

# 2008 Medicare Payment Policy Updates

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## Physician Fee Schedule

The Medicare Physician Fee Schedule Final Rule for calendar year 2008 (CMS-1385-FC) was published in the November 27, 2007, issue of the *Federal Register*. The 2008 Medicare program changes take effect on January 1, 2008. The rule announces that, under current law, unless congress acts, the fee schedule update factor for 2008 will be -10.1 percent, which will produce a conversion factor of \$34.0682 (compared to \$37.8975 in 2007). The initial estimate for the sustainable growth rate (SGR) for CY 2008 is -0.1 percent.

The overall impact on otolaryngology (from physician work RVU changes, practice expense RVU changes, DRA imaging reductions, and the reduced conversion factor) is a 9 percent reduction in allowed charges. Most of the impact stems from the change to the conversion factor.

## New Values for Audiology Testing Codes

The audiology testing codes were re-surveyed for fee schedule values in early 2007. These codes did not previously have physician work values. In the final rule, you will see the addition of these physician work RVUs:

CPT CODE	2008 WORK RVU
92557	0.60
92567	0.20
92568	0.29
92569	0.20
92579	0.70
92601	2.30
92602	1.30
92603	2.25
92604	1.25

# Medicare & Medicaid

## Additional Codes from the 5-Year Review of Work RVUs

As discussed in the CY 2007 PFS final rule, CMS deferred decisions on proposed changes to the work RVUs for a number of codes from the 5-Year Review, for one year, either because they had not yet received the RUC recommendation, or because they were suggesting that the RUC reevaluate the original recommendation. In the CY 2008 proposed rule, CMS proposed to accept all of the RUC recommendations for these deferred codes, with one exception. As proposed by CMS, the work RVUs would increase for 33 codes, decrease for 10 codes, and be maintained for 15 codes. The one RUC recommendation that was not accepted was for CPT code 93325 Doppler echocardiography color flow velocity mapping (list separately in addition to codes for echocardiography) which CMS proposed to bundle (that is, make no separate payment for the service).

CMS received comments on 17 of the codes and convened a multi-specialty panel of physicians to assist them in the

review of 16 codes. (Two of the codes, 92557 and 92579, affect the otolaryngology specialty.) The composition of the refinement panel and the methodology used to analyze the panel members' ratings of work were generally consistent with the refinement process first used for the CY 1993 PFS final rule. Despite pressure from other specialty groups to assign inappropriate values to these audiology testing codes, the Academy successfully defended what it believes to be reasonable values.

## Budget neutrality (BN) adjustment

In the CY 2008 PFS proposed rule, CMS proposed to revise the work adjustor to maintain budget neutrality to account for the proposed work RVU changes associated with the additional codes from the 5-Year Review of Work RVUs and the proposed increases in the work of anesthesia services. Based upon the increases, the final revised work adjustor will be 0.8806. Although the Academy and other organizations recommended using the conversion factor (which would have affected all

services in the fee schedule equally), CMS decided to apply the adjustor to only the physician work RVUs.

## Sustainable growth rate (SGR)

In this final rule, CMS makes its preliminary estimate of the 2008 sustainable growth rate (-0.1 percent), revises the 2007 SGR (from 1.8 to 3.2 percent), and makes its final revision to the 2006 SGR (1.5 percent, compared to the original estimate of 1.7 percent and the first revision of 2.1 percent). The preliminary estimate of the 2008 SGR is based on the following assumptions:

- A weighted average increase in fees for services under the SGR (before applying any legislative adjustments) of 1.9 percent;
- A decrease of 0.7 percent in the number of fee-for-service enrollees from CY 2007 to CY 2008;
- A 1.7 percent growth in real GDP per capita from CY 2007 to CY 2008; and
- A 2.9 percent reduction in expenditures because of statutory and regulatory provisions.

CMS rejected comments (including those from the Academy) recommending the exclusion of Medicare-covered physician-administered drugs from the SGR calculation, arguing that such administrative changes are “statutorily difficult.” It also again rejected comments recommending that the SGR take into account the impact of national coverage decisions. In the final rule, CMS also noted the 2007 Medicare Trustees Report projected an approximate 10 percent reduction in the fee schedule update factor in CY 2008 and about a 5 percent reduction in each subsequent year through CY 2016.

### Geographic practice cost indices (GPCIs)

CMS is required to develop separate geographic practice cost indices (GPCIs) to measure resource cost differences among the 89 Medicare physician payment localities (34 of which are statewide). These GPCIs are used to adjust the work, practice expense, and malpractice RVUs assigned to a service in calculating the applicable Medicare payment amount for the service in a given locality.

The physician work GPCIs listed in Addendum E do not reflect the 1.000 floor that was in place during 2006 and 2007. This floor expires as of January 1, 2008 in accordance with section 102 of the Medicare Improvements and Extension Act of 2006, Division B of the Tax Relief and Health Care Act of 2006 (MIEA TRHCA).

Although the proposed rule had outlined three options for reconfiguring certain California payment localities, the final rule leaves those things unchanged. CMS notes that it plans to “revisit statewide localities to determine if revisions are appropriate.”

### Medicare telehealth services

For CY 2008, the Medicare payment amount for HCPCS code Q3014, telehealth originating site facility fee, is 80 percent of the lesser of the actual charge or \$23.35 (up from \$22.94 in 2007).

CMS will continue to evaluate whether subsequent hospital care should be approved for telehealth. The agency notes that it continues to have concerns about using a telecommunications sys-

tem as a substitute for the ongoing, in-person evaluation and management of a hospital inpatient. One recommendation suggests the creation of a special modifier to identify when a subsequent hospital care service is actually a follow-up inpatient consultation (as a means for approving telehealth service status at least for this subset of subsequent hospital care services), given the AMA’s deletion of separate follow-up inpatient consultation codes. CMS will assess this recommendation.

### Physician self-referral issues

The proposed rule included several proposed changes to the physician self-referral regulations, for which CMS received 1,100 comments. In the final rule, CMS decides that, given that number of proposals, “the significance of the provisions both individually and in concert with each other, and the volume of public comments,” the agency does not believe it is prudent to finalize any of the proposals except for the proposal for anti-markup provisions for diagnostic tests.

In the final rule, CMS imposes an anti-markup provision on the technical components (TCs) of diagnostic tests that are ordered by the billing physician or other supplier (or ordered by a party related by common ownership or control to such billing supplier) if the TC is outright purchased or if the TC is performed at a site other than the office of the billing physician or other supplier. In addition, CMS is imposing the same anti-markup policy on professional components (PCs) of diagnostic tests. Thus, where the anti-markup provision applies, Medicare payment to the billing entity would be limited to the lowest of: (1) the performing physician’s or other supplier’s net charge to the billing entity; (2) the billing entity’s actual charge; or (3) the fee schedule amount for the service that would be allowed if the physician or other supplier performing the service billed directly.

Under the final rule, a “centralized building” does not qualify as a part of the office of the billing physician or other supplier; thus the anti-markup provision would apply to TCs and PCs performed in such a centralized building.

Instead, the office of the billing physician or other supplier is the “medical office space in which the physician organization provides substantially the full range of patient care services that the physician organization provides generally.” CMS notes more specifically that a physician group’s office does not include space utilized by the group as a “centralized building” (or other space) “where only (or primarily) diagnostic testing is performed by radiologists or pathologists.”

Although the proposed rule also would have applied different anti-markup policies to tests performed by part-time and full-time employees or contractors, this language is not present in the final rule. Thus, the employment status of the individual performing a diagnostic test (that is, whether full-time or part-time) is not a consideration in deciding whether the anti-markup provisions apply in a particular instance.

### Hospital outpatient prospective payment system (HOPPS)

#### Cochlear implantation

As a result of the proposed CY 2008 reconfiguration of several device-dependent ambulatory payment classifications (APCs) under the OPSS and the proposed updated APC device offset percentages, CMS proposed to designate an additional 10 ambulatory surgery center (ASC) covered surgical procedures including cochlear device implantation as device-intensive.

For the cochlear implant procedure (CPT code 69930) performed in the outpatient hospital, we submitted that the proposed payment level is insufficient, despite the 1 percent payment increase for next year. CMS is proposing to reimburse the hospital, including the physician’s surgical procedure charge (CPT code 69930), \$25,046.42. However, the cost of the components of the service (physician fee plus the device and processors) is more than \$41,000, leaving an approximate difference of \$15,000 for the hospital to absorb. CMS rejected the Academy’s recommendation that the payment level be increased, so as not to create a disincentive for hospitals and physicians to provide this critical service to hearing impaired patients.

In the ASC, the situation is similar. CMS determined that the ASC's reimbursement for the device and surgical fee is approximately \$24,223.83—yet the proposed payment in CY2008 is only \$23,550 (fully implanted after the 4-year transition phase). Again, we view this as an inappropriate reimbursement level for the service, with significant and detrimental consequences for patients.

### BAHA system

Under the proposed rule, another implantable hearing device, the BAHA system, is also subjected to an insufficient payment level. BAHA, a low-volume procedure, is effective treatment for beneficiaries with conductive, mixed, or single-sided deafness. Medicare currently reimburses \$2,200 for the BAHA implantation surgery, with no payment for the device.

As a means of determining an appropriate payment amount, CMS issued a new HCPCS code (L8690) for the device, and authorized pass-through payment for a period of two to three years. The pass-through period is designed to allow time for sufficient claims data to be collected and analyzed before a permanent OPPS payment rate is set by CMS. During that time, hospitals would be paid for the device using a cost-to-charge ratio.

Despite a recommendation from the Academy to extend the pass-through period to December 2010, CMS will end the pass-through status of BAHA after two years, in 2008. As currently written, the pass-through began in January 2007, and will end in December 2008, with less than two years' worth of data (from 2007 and part of 2008) for analysis and incorporation into the rule. We do not believe this will allow enough claims data to be collected; CMS does not receive enough BAHA claims in a year to perform a meaningful analysis of the costs and billing patterns.

### OPPS: Packaged services - computer-aided navigation

The proposed rule states "We are proposing to package CPT code +61795 (stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal

(list separately in addition to code for primary procedure)) because we consider it to be a guidance service that provides three-dimensional information to direct the performance of intracranial or other diagnostic or therapeutic procedures."

In the final rule, computer-guided navigation (CPT code +61795) is unconditionally packaged into the payment for sinus surgical procedures. The Academy opposed this bundling, on the basis that 1) imaging guidance is not used in every instance of sinus surgery, and 2) bundling the use of +61795 into the reimbursement for sinus surgery will have the effect of reducing payment for these sinus surgeries, because no additional reimbursement accompanies the bundling.

The Academy will continue to bring its policy issues and recommendations to CMS, to ensure that fair and appropriate payment is given to the otolaryngology specialty.

#### Resources:

1. A more detailed explanation of the anti-markup provisions is available from the Health Policy Department, by request to [practiceservices@entnet.org](mailto:practiceservices@entnet.org).
2. The full text of the 2008 Medicare Physician Fee Schedule Final Rule in the Federal Register is available online at <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-5506.pdf>.
3. The full text of the 2008 Medicare Hospital Outpatient Prospective Payment System Final Rule in the Federal Register is available online at <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-5507.pdf>. **B**

## CODING CORNER: 2008 CPT Code Changes

For 2008, there are no changes in the CPT codes for otolaryngology surgeries or procedures.

There are, however, several codes that have been removed from the Modifier -51 Exempt list (or, Appendix E of the CPT book), and no longer appear with the "modifier -51 exempt" symbol.

- **20912** cartilage graft; nasal septum
- **20926** tissue grafts, other (eg, paratendon, fat, dermis)