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CMS Proposes Bold Changes for the 2009 Medicare Physician Fee Schedule

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On July 7, 2008, CMS published its **Proposed Rule for the 2009 Medicare Physician Fee Schedule**. CMS must issue the final regulations by November 1, 2008.

The proposed rule would revise several enrollment and billing rules, including:

- Revising the effective date for Medicare billing privileges for physician and non-physician organizations and individual practitioners.
- Prohibiting physicians and non-physician practitioners (NPPs) whose billing privileges are suspended or who have an existing overpayment from obtaining additional billing privileges.
- Requiring notice within 30 days when physicians or NPPs experience a change of ownership, adverse legal action, or a change of location that is relevant to payment amount.
- Requiring physicians and NPPs to maintain written documentation for ordering and referring.
- Establishing a 15 day deadline for submission of all outstanding claims when a provider's or supplier's billing privileges are revoked.

The proposed rule would also implement the following changes:

- Update the standards for physicians and NPPs that perform diagnostic tests in their offices by requiring them to enroll as an independent diagnostic testing facility (IDTF) yet and meet licensure and performance standards currently applicable to IDTFs. [See Julie Kass' article **"Proposed Rule Requires Physicians and Non-Physician Practitioners to Enroll as IDTFs"**]
- Add an exception to the physician self-referral rules in order to permit

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Watch for E-mails from the PRRB

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remuneration under certain incentive payment or shared savings programs.

- Revise the anti-markup rule in two ways. One alternative would exclude certain diagnostic testing services from application of the anti-markup rule. The other would "clarify" the meaning of terms used in the MPS 2008 final rule, including "office of the billing physician or other supplier" and "outside supplier." [See Rob Mazer's article **"Proposed Changes to Anti-markup Prohibition Leave Providers of Diagnostic Services in a Quandry"**]

- Allow specified documentation requirements to replace the beneficiary signature requirement for non-emergency ambulance service in situations where no other authorized individual can sign a claim on behalf of a beneficiary who is not capable of signing.

- Add new HCPCS codes for physicians who provide telehealth consultations pursuant to consultation by the beneficiary's attending physician in the context of inpatient follow-up care.

- Consider comments and data that could be used to analyze the payment rate to physicians for certain organ retrieval services.

- Revise the Competitive Acquisition Program (CAP) by "clarifying" rules regarding the annual payment amount calculation, the definition of physician for CAP purposes and the consequences of suspension of a CAP physician or vendor from participation in the CAP.

- Update the wage data and complete the transition to a wage index for End Stage Renal Disease facilities.

CMS will accept comments until August 29, 2008.