



Medicare Releases Advance Copies of 2009 Physician Fee Schedule and Hospital Outpatient Prospective Payment System Final Rules

October 31, 2008 – The Centers for Medicare and Medicaid Services (CMS) has released advanced copies of two Final Rules that outline 2009 changes to payment policies for items and services covered by Medicare Part B. Both Final Rules are currently available for viewing on the CMS website and are expected to be published in the *Federal Register* around November 19.

2009 Medicare Physician Fee Schedule Final Rule

The Medicare Physician Fee Schedule (PFS) affects payment for items and services provided by physicians in 2009. Items of particular interest within this Final Rule include:

- **Drug Reimbursement:** No changes are slated to the current Part B drug reimbursement methodology (generally Average Sales Prices [ASP] plus 6%).
- **ASP Calculation:** CMS is finalizing the ASP calculation methodology for multi-source drugs that was implemented on April 1, 2008, in which CMS sums the product of the manufacturer's ASP and the number of units of the 11-digit NDC sold for each NDC assigned to the billing and payment code, and then divides this total by the sum of the product of the number of units of the 11-digit NDC sold and the number of billing units in that NDC for each NDC assigned to the billing and payment code.^[1]
- **Average Manufacturer's Price (AMP) and Widely Available Market Price (WAMP):** There is a provision within Medicare Part B under which CMS has the authority to replace the ASP-based reimbursement rate for a drug with another reimbursement rate based on AMP or WAMP if the Office of Inspector General (OIG) determines that ASP for the drug exceeds AMP or WAMP by 5 percent or more. CMS indicates that the OIG has recently completed a study comparing ASP to AMP, but CMS has not had sufficient time to evaluate it. In the Final Rule, CMS states that "...we understand that there are complicated operational issues associated with potential payment substitutions. We will continue to proceed cautiously in this area and provide stakeholders, particularly manufacturers of drugs impacted by potential price substitutions, with adequate notice of our intentions regarding such, including the opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP."
- **Competitive Acquisition Program (CAP):** As previously announced, CAP has been postponed for 2009. CMS is accepting comments related to the categories of drugs provided under the CAP; the distribution of areas that are served by the CAP; and procedural changes that may increase the program's flexibility and appeal to potential vendors and physicians. Interested parties can submit feedback to CMS about the CAP electronically or can request to meet with CMS in person.

- **Chemotherapy Administration:** The Final Rule indicates that about 15 new CPT codes will be added in 2009 to describe services such as infusion for hydration and subcutaneous infusions. Although the new codes are listed, there is very little information provided about them (such as full descriptions or how they are to be used). We expect more details as the 2009 CPT guidelines are released later this year.
- **Electronic Prescribing Incentives:** In 2009 and 2010, “successful electronic prescribers” will be eligible for incentive payments that are 2 percent of the eligible professional’s allowed charges under the Medicare Physician Fee Schedule. The incentive payment will drop to 1.5 percent in 2011 and 2012, and to 0.5 percent in 2013. Conversely, those who are not “successful electronic subscribers” will be subject to payment reductions, or disincentives. In 2012, payments made under the Physician Fee Schedule will be reduced by 1 percent – the reduction will be 1.5 percent in 2013 and 2 percent in 2014 and later. This is expected to be a significant inducement for physicians to migrate to electronic prescribing.
- **Physician Quality Reporting Initiative (PQRI):** In 2009, physicians voluntarily and successfully participating in PQRI will be eligible for an incentive payment equal to 2 percent of their total allowed charges for all covered professional services furnished between January 1 and December 31, 2009 and reported by February 28, 2010.
- **Retraction of Elimination of the Use of Computer-Generated Facsimiles for E-Prescribing:** A regulation requiring pharmacies that conduct electronic transactions (virtually all of them) to cease using computer-generated faxes to communicate with prescribers (except in certain circumstances) effective January 1, 2009 has been retracted and delayed until 2012.
- **Conversion Factor:** The conversion factor used to calculate payment for items and services covered under the Medicare PFS (e.g., visits, chemotherapy administration, surgery, and radiology) will drop 5.3 percent, from \$38.0870 in 2008 to \$36.0666 in 2009.

2009 Hospital Outpatient Prospective Payment System Final Rule

The second Final Rule applies to hospital outpatient items and services covered under Medicare Part B via the Hospital Outpatient Prospective Payment System (OPPS). Of particular interest:

- **Drug Reimbursement:** Payment for drugs and biologicals without pass-through status will be ASP+4 percent in 2009. Payment for drugs and biologicals with pass-through status will be ASP+6 percent. If the Competitive Acquisition Program (CAP) is reinstated during 2009, then payment for drugs and biologicals that have pass-through status and are also included in the CAP program will equal the CAP rate.
- **Packaging threshold** – Payment for drugs that cost \$60 or less per day will be bundled with other items and services paid on that day. Drugs that exceed the \$60 per day threshold are eligible for separate payment. An exception to this general rule applies to oral anti-emetics, which are paid separately regardless of their cost.
- **IVIG Pre-Administration Reimbursement** – Separate payment for Intravenous immune globulin pre-administration-related services (HCPCS code G0332) will be discontinued in 2009 in both the hospital outpatient and the physician practice settings because it appears that the market for IVIG has become more stable.
- **Chemotherapy Administration:** The current 6-level APC system has been restructured to a 5-level system. Although hospitals will continue to use standard CPT coding for chemotherapy administration, Medicare reimbursement in the hospital outpatient setting

will be adjusted. For example, the following are some commonly used chemotherapy administration codes and their national average payment rates in 2009 –

- 96401 – chemo, anti-neopl, sq/im - \$36.13 (2008 payment rate - \$51.22)
- 96409 – chemo, iv push, single drug - \$128.62 (2008 payment rate - 105.38)
- 96411 – chemo, iv push, addl drug - \$73.67 (2008 payment rate - \$105.38)
- 96413 – chemo, iv infusion, 1 hour - \$187.96 (2008 payment rate - \$149.34)
- 96415 – chemo, iv infusion, addl hr - \$36.13 (2008 payment rate - \$51.22)
- **New HCPCS Codes:** New HCPCS codes have been assigned to at least 15 drugs and biologicals, effective January 1, 2009.

Both Final Rules are lengthy documents that address not only the topics described above but also other reimbursement issues of importance to physicians and hospitals. The 2009 Medicare Physician Fee Schedule rule is available at

<http://www.cms.hhs.gov/apps/ama/license.asp?file=/physicianfeesched/downloads/CMS-1403-FC.pdf>

The 2009 Hospital Outpatient Prospective Payment Final Rule can be viewed at

<http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS-1404-FC.pdf>

If you wish to subscribe additional members of your team, unsubscribe, or speak with a reimbursement consultant, please email reimbursement.highlights@accessmed.com.

AccessMED

The Experts in Complex Drug Reimbursement Solutions



AccessMED • 6900 College Blvd, Suite 1000 • Overland Park, KS 66211