

Proposed Medicare cuts of 11-15 percent will restrict patient access to cardiac care

SGR-mandated cut of 21.5 percent an additional, fatal blow

Medicare's Proposed 2010 Physician Fee Schedule contains numerous provisions that will prove devastating to private practice Cardiology—and dramatically affect patient access—if made permanent in the final rule:

Practice expense cuts of 11-15 percent or more will cut reimbursement for common cardiac procedures by a staggering 40 percent or more.

1) Incomplete data used to cut practice expense payments: The Centers for Medicare and Medicaid Services (CMS) used data from the American Medical Association's Physician Practice Information Survey (PPIS) to help determine reimbursement for practice expenses. But the AMA survey provided data from only 53 cardiologists—representing only one-quarter of 1 percent of the cardiologists in the United States. 2009 practice expense payments were based on survey data that passed stringent statistical tests regarding reliability and representativeness. CAA believes the latest PPIS survey and resultant data was insufficient to base such drastic changes to the reimbursement formula.

If implemented, this proposal alone would decrease total Medicare cardiology payments by a minimum of 10 percent. It could be as high as 15 percent depending on practices' mix of services, since reimbursement for most of the commonly performed cardiac procedures would be cut by 11-45 percent or more from 2009 to 2010 (global payment national rate examples):

- ◆ Echo with Doppler Colorflow: (-42%)
- ◆ Stress Echo: (-22%)
- ◆ Nuclear Stress Test: (-37%)
- ◆ Left Heart Catheterization: (-47%)

2) Incomplete data used to increase EU assumption rate: In the Proposed 2010 fee schedule, CMS would increase the equipment utilization (EU) assumption rate from its current 50 percent to 90 percent for equipment costing \$1 million or more (MR, CT and PET). An increase of this magnitude would cut Cardiology imaging reimbursement by 2 -5 percent.

CAA believes this massive increase is based on flawed, incomplete data and erroneous assumptions by the Medicare Payment Advisory Committee (MedPAC). CMS and MedPAC fail to take into consideration re-scans, no-shows, down time, empty slots, time required for preparing a patient and other realities of providing imaging services.

A survey by the Radiology Business Management Association, a national association of business professionals in radiology, shows that imaging equipment in rural regions of the country operates only 48 percent of the time an office is open, while equipment in non-rural areas operates 56 percent of the time a center is open for business.

3) Cuts to medical malpractice premium payments: Medicare proposes to update malpractice insurance premium values for practice expenses and change how it determines the medical malpractice reimbursement for Technical Component (TC) services. CMS predicts this will reduce cardiology reimbursement by 1 percent. One of the key flaws in this proposal is the belief that the TC does not require a medical malpractice component—leaving the facility uncovered in this area. In addition, there are errors in the values CMS provides for the malpractice units that prevent accurate formula inputs.

4) Non-payment of consults: Medicare proposes to replace the consultation codes that physicians use in the office or hospital setting with existing in-office codes. Given that Cardiology is a specialty, consultations are an important aspect of the provision of cardiac care. This change will reduce cardiology reimbursement by another 1-2 percent.

5) Mis-valued codes and bundling of payments: While vague in the proposed rule, it is assumed these changes also will decrease Cardiology reimbursement. Bundling procedures based on inaccurate practice expense values will result in erroneous reimbursement levels.

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Other Medicare proposals that will negatively affect access to cardiac care

SGR cut of 21.5 percent: Medicare is mandated to implement the Sustainable Growth Rate formula annually unless Congress intervenes to mitigate its effects. The 2010 scheduled decrease is 21.5 percent. That cut alone would force closure of many private practice cardiology offices nationwide.

Barriers to participation in PQRI, e-Prescribing initiatives: CMS proposes changes in how practices can submit Physicians Quality Reporting Initiative (PQRI) data and new PQRI measurement options. In addition, CMS calls for new minimum data submission requirements for the e-Prescribing initiative. These changes will make it more difficult for physicians to qualify for the 2-percent bonuses offered under the 2008 Medical Improvements to Patients and Providers Act (MIPPA) and could decrease participation in these critical programs.

Patient access to cardiology care will suffer

Private practices cannot absorb these dramatic payment cuts without significantly reducing services, closing rural offices and/or laying off staff. The result?

- ◆ Patients would be directed to the hospital outpatient setting for diagnostic imaging.
- ◆ Patients would have higher co-pays and longer waits for appointments and test results.
- ◆ Medicare costs will INCREASE, as the outpatient hospital setting reimbursement rate is UP TO FIVE TIMES HIGHER for the same procedure performed in the physician office setting.

Medicare Beneficiary Co-Pays, Proposed 2010 Fee Schedules		
	In-Office Setting	Outpatient Hospital Setting
Nuclear Stress Test	\$ 87	\$ 187
Stress Echo	\$ 43	\$ 105
Echo Doppler Colorflow	\$ 31	\$ 104
Left Heart Cath	\$197	\$ 601

How can we ensure continued access to cardiac care?

CAA submitted comments to CMS regarding the proposed 2010 Physician Fee Schedule to recommend that Medicare:

- ◆ Place a moratorium on the use of the results of the AMA's PPIS survey data related to practice expense components;
- ◆ Leave the EU assumption rate at 50 percent;
- ◆ Leave e-Prescribing reporting requirements in place until the infrastructure of SureScripts is consistently reliable; and
- ◆ Ensure PQRI registry options are in place before removing the claims reporting process currently in use.

Proposed 2010 Physician Fee Schedule Cardiology Reimbursement Cuts	
Practice expense, EU rate changes	-10 to -15%
Changes in malpractice payments	-1 %
Non-payment of consultation codes	-1 to -2 %
Implementation of SGR formula	-21.5 %
TOTAL % CUTS	-33.5 to - 39.5 %

America's cardiologists have made great strides in the fight against heart disease, reducing heart-related deaths and the severity of heart-related illness by 27 percent during the past 10 years. But Medicare's proposed PFS threatens the advances in cardiac care that have benefited patients across the country.

Medicare's Proposed 2010 Physician Fee Schedule: devastating to private practice Cardiology and patients' access to cardiac care, the nation's Number One Killer.



CAA provides national leadership on legislation, policies and reimbursement methodologies that affect cardiovascular patients' quality of care, access to services and the stability of cardiovascular group practices. CAA represents the interests of more than 5,000 private practice physicians. For more information, please visit our website: cardiologycaa.com