

2012 Medicare Fee Schedule Policy Updates

Three Day Payment Window

Outpatient services provided by a hospital within 72 hours of an inpatient admission are not separately reimbursable to a hospital facility. The 2012 fee schedule now expands this bundling to include services rendered at a wholly owned or wholly operated physician practice within 72 hours of admission to the owner hospital. The payment window will apply to all diagnostic services furnished and to any non-diagnostic services that are clinically related to the reason for the patients' inpatient admission regardless of whether the reported inpatient and outpatient diagnosis are the same. Services affected by the payment window must be submitted with a modifier PD. Effective July 1, 2012, the practice will discontinue receiving the technical component for diagnostic services rendered during the payment window and affected non-diagnostic services will be reimbursed at the facility rate.



Lab Requisition Signatures

The finalized fee schedule reversed a change from 2011 to clarify that the ordering physician's signature is not required on the actual laboratory requisition. The laboratory requisition must be supported by a written order from the physician or midlevel practitioner including medical necessity for the tests ordered.

Health Risk Assessment

The Health Risk Assessment is now a clearly required component of the Annual Wellness Visit. The health risk assessment is intended to be self-reported by the beneficiary. It must include at minimum: demographic data; self assessment of health status, frailty, and physical functioning; psychosocial risks, including depression, life satisfaction, stress, anger, loneliness, social isolation, pain and fatigue; behavioral risks including tobacco use, physical activity, nutrition, oral health, alcohol consumption, sexual practices, seatbelt use, and home safety; activities of daily living including dressing, feeding, toileting, grooming, physical ambulation, and bathing; and instrumental activities of daily living including shopping, food preparation, telephone, housekeeping, laundry, mode of transportation, responsibility for medications, and ability to handle finances.

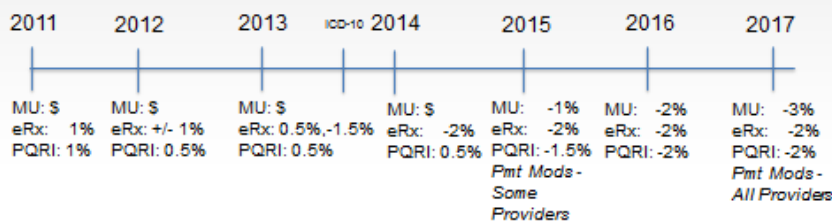
Physician Compare Website

The Physician Compare website is now live at <http://www.medicare.gov/find-a-doctor/provider-search.aspx> and includes names of eligible professionals who submitted quality data for 2009. Additional information must be posted by January 1, 2013 including PQRS Measures, patient health outcomes and functional status, coordination of care, efficiency, and patient experience.

Value Based Payment Modifier

Initial information regarding the value based payment modifier was also included in the 2012 fee schedule. This modifier will be applied to the RBRVS calculation and is intended to be risk adjusted and budget neutral. The modifier will be applied to specific physicians effective in 2015, based on 2013 data, and for all physicians in 2017. The initial determination will be based on reporting of PQRS and meaningful use quality measures as well as cost measures, outcomes and preventable readmissions for heart failure and chronic obstructive pulmonary disease. Measures for episodic care, care coordination/transition and patient experience will be added in the future.

Timelines for Incentives, Penalties



* Positive Values or Dollar Signs Reflect Incentive Payments; Negative values reflect penalties assessed on a provider's annual Medicare allowed charges for failing to satisfy program criteria

Physician Feedback Program

Resource use and quality data reports will be sent to providers in Kansas and Missouri via e-mail during the first quarter of 2012. The reports will include performance on PQRS quality measures and per capita costs for Medicare patients. The report will compare individual providers and group practices with other similar providers.