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Highlights of the 2009 Physician Fee Schedule Final Rule

On October 30, the Centers for Medicare and Medicaid Services (CMS) released the final 2009 Medicare physician fee schedule rule that updates 2009 payment amounts and revises other payment policies. The provisions in this rule become effective for services furnished during calendar year 2009. This document provides highlights of provisions in the fee schedule rule that will impact the provision of physical therapy services. A comprehensive summary is available on the APTA website.

SGR update and Conversion Factor

- CMS announces in the final rule the physician fee schedule update for CY 2009 is 1.1% (instead of a projected 15.1% cut which would have occurred if Congress did not enact legislation).

- The specific impact on physical therapy services in aggregate of the combined CY 2009 update changes to the practice expense RVUs, work RVUs, and the budget neutrality adjustment is plus 3%.

- The 2009 physician fee schedule conversion factor is $36.0666.

Therapy Cap

- The dollar amount of the therapy caps in CY 2009 will be $1840 for physical therapy and speech language pathology combined and $1840 for occupational therapy. The exceptions process will be in effect through December 31, 2009.

Speech Language Pathology Private Practice

- In the rule, CMS implements a provision in the MIPPA legislation that allows speech-language pathologists to enroll and begin billing Medicare for outpatient SLP services furnished in private practice, beginning July 1, 2009.

- The SLP private practice benefit is modeled after the physical therapist private practice benefit under Medicare regulations.

Physician Quality Reporting Initiative

- CMS announces its plans for continuation of the Physician Quality Reporting Initiative (PQRI). CMS will make incentive payments of 2% for successfully reporting on quality measures under the PQRI program in 2009 and 2010.

- The measures finalized in the physician fee schedule rule would be measures that would apply in 2009. CMS will allow claims based reporting for individual measures or for Measures Groups.

- CMS selects a final set of 153 quality measures for reporting in 2009, which is an increase of 35 measures from 2008. The new measures proposed in the rule are either endorsed by the National Quality Forum (NQF), adopted by the AQA Alliance (AQA), or measures currently under consideration by the NQF or the AQA.

- Of the 153 individual measures, the following measures would apply to physical therapists: Falls: Plan of Care; Falls: Risk Assessment; Health Information Technology: Adoption/Use of Electronic Medical Records; Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation; Diabetic Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention Evaluation of Footwear; Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up; Documentation and Verification of Current Medications in the Medical Record; and Pain Assessment Prior to Initiation of Patient Treatment.

- Due to the development of two new falls measures that would be included in PQRI, CMS removes the Screening for Future Fall Risk from the list of PQRI measures.

- CMS selects Measures Groups for Diabetes Mellitus, Chronic Kidney Disease, Preventive Care, Coronary Artery Bypass Surgery, Rheumatoid Arthritis, Perioperative Care, and Back Pain.

- With respect to clinical registry data reporting, CMS has selected 32 registries that can be used for PQRI reporting. The list includes two (FOTO and Cedaron) that could be used by physical therapists.

- CMS will begin accepting data from electronic health records for a limited subset of proposed 2009 PQRI measures.

Rehabilitation Agency Issues

- CMS defines "extension location" as: 1) a location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site; 2) is part of the rehabilitation agency; and 3) is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency.

- CMS removes the requirement the rehabilitation agency provide one or more doctors of medicine or osteopathy to be available on call to furnish necessary medical care in case of an emergency. The rehabilitation agency can establish its own internal policies.

- CMS deletes the requirement that a rehabilitation agency provide social or vocational services.

- CMS states that it does not intend to revise the Conditions of Participation for rehabilitation agencies to conform to changes in the timing for recertification of outpatient therapy plans of care as delineated in the 2008 Medicare Fee Schedule final rule- which mandates that the outpatient therapy plan of care be recertified every 90 days. Currently, CMS requires that the plan of care and results of treatment be reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken, which for Medicare patients being treated in a rehabilitation agency must be at least every 30 days.

Comprehensive Outpatient Rehabilitation Facility Issues

- CMS finalizes provisions that reference personnel qualifications for physical therapy, occupational therapy, and speech-language pathology as delineated in 42 CFR 484.4.

- CMS finalizes its proposal to create the CORF specific G-code which will be G0409. The description of the G-code is G0409 "Social work and psychological services." The purpose of this code is to directly relate to the patient's rehabilitation goals, each 15 minutes, face-to-face; individual encounter – to accurately describe the unique social and psychological services provided by CORF staff and to establish appropriate payment for these services.

- CMS finalizes the clarification that alternate premises for the provision of PT, OT, and SLP services may be the patient's home.

Physician and Nonphysician Practitioner Enrollment Issues

- CMS adopts a new approach for establishing an effective date for Medicare billing privileges for physicians and nonphysician organizations and individual practitioners. Specifically, CMS establishes the initial enrollment date as the later of: 1) the date of filing of Medicare enrollment application that was subsequently approved by a fee-for-service (FFS) contractor; or 2) the date an enrolled supplier first started rendering services at a new practice location.

- If a physician or NPP's billing privileges have been suspended or they have an existing overpayment, CMS decides to prohibit them from obtaining additional billing privileges.

- CMS changes its regulations to require that physicians and nonphysicians report a change in ownership, change in practice location, and any adverse legal actions within 30 days (the previous reporting time frame was 90 days). If they do not comply with this requirement, CMS may revoke billing privileges or assess an overpayment.

Quality Standards for Physicians and Nonphysician Practitioners Providing Diagnostic Testing Services

- CMS decides not to adopt its proposal that would have required physicians and NPPs who furnish diagnostic testing services to enroll as an independent diagnostic testing facility for each practice location furnishing these services.

Canilith Repositioning

- The CPT Editorial panel created and the AMA RUC valued a new CPT code (95992, Canilith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day) for canilith repositioning. CMS assigns a work RVU of .75, a fully implemented practice expense RVU of .25 and a malpractice RVU of .02.

- CMS assigns a status indicator of bundled code for this service (this means it will not be paid for separately by Medicare).

Physician Self-Referral and Anti-markup Issues

- CMS is reopening the public comment period for the shared savings proposed provisions to obtain specific information regarding: whether the creation of the exception poses any risk of program or patient abuse and what are the best ways to achieve transparency and accountability, ensure quality of care, and prevent disguised payments for referrals.

- CMS finalizes a flexible approach to the anti-markup rule. CMS states that the physician who supervises the TC or performs the PC or both or performs at least 75 percent ("substantially all") of his or her professional services for the billing physician or other supplier will be subject to the anti-markup limitations.

- CMS declines to finalize a definition of outside supplier in the final rule.

Discussion of Chiropractic Services Demonstration

- CMS gives a brief overview of the existing chiropractic demonstration project and lays out a plan to recoup funds in the event that the demonstration results in costs higher than those that would occur in the absence of the demonstration.

Physician Certification and Recertification for Medicare-Covered Home Health Services

- In the proposed rule, CMS put forward two proposals to ensure physician involvement in the plan of care for home health. In this final rule, CMS decides not to adopt the proposals. CMS acknowledges that it received several comments on this matter and will continue to analyze and consider those comments and suggestions in future rulemaking.