current 2008 PQRI program

Funding will continue for the 2008 Medicare Physician Quality Reporting Initiative (PQRI), which will contain 119 measures. A medical group could receive 1.5 percent of its entire Medicare Part B total allowed charges as a bonus during the 2008 reporting period.

CMS has published updated PQRI documents:

- [2008 PQRI Coding for Quality Handbook](#) – provides coding and reporting principles and describes successful reporting for each measure.
- [2008 Measure Specifications Release Notes](#) – describe recent changes to measure specifications due to recent technical corrections posted in November on the CMS PQRI Web site.
- [PQRI Data Collection Worksheets](#) were developed for each 2008 PQRI measure, through a partnership with the American Medical Association. (These worksheets provide a step-by-step description on how to document and code each PQRI measure.)