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NEWS FLASH	Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html on the CMS website.

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Related CR Transmittal #: R258OTN | Implementation Date: January 2, 2007

2007 Physician Fee Schedule Payment Policies

Note: This article was updated on June 5, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI) and A/B MACs for services, including ambulance and telehealth services.

What you Need to Know

CR 5443, from which this article was taken: 1) Summarizes significant issues contained in the Medicare Physician Fee Schedule Regulation for 2007 (including publishing the Ambulance Inflation Factor (AIF) for CY 2007); and 2) Announces the telehealth originating site facility fee for 2007. CR5443 also discusses several provisions of the recently-enacted Tax Relief and Health Care Act of 2006. You should refer to the Background and Additional Information sections, below, for more details and information on how to find the background/reference documents.

Background

Tax Relief and Health Care Act of 2006

The Tax Relief and Health Care Act of 2006 set the 2007 conversion factor for physician payment at the same level as in 2006 ($37.8975), reversing the statutorily mandated 5.0 percent negative update. However, it does not maintain

2007 physician payments at 2006 levels. There are a number of other factors that affect payment rates for 2007 and this article discusses several of those factors. The legislation also extends the 1.0 floor on work Geographic Practice Cost Indices (GPCIs) through December 31, 2007. Practice expense GPCIs and malpractice GPCIs are not affected by this provision.

Section 202 of this act mandates that Medicare Part B will cover, for 2007 only, the administration of vaccines that are covered under Part D of Medicare. A new G code (G0377) has been created for the administration of Part D vaccines and payment for G0377 will be crosswalked to CPT code 90471 for one year. When a physician administers a Part D vaccine, the physician should use G0377

to bill the local carrier for the administration of the vaccine. Payment to the physician will be on an assigned basis only. Normal beneficiary deductible and coinsurance requirements apply to the administration. Payment for Part D covered vaccines is made solely by the participating Prescription Drug Plan. Medicare Part B will not pay for the vaccine itself.

Medicare Physician Fee Schedule Regulation for 2007

Section 1848(b)(1) of the Social Security Act requires the Centers for Medicare and Medicaid Services (CMS) to establish (by regulation, before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year.

Accordingly, on November 1, 2006, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) final rule for calendar year 2007. In this rule (effective January 1, 2007) Medicare:

- Will increase physician payment for the time spent talking with Medicare beneficiaries about their health care. The 2007 final rule significantly increases the Relative Value Units' (RVU) work component for the face-to-face visits (evaluation and management or "E&M services"), during which the physician and patient discuss the patient's health status and the steps that can be taken to maintain or improve the patient's health.
- Adopts work values for CPT codes 97802, 97803, 97804, G0270, and G0271.
- Expands its preventive services benefits to include:
    - Adding a one-time preventive ultrasound screening for abdominal aortic aneurysms (AAA), for at risk beneficiaries, only available as part of the Initial Preventive Physical Examination (also referred to as the Welcome to Medicare physical);
    - Insuring more accurate and reliable bone mass measurements are performed for Medicare beneficiaries; and

  - Exempting the colorectal cancer screening benefit from the Part B deductible.

- Adjusts the methodology for determining practice expense (such as office overhead) RVUs. As part of the methodology, CMS will use a bottom-up methodology for direct costs, use supplementary survey data for indirect costs, and eliminate the non-physician workpool. This methodology (to be phased over a four-year period), will be more transparent than the existing methodology, allowing specialties and other stakeholders to predict the effects of proposals to improve accuracy of practice expense payments.
- Adds diabetes outpatient self-management training and medical nutrition therapy services to the list of covered and separately payable services included in the Federally Qualified Health Center benefit, making these services more available to beneficiaries in both rural and urban underserved areas.
- Caps payment rates for imaging services under the physician fee schedule at the amount paid for the same services when performed in hospital outpatient departments; includes a list of codes to which the outpatient prospective payment system (OPPS) cap would apply; and reduces the payment for certain multiple imaging procedures on contiguous body parts by 25% after full payment for the first procedure.

Note: CMS will apply the multiple imaging reductions first, followed by the OPPS imaging cap, if applicable.

The final rule also:

- Finalizes drug manufacturer reporting requirements and addresses a number of technical average sales price (ASP) issues such as the treatment of *bona fide* service fees in the context of the ASP calculation and the definition of nominal sales;
- Codifies the public consultation process for developing payment amounts for new clinical laboratory tests;
- Adopts supplier standards for independent diagnostic testing facilities (IDTFs);
- Continues the temporary intravenous immune globulin preadministration-related services fee into 2007;
- Addresses the final regulations affecting ambulance payment policy under the ambulance fee schedule, which will improve the accuracy of payments for ambulance services and incorporate changes in geographic adjustments based on the most recent census data.

- Announces an Ambulance Inflation Factor (AIF) for CY 2007 of 4.3%, and further 1) Clarifies the designation of areas as urban or rural to incorporate changes made by the Office of Management and Budget to the Metropolitan Statistical Areas (MSAs); 2) Replaces the Goldsmith Modification (identifying rural census tracts within MSAs) with the most recent version based on Rural Urban Commuting Areas; and 3) Discontinues formal annual reviews of "low billers" and air ambulances to determine whether adjustments are needed in the ambulance fee schedule conversion factors.
- Includes a discussion of exceptions to the therapy cap for CY2006 and 2007 and announces that the 2007 therapy cap is $1,780. (Note that Section 201 of the Tax Relief and Health Care Act of 2006 extended the exceptions process until December 31, 2007.)
- Amends the reassignment of payment regulations to state that an individual supplier furnishing a service has unrestricted access to the billings submitted by the entity receiving Medicare payment for services furnished by that supplier, irrespective of whether the supplier is an employee or independent contractor.
- Announces that the drug add-on adjustment to the end stage renal diseased (ESRD) composite payment rate for 2007 will increase from 14.5 percent to 15.1 percent.

Lastly, the final rule addresses comments received on the separate notice published June 29, 2006 (*Five Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology* (CMS-1521-PN)), which is contained in an attachment to CR 5443. Further discussion of the above summarized items is in that same attachment to CR5443.

Telehealth originating site facility fee for 2007

Section 1834(m) of the Social Security Act established the Medicare telehealth originating site facility fee payment amount for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI).

The MEI increase for 2007 is 2.1%. Thus for calendar year 2007, the payment amount for HCPCS code "Q3014, telehealth originating site facility fee" is 80%t of the lesser of the actual charge, or $22.94.

Note that the beneficiary is responsible for any unmet deductible amount or coinsurance.

The Medicare telehealth originating site facility fee and MEI increase by applicable time period is shown in Table 1, below.

Table 1

Medicare Telehealth Originating site Facility Fee and MEI by Time Period		
Facility Fee	MEI	Time Period
$20.00	N/A	10/01/2001 – 12/31/2002
$20.60	3.0%	01/01/2003 – 12/31/2003
$21.20	2.9%	01/01/2004 – 12/31/2004
$21.86	3.1%	01/01/2005 – 12/31/2005
$22.47	2.8%	01/01/2006 – 12/31/2006
$22.94	2.1%	01/01/2007 – 12/31/2007

Additional Information

You can find more information about the 2007 Physician Fee Schedule Payment Policies by going to CR 5443, located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R258OTN.pdf on the CMS website.

Please see, as an attachment to that CR, a document entitled *Revisions to Payment Policies and Five-Year Review of Work Relative Value Units Under the Physician Fee Schedules for CY 2007, and Other Changes to Payment Under Part B; Revisions to the Payment Policies of Ambulance Services Under the Fee Schedule for Ambulance Services; Ambulance Inflation Factor Update for CY 2007*, for more details on the significant issues discussed in the final rule.

You can find the November 1, 2006 CMS press release entitled *MEDICARE ANNOUNCES FINAL RULE SETTING PHYSICIAN PAYMENT RATES AND POLICIES FOR 2007,* by going to http://www.cms.gov/apps/media/press/release.asp?counter=2044; and other information about the physician fee schedule by going to the CMS Physician Center Website at http://cms.gov/Center/Provider-Type/Physician-Center.html on the CMS website. .

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Flu Shot Reminder As a respected source of health care information, patients trust their doctors' recommendations. If you have Medicare patients who haven't yet received their flu shot, help protect them by recommending an annual influenza and a one time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – And don't forget to immunize yourself and your staff. **Protect yourself, your patients, and your family and friends.** Get Your Flu Shot. Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf on the CMS website.