

2012 Medicare Physician Fee Schedule Final Rule Summary

On November 1, 2011, the Centers for Medicare and Medicaid Services (CMS) posted the final Medicare Physician Fee Schedule (PFS) for 2012. It is expected to be published in the Federal Register on November 28. The rule in its entirety can be found [here](#). The addenda to the rule, including Addendum B, which lists the proposed RVUs for each CPT code, can be found [here](#). (Please note: once this notice is published in the Federal Register the link will change). The provisions of the rule will be effective January 1, 2012 unless stated otherwise. Comments on those issues subject to comment are due by January 3, 2012.

Highlights of the rule include:

- **Conversion Factor:** The current CF, which expires on December 31, 2012, is \$33.9764. Without congressional action, the CF will be reduced by 27.4 in 2012, due to the SGR formula. Assuming that Congress acts to prevent this reduction, as it has in previous years, we estimate a 2012 CF identical to the 2011 CF in the prepared charts.
- **Specialty Impact:** Most gastroenterological procedural codes remain the same, while evaluation and management codes will see increases of approximately 1 percent. The total impact of the changes in the rule on the average hepatologist will vary depending on the mix of services provided.
- **RUC Review of Potentially Misvalued Codes:** CMS has asked the AMA's Relative Value Update Committee (RUC) to review a number of high volume codes which have not been reviewed in the last 6 years. In the proposed rule, CMS included a provision to have the RUC review virtually all the E/M codes. However, based on comments received CMS decided to withdraw this request to the RUC.
- **Physician Quality Reporting System (PQRS):** CMS proposes to redefine a group practice for the group practice reporting option as 25 or more eligible professionals. CMS also proposes to reduce the number of options for 6-month registry-based measures reporting.
- **The Electronic Prescribing Incentive Program:** This program is transitioning into its penalty phase in 2012. Participation will be required in 2012 to avoid a 1.5 percent payment reduction in 2013.
- **Medicare Electronic Health Records Incentive Program:** CMS proposes to harmonize the EHR incentive program with PQRS.

SGR and Conversion Factor (CF) Impact

The current CF, which expires on December 31, 2012, is \$33.9764. Without congressional action, the CF will be reduced by 27.4 percent, due to the SGR formula. The President's budget calls for an extension of the 2011 CF through December 31, 2013, but legislation is needed enact this proposal or to maintain the current CF. Congress has prevented reductions in the CF due to the SGR formula for numerous years and it is anticipated that it will once again take similar action. Assuming that the SGR reductions are prevented by legislation, we are estimating a 2012 CF of \$33.9764 for purposes of the payment projections in the prepared charts.

Specialty Impact

Table 84 (see Attachment 1), extracted from the rule, provides a summary of the impact of the proposed changes in the rule by specialty. The impact, positive or negative, is due to a number of factors highlighted in the table, particularly the continued transition to the new practice expense (PE) values

(2012 is the third year of the 4-year transition), the change in the weights assigned to physician work, PE and professional liability insurance (PLI) components, and other changes in the proposed rule.

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges (mil)	Impact of Work & MP RVU Changes	Impact of PE RVU Changes		Combined Impact	
			2013	2012	2013	2012
TOTAL	\$83,313	0%	0%	0%	0%	0%
GASTROENTEROLOGY	\$1,852	0%	1%	0%	-1%	0%

*Table 84 shows only the payment impact on PFS services. We note that these impacts do not include the effects of the January 2012 conversion factor change under current law.

RUC Review of Potentially Misvalued Codes

At the direction of CMS, the AMA’s Relative Value Update Committee (RUC) has reviewed the relative values assigned to various categories of services. CMS has typically identified for review, codes with substantial growth in utilization, codes billed in multiple units, and codes for which the site of service had changed. In the proposed rule, CMS indicated that the RUC should review the physician work and practice expense values for all of the evaluation and management codes along with a number of high volume/high expenditure services which had not been reviewed by the RUC in the last 6 years. CMS stated that a majority of the commenters indicated that a reexamination of the values of E/M services was not likely to be productive since these codes were recently reviewed and urged CMS to drop the request. CMS accepted these comments and decided not to ask the RUC to review the E/M codes at this time. A number of commenters, however, urged CMS to recognize some of the non-face to face services provided by primary care and other physicians who provide care to chronically ill patients such as telephone calls and team conferences. In response, CMS indicated it will continue to explore the valuations of E/M services and other refinements to the physician fee schedule.

Consistent with the proposed rule, in the final rule, CMS has asked the RUC to review some 70 of the highest volume procedural codes which have not been reviewed in the last 6 years.

Multiple Procedure Payment Reductions

Currently a 50% multiple procedure payment reduction (MPPR) is applied to the technical component of (TC) of advanced imaging codes provided in the same session. This policy is based on the assumption that there are efficiencies in labor, supplies and equipment when more than one imaging procedure is performed. The policy was extended to the Practice Expense (PE) of therapy services (PT, speech therapy and occupational therapy). A 20 percent reduction is applied to the PE of the second and additional therapy codes billed the same day.

CMS proposed to apply a 50 percent reduction to the Professional Component (PC) of multiple advanced imaging services (MRI, PET, CT) performed in the same session based on the rationale that there are efficiencies when multiple images are interpreted. In the final rule, CMS decided to proceed with this change but has reduced the MPPR adjustment to a 25 percent reduction.

CMS indicated it is still considering additional options which were discussed in the proposed rule to extend the application of the MPPR in the future including Applying the MPPR to the TC of all imaging codes, not just advanced imaging

- Applying the MPPR to the PC of all imaging codes

- Applying the MPPR to the TC of all diagnostic codes including radiology, audiology, cardiology, neurology, etc.

It certainly seems likely that one or more of these options will be proposed in the future.

Geographic Practice Expense Index (GPCI)

The GPCI is an adjustment CMS calculates and applies to both the work and practice expense relative value units for each code to reflect differences in labor, rent and other cost elements. CMS is finalizing several changes to the GPCI and how it is applied to payment for physician services:

- A technical change in how the GPCI applies to office rents, purchased services and employee compensation.
- Implementation of a provision of the Affordable Care Act establishing a PE index of 1.0 in several so-called frontier states. These are Montana, Wyoming, North Dakota, South Dakota and Nevada. A PE index of 1.0 would be equivalent to the national average. The actual GPCI in these states would be less than 1.0 so this change raises payments in these states.
- Elimination of the statutory floor on the GPCI the authority for which expired to protect lower cost and rural areas.

While the overall impact of the GPCI changes will be modest (in the range of +/- 1 or 2 percent), removing the floor in some areas will lead to substantial reductions in payment. For instance, payments in Puerto Rico will be reduced by 15 percent and in West Virginia, Oklahoma, Mississippi, Iowa, Kentucky and Arkansas will be reduced by -5 to -6 percent. There are a few geographic areas that will see some increases in the 2-3% range as a result of the change including Seattle, Washington and some Maryland localities. Table 86 in the rule, which is attached, has a complete listing of the estimated changes in the weighted geographic adjustment factor by locality.

Telehealth Services

CMS is proposing to add smoking cessation counseling to the list of approved telehealth services. CMS is also changing the criteria it uses to approve additional telehealth services. CMS also modified the definition of the G codes for inpatient telehealth consultations to include telehealth consultations in an emergency department setting. is proposing to evaluate whether to approve telehealth services based on the clinical benefit to the patient rather than the current requirement that a telehealth service must be equivalent to an in-person service to be approved.

Annual Wellness Visit

As of January 1, 2011, Medicare has covered an annual wellness visit for beneficiaries as mandated in the Affordable Care Act (ACA). The law also provided coverage for a personalized prevention plan which is to include a health risk assessment (HRA) that meets guidelines established by the Secretary. CMS adopted the following criteria for a HRA:

- Collects self-reported information about the beneficiary.
- Can be administered independently by the beneficiary or administered by a health professional prior to or as part of the AWV encounter.
- Takes into account the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs,
- Takes no more than 20 minutes to complete.
- Addresses, at a minimum, demographic data, including but not limited to age, gender, race, and ethnicity; self-assessment of health status, frailty, and physical functioning, psychosocial risks, including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, or fatigue; behavioral risks, including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual practices, motor vehicle safety (seat belt use), and home safety and activities of daily living (ADLs), including but not limited to dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing.

CMS increased the payment for the annual wellness visit to reflect the additional time required to administer a HRA.

Payment for Part B Drugs

Currently, Medicare pays for drugs provided by a physician based on 106 percent of ASP. While the authority has never been used, current law permits CMS to substitute the Average Manufacturer Price (AMP) determined under Title 19 if it is lower than ASP. If ASP exceeds the AMP by 5 percent or more for two quarters (to eliminate a short term anomaly) CMS will base payment on 103 percent of AMP rather than 106 percent of ASP. The impact analysis in the rule indicates that CMS expects very modest savings from this authority. Any decisions made regarding the use of ASP will be reflected in the CMS website at least 2 weeks prior to the change.

2012 Physician Quality Reporting System (PQRS)

Since its initial implementation in 2007, PQRS has continued to evolve largely as a result of statutory updates enacted by Congress. Under the current program, those who successfully report quality measures in CY 2012 will receive a bonus payment of 0.5 percent of total allowed charges for services provided during the reporting period. Like last year, an additional 0.5 percent will be available for those who participate in a maintenance of certification (MOC) program required for board certification by a recognized physician specialty organization.

Eligible professionals who choose not to participate in CY 2012 should note that beginning in 2015 penalties will be assessed for those who do not satisfactorily submit quality data. The initial penalty will be 1.5 percent and rise to 2.0 percent in CY 2016. The reporting period for the 2015 payment adjustment will be the reporting period of January 1, 2013 through December 31, 2013. CMS received many comments objecting to basing the CY 2015 payment adjustment on the 2013 reporting period, but CMS maintained that it is not operationally feasible to impose a payment adjustment in 2015 based on data from any later than 2013 and avoid retroactive payments or the reprocessing of claims.

Measures Selection. Measures included in the PQRS are endorsed by the NQF or adopted by the AQA except in limited circumstances as determined by the agency. The following hepatology-specific measures will be included in the 2012 PQRS:

- 83: Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia
- 84: Hepatitis C: RNA Testing Before Initiating Treatment
- 85: Hepatitis C: HCV Genotype Testing Prior to Treatment
- 86: Hepatitis C: Antiviral Treatment Prescribed
- 87: Hepatitis C: HCV RNA Testing at Week 12 of Treatment
- 89: Hepatitis C: Counseling Regarding Risk of Alcohol Consumption
- 90: Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy
- 183: Hepatitis C: Hepatitis A Vaccination in Patients with HCV
- 184: Hepatitis C: Hepatitis B Vaccination in Patients with HCV

All of the measures except number 83 are included in the hepatitis measures group.

CMS retained all of the measures included in the 2011 PQRS as proposed, including the hepatitis measures. Of the 199 measures retained, 55 are registry-only measures and 144 are reportable either by claims or registry. CMS added 26 new measures to the PQRS, 13 of which will be registry only measures and the other 13 will be reportable by claims or registry.

To further align the PQRS and the EHR Incentive Program, CMS is proposing the inclusion of all clinical quality measures available for reporting under the Medicare EHR Incentive Program in the EHR-based reporting option in the 2012 PQRS.

CMS is retaining 14 of last year's measures groups, including the hepatitis C measures group. In addition, CMS added 10 new measures groups; none of these apply to AASLD members. All measures included in measures groups would be reportable as part of a group or individually, except for the measures in the back pain measures group.

For the group practices participating in the PQRS, CMS is proposing that they be required to report on 40 measures listed in Table 56 of the proposed rule.

Maintenance of Certification Program Incentive. The Affordable Care Act authorized this additional incentive. There are four parts to the program that physicians must satisfy:

1. Maintain a valid and unrestricted license in the United States;
2. Participate in educational and self-assessment programs;
3. Demonstrate through a formalized secure examination that the physician has fundamental diagnostic skills, medical knowledge and clinical judgment to provide care in his specialty; and
4. Successfully complete a qualified maintenance of certification program practice assessment.

In CY 2011, those wishing to qualify for the bonus had to meet these 4 requirements more frequently than required. CMS has revised this requirement for CY 2012 through 2014, by requiring an eligible professional to participate more frequently than is required in at least one of the four parts of the MOC program, not all four. CMS will look to the specific requirements of Board certification to determine if the "more frequently" requirement is met. However, CMS will interpret the statute to require the participation and successful completion in at least one MOC program practice assessment for each year the physician participates in the MOC Program Incentive.

Participation Options. Eligible professionals will be able to participate either individually or as part of a group practice through the group practice reporting option (GPRO). CMS redefined a group practice to be 25 or more eligible professionals who have reassigned their billing rights to a TIN. CMS is interested in having practices with less than 25 eligible professionals participate through the GPRO option in the future, but it is not operationally feasible to do so now. CMS is considering further redefining of what constitutes a group practice in future rulemaking to better align all of the agency's quality reporting programs. Those wishing to participate under GPRO would be required to self-nominate by January 31, 2012. For practices wishing to participate in the PQRS and the e-Prescribing (eRx) program must indicate that in the self-nomination statement.

Reporting Period Options. CMS is statutorily required to have multiple reporting periods. To remain in compliance, CMS is retaining the 6-month reporting period option for reporting measures groups via registry. However, CMS has eliminated the 6-month reporting period for claims and registries; CMS believes this will help standardize the PQRS with the EHR reporting mechanism and the GPRO. For the reporting options of claims, registry, EHR-based, and GPRO, there will be a 12-month reporting period.

Reporting Mechanisms. CMS retained the claims-based, registry-based and EHR-based reporting mechanisms for 2012 and future years. Eligible professionals can report through multiple mechanisms, but must satisfy the reporting criteria for a single reporting mechanism to be eligible for the bonus payment.

- *Claims-based reporting:* Eligible professionals are required to submit the appropriate PQRS data codes on their Medicare Part B claims for the measures of their choosing.

- *Registry-based reporting:* Those electing to report via registry must maintain an appropriate legal arrangement with a qualified registry to submit individual measures or measures groups. Registries must self-nominate to become qualified. AASLD members can participate through an AGA-sponsored registry.
- *EHR-based reporting:* Eligible professionals can submit quality data either directly from a qualified EHR or indirectly from a qualified EHR data submission vendor. Those choosing the indirect method must maintain an appropriate legal arrangement with a qualified 2012 EHR data submission vendor. EHR technology that was purchased to meet the specifications of the Medicare and Medicaid EHR Incentive programs may not be qualified for the PQRS. CMS is exploring ways to align these programs' requirements moving forward.

Criteria to Satisfactorily Report. This year CMS proposed to alter the criteria for satisfactory reporting by specialty, requiring those in certain specialties to report on a set of core measures. However, CMS did not finalize this proposal because of operational limitations. Responding to comments from those opposed to the proposal, CMS continues to support the aim of requiring certain providers to report on core measures. It seems likely that this proposal may be made again once it is operationally feasible.

CMS is required to integrate the PQRS and EHR reporting. The agency is proposing that integration will consist of the following: the selection of measures that reporting would demonstrate meaningful use of an EHR and the quality of care furnished to an individual as well as other activities to be specified by the Secretary. This year CMS is taking the first step towards integration and providers can report can choose an option that reflects this integration. This is detailed in the chart under the heading "EHR – Aligning with the Medicare Incentive Program."

The reporting requirements are below.

Individual Measures – Eligible Professionals	
Claims-Based Reporting	
Reporting Criteria: <ul style="list-style-type: none"> - Report at least three Physician Quality Reporting System measures; OR - If less than three measures apply to the eligible professional, 1-2 measures; AND - Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period - Measures with 0% performance rate will not be counted. 	Reporting Period: January 1, 2012 – December 31, 2012
Registry-Based Reporting	
Reporting Criteria: <ul style="list-style-type: none"> - Report at least three Physician Quality Reporting System measures; AND - Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which these measures apply - Measures with 0% performance rate will not be counted. 	Reporting Period: January 1, 2012 – December 31, 2012
EHR – Aligning with the Medicare EHR Incentive Program	
Reporting Criteria: <ul style="list-style-type: none"> - Reports on ALL three Medicare EHR Incentive Program core measures - If the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to three Medicare EHR Incentive Program alternate core measures; AND - Report on three (of the 38) additional measures available for the Medicare EHR Incentive Program. 	Reporting Period: January 1, 2012 – December 31, 2012

EHR – Direct EHR- based reporting & EHR data submission	
Reporting Criteria: <ul style="list-style-type: none"> - Report at least three Physician Quality Reporting System measures; AND - Report each measure for at least 80% of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to which the measure applies - Measures with 0% performance rate will not be counted. 	Reporting Period: January 1, 2012 – December 31, 2012

Measures Groups – Eligible Professionals

Claims-Based Reporting – Two Options		
<i>Option 1</i>	Reporting Criteria: <ul style="list-style-type: none"> - Report at least 1 Physician Quality Reporting System measures group; AND - Report each measure group for at least 30 Medicare Part B FFS patients. - Measures groups containing a measure with a 0% performance rate will not be counted 	Reporting Period: January 1, 2012 – December 31, 2012
<i>Option 2</i>	Reporting Criteria: <ul style="list-style-type: none"> - Report at least 1 Physician Quality Reporting System measures group; - Report each measures group for at least 50% of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT - Report each measures group on no less than 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies. - Measures groups containing a measure the 0% performance rate will not be counted. 	Reporting Period: January 1, 2012 – December 31, 2012
Registry-Based Reporting – Three Options		
<i>Option 1</i>	Reporting Criteria: <ul style="list-style-type: none"> - Report at least 1 Physician Quality Reporting System measures group; AND - Report each measures group for at least 30 Medicare Part B FFS patients. - Measures groups containing a measure with a 0% performance rate will not be counted 	Reporting Period: January 1, 2012 – December 31, 2012
<i>Option 2</i>	Reporting Criteria: <ul style="list-style-type: none"> - Report at least 1 Physician Quality Reporting System measures group; AND - Report each measures group for at least 80% of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT - Report each measures group on no less than 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies. - Measures groups containing a measure with a 0% performance rate will not be counted. 	Reporting Period: January 1, 2012 – December 31, 2012
<i>Option 3</i>	Reporting Criteria: <ul style="list-style-type: none"> - Report at least 1 Physician Quality Reporting System measures group; 	Reporting Period: July 1, 2012 –

	<p>AND</p> <ul style="list-style-type: none"> - Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT - Report each measures group on no less than 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies. - Measures groups containing a measure with a 0% performance rate will not be counted. 	December 31, 2012
--	--	-------------------

For group practices with 25-99 eligible professionals, CMS is proposing that the group practice report on all the GPRO measures specified in the rulemaking for up to 218 beneficiaries for each disease module and preventive care measure. If the pool of beneficiaries is less than 218, CMS would require that reporting be completed for 100 percent of eligible assigned beneficiaries for the disease module or preventive care measure. For group practices with 100 or more eligible professionals, they will need to report on 411 beneficiaries. Regardless of size, the group practices will be required to report on consecutive patients; "skipping" will be allowed in limited circumstances.

Feedback Reports. CMS is statutorily required to provide feedback reports to eligible professionals. These reports will be provided on or about the time of issuance of the incentive payments as is current practice. For 2012, CMS finalized its proposal to provide interim feedback reports for those reporting individual measures and measures groups through the claims-based reporting mechanism.

The Electronic Prescribing Incentive Program (eRx program)

Electronic prescribing is the transmission using electronic media of prescription or prescription-related information between the prescriber, dispenser, pharmacy benefit manager or health plan, using an electronic prescribing network. The program provides for a combination of incentives and payment adjustments through 2014.

The eRx incentive payment for 2012 is 1.0 percent and 0.5 percent for 2013. Eligible professionals and group practices who are successful e-prescribers may earn an incentive payment based on the estimated total allowed charges for services under Medicare Part B provided during the reporting period. To qualify for the program, eligible practitioners will need to submit e-prescribing measures for at least 25 unique electronic prescribing events in 2012. For group practices of 25-99 and of 100 or more, they must report 625 and 2,500 unique measures respectively. Eligible professionals can report via claims, qualified registry or qualified EHR; however, the requirement must be met by reporting through a single mechanism.

Starting in 2012, eligible professionals who are not successful or do not participate will encounter reductions to their Medicare payments equal to: – 1% in 2012; – 1.5% in 2013; and -2.0% in 2014.

To avoid the 2013 payment adjustment, electronic prescribing measures must be reported at least 25 times between January 1, 2011 – December 31, 2011 or 10 times between January 1, 2012 – June 30, 2012 by individual eligible providers. Group practices of 25-99 must report 625 times and group practices of 100 or more must report 2500 or more times between January 1, 2012 and June 30, 2012.

To avoid the 2014 payment adjustment electronic prescribing measures must be reported 25 times by individuals between January 1, 2012 and December 31, 2012 or 10 times between January 1, 2013 and June 30, 2013. Group practices of 25-99 must report the electronic prescribing measure 625 times between January 1, 2012 and December 31, 2012 or 625 times between January 1, 2013 and June 30, 2013. Group practices of 100 or more must report the electronic prescribing measure 2,500 times between January 1, 2012 and December 31, 2012 or 2,500 times between January 1, 2013 and June 30, 2013.

Significant Hardship Exemptions. The Secretary may exempt eligible professionals from the payment adjustment on a case-by-case basis if complying with the requirement would result in a significant hardship. CMS is proposing the following exemptions:

- The eligible professional or eRx GPRO practices in a rural area with limited high speed internet access.
- The eligible professional or eRx GPRO practices in an area with limited available pharmacies for electronic prescribing.
- Inability to prescribe due to local, state or federal law or regulation.
- Eligible professionals who prescribe fewer than 100 prescriptions during a 6-month payment adjustment reporting period.

Those who believe they qualify under one of the exemptions must provide the following information to CMS by June 30, 2012 for the 2013 payment adjustment and June 30, 2013 for the 2014 payment adjustment:

- The name of the practice and other identifying information.
- The proposed exemption that applies.
- A justification statement describing how compliance would create a significant hardship.
- An attestation of the accuracy of the information provided.

Medicare EHR Incentive Program

CMS finalized its proposal to allow eligible professionals participating in the Medicare EHR Incentive Program to report clinical quality measures (CQMs) in 2012 by attesting to the CQMs utilizing CMS certified EHRs or by participating in the voluntary PQRS-Medicare EHR Incentive Pilot. For those individuals participating in the pilot, measures can be submitted either through a PQRS EHR data submission vendor or from a certified PQRS EHR via a web portal. CMS has approved 44 EHR Incentive Program measures.

Value-Based Payment Modifier

The ACA directed CMS to apply a separate, budget-neutral payment modifier, known as the value-based payment modifier, to the physician fee schedule payment formula which will be phased in beginning January 1, 2015 through January 1, 2017. The modifier will provide for differential payment under the fee schedule to a physician or group of physicians, and later possibly to other eligible professionals, based upon the relative quality and cost of care of their Medicare beneficiaries. The final rule sets the initial performance year as CY 2013. Performance during 2013 will be used to calculate the modifier that would apply to items and services furnished under the 2015 MPFS. The quality measures for 2013 are identified in the rule as the PQRS core set (cardiovascular conditions) and Group Practice Reporting Option measures and EHR incentive program measures, which are listed in Tables 80 and 81 of the rule. There are no hematology-related measures included at this time. The rule also describes how cost measures for the conditions (related to the quality measures) will be developed. CMS will propose the complete methodology for the value modifier in the CY 2013 MPFS proposed rule.

Attachment 1

TABLE 84: CY 2012 PFS FINAL RULE WITH COMMENT PERIOD TOTAL ALLOWED CHARGE ESTIMATED IMPACT FOR RVU AND MPPR CHANGES*

(A) Specialty	(B) Allowed Charges (in millions)	(C) Impact of Work and MP RVU Changes	(D) & (E) Impact of PE RVU Changes		(F) & (G) Combined Impact	
			Full	Tran	Full	Tran
TOTAL	\$83,313	0%	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	\$196	0%	-1%	-1%	-1%	-1%
ANESTHESIOLOGY	\$1,756	0%	2%	1%	2%	1%
CARDIAC SURGERY	\$386	0%	-2%	-2%	-3%	-2%
CARDIOLOGY	\$6,808	0%	-3%	-1%	-3%	-2%
COLON AND RECTAL SURGERY	\$147	0%	3%	2%	3%	1%
CRITICAL CARE	\$255	0%	0%	0%	0%	-1%
DERMATOLOGY	\$2,950	0%	1%	1%	1%	1%
EMERGENCY MEDICINE	\$2,677	0%	-1%	-1%	0%	-1%
ENDOCRINOLOGY	\$416	0%	2%	1%	2%	1%
FAMILY PRACTICE	\$5,689	0%	2%	1%	2%	1%
GASTROENTEROLOGY	\$1,852	0%	1%	0%	1%	0%
GENERAL PRACTICE	\$655	0%	2%	1%	2%	1%
GENERAL SURGERY	\$2,285	0%	1%	0%	1%	0%
GERIATRICS	\$203	0%	2%	1%	3%	1%
HAND SURGERY	\$123	0%	2%	1%	2%	1%
HEMATOLOGY/ONCOLOGY	\$1,922	0%	-1%	0%	-1%	0%
INFECTIOUS DISEASE	\$601	0%	2%	1%	2%	1%
INTERNAL MEDICINE	\$10,826	0%	2%	1%	2%	1%
INTERVENTIONAL PAIN MGMT	\$450	-2%	0%	0%	-1%	-2%
INTERVENTIONAL RADIOLOGY	\$208	-1%	-3%	-1%	-4%	-2%
MULTISPECIALTY CLINIC/OTHER	\$91	1%	0%	0%	1%	1%
NEPHROLOGY	\$2,022	0%	0%	0%	0%	0%
NEUROLOGY	\$1,533	0%	3%	2%	3%	1%
NEUROSURGERY	\$650	-1%	0%	0%	-1%	-1%
NUCLEAR MEDICINE	\$54	0%	-3%	-1%	-3%	-1%
OBSTETRICS/GYNECOLOGY	\$679	0%	1%	1%	1%	1%
OPHTHALMOLOGY	\$5,328	0%	3%	2%	3%	1%
ORTHOPEDIC SURGERY	\$3,584	-1%	0%	0%	0%	-1%
OTOLARNGOLOGY	\$1,003	0%	2%	1%	2%	1%
PATHOLOGY	\$1,129	0%	-2%	-1%	-2%	-1%
PEDIATRICS	\$68	0%	1%	0%	1%	0%
PHYSICAL MEDICINE	\$933	0%	2%	1%	2%	1%
PLASTIC SURGERY	\$343	0%	2%	1%	1%	0%
PSYCHIATRY	\$1,154	0%	0%	0%	0%	0%
PULMONARY DISEASE	\$1,769	-1%	-1%	-1%	-1%	-2%
RADIATION ONCOLOGY	\$1,981	0%	-10%	-6%	-10%	-6%
RADIOLOGY	\$4,716	-1%	-4%	-2%	-5%	-3%
RHEUMATOLOGY	\$528	0%	-1%	0%	-1%	-1%

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges (in millions)	Impact of Work and MP RVU Changes	Impact of PE RVU Changes		Combined Impact	
			Full	Tran	Full	Tran
THORACIC SURGERY	\$369	-1%	-2%	-1%	-3%	-2%
UROLOGY	\$1,925	0%	-3%	-2%	-3%	-2%
VASCULAR SURGERY	\$745	0%	-2%	-1%	-2%	-1%
AUDIOLOGIST	\$57	1%	-8%	-5%	-7%	-4%
CHIROPRACTOR	\$752	0%	2%	2%	2%	2%
CLINICAL PSYCHOLOGIST	\$567	0%	-5%	-3%	-5%	-3%
CLINICAL SOCIAL WORKER	\$394	0%	-6%	-3%	-6%	-3%
DIAGNOSTIC TESTING FACILITY	\$839	0%	-8%	-3%	-8%	-3%
INDEPENDENT LABORATORY	\$1,057	0%	-3%	-1%	-3%	-1%
NURSE ANES / ANES ASST	\$738	0%	3%	2%	3%	2%
NURSE PRACTITIONER	\$1,385	0%	2%	1%	2%	1%
OPTOMETRY	\$990	0%	4%	2%	4%	2%
ORAL/MAXILLOFACIAL SURGERY	\$44	0%	3%	2%	3%	2%
PHYSICAL/OCCUPATIONAL THERA	\$2,349	0%	6%	4%	6%	4%
PHYSICIAN ASSISTANT	\$1,021	0%	1%	0%	1%	0%
PODIATRY	\$1,921	0%	4%	2%	4%	2%
PORTABLE X-RAY SUPPLIER	\$99	0%	5%	4%	5%	4%
RADIATION THERAPY CENTERS	\$74	0%	-11%	-6%	-11%	-6%
OTHER	\$18	0%	3%	3%	3%	3%

* Table 84 shows only the payment impact on PFS services. We note that these impacts do not include the effects of the January 2012 conversion factor change under current law.

Attachment 2

**TABLE 86: CY 2012 GEOGRAPHIC ADJUSTMENT FACTORS (GAFS)
CHANGES UNDER CURRENT LAW AND THE FINAL RULE WITH COMMENT
PERIOD**

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Medicare Locality	CY 2011 GAF	CY 2012 GAF (Current law/reg)	CY 2012 GAF (Final Rule)	% Change CY 2011 to CY 2012 (current) Col (C)/ Col (B)-1	% Change CY 2012 (Curr) to CY 2012 (Final) Col (D)/ Col (C)-1	% Change Combined Impact CY 2011 to CY 2012 Col (D)/ Col (B)-1
PUERTO RICO	0.903	0.786	0.771	-13%	-2%	-15%
WEST VIRGINIA	0.972	0.910	0.910	-6%	0%	-6%
OKLAHOMA	0.955	0.904	0.898	-5%	-1%	-6%
MISSISSIPPI	0.961	0.910	0.908	-5%	0%	-6%
REST OF MISSOURI	0.962	0.903	0.909	-6%	1%	-5%
ARKANSAS	0.945	0.893	0.896	-6%	0%	-5%
REST OF LOUISIANA	0.965	0.914	0.915	-5%	0%	-5%
IOWA	0.950	0.898	0.903	-5%	1%	-5%
KENTUCKY	0.959	0.917	0.914	-4%	0%	-5%
BEAUMONT, TX	0.978	0.925	0.933	-5%	1%	-5%
ALABAMA	0.949	0.905	0.908	-5%	0%	-4%
TENNESSEE	0.959	0.918	0.918	-4%	0%	-4%
NEBRASKA	0.947	0.905	0.909	-4%	0%	-4%
REST OF MAINE	0.961	0.922	0.923	-4%	0%	-4%
IDAHO	0.959	0.926	0.923	-3%	0%	-4%
SOUTH CAROLINA	0.959	0.925	0.925	-4%	0%	-4%
KANSAS	0.964	0.923	0.930	-4%	1%	-4%
INDIANA	0.966	0.928	0.932	-4%	0%	-4%
METROPOLITAN BOSTON	1.106	1.079	1.068	-2%	-1%	-3%
REST OF GEORGIA	0.970	0.936	0.937	-4%	0%	-3%
REST OF TEXAS	0.973	0.934	0.940	-4%	1%	-3%
NORTH CAROLINA	0.970	0.934	0.938	-4%	0%	-3%
UTAH	0.982	0.946	0.951	-4%	1%	-3%
MANHATTAN, NY	1.153	1.142	1.118	-1%	-2%	-3%
REST OF PENNSYLVANIA	0.986	0.957	0.958	-3%	0%	-3%

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Medicare Locality	CY 2011 GAF	CY 2012 GAF (Current law/reg)	CY 2012 GAF (Final Rule)	% Change CY 2011 to CY 2012 (current) Col (C)/ Col (B)-1	% Change CY 2012 (Curr) to CY 2012 (Final) Col (D)/ Col (C)-1	% Change Combined Impact CY 2011 to CY 2012 Col (D)/ Col (B)-1
LOS ANGELES, CA	1.106	1.099	1.075	-1%	-2%	-3%
NEW ORLEANS, LA	1.005	0.980	0.977	-2%	0%	-3%
SOUTH DAKOTA**	0.978	0.952	0.951	-3%	0%	-3%
NEW MEXICO	0.979	0.949	0.954	-3%	1%	-3%
REST OF ILLINOIS	0.985	0.950	0.960	-4%	1%	-3%
REST OF MICHIGAN	0.985	0.962	0.962	-2%	0%	-2%
ALASKA*	1.289	1.289	1.259	0%	-2%	-2%
VENTURA, CA	1.113	1.105	1.091	-1%	-1%	-2%
REST OF NEW YORK	0.965	0.948	0.946	-2%	0%	-2%
CONNECTICUT	1.094	1.086	1.074	-1%	-1%	-2%
MONTANA**	0.996	0.976	0.978	-2%	0%	-2%
OHIO	0.992	0.970	0.975	-2%	1%	-2%
METROPOLITAN KANSAS CITY, MO	0.996	0.975	0.979	-2%	0%	-2%
NORTH DAKOTA**	0.979	0.964	0.963	-2%	0%	-2%
ANAHEIM/SANTA ANA, CA	1.129	1.129	1.111	0%	-2%	-2%
NYC SUBURBS/LONG I., NY	1.161	1.159	1.143	0%	-1%	-2%
SAN MATEO, CA	1.199	1.194	1.182	0%	-1%	-1%
REST OF FLORIDA	1.014	0.996	1.000	-2%	0%	-1%
HAWAII	1.074	1.091	1.060	2%	-3%	-1%
EAST ST. LOUIS, IL	1.016	0.997	1.003	-2%	1%	-1%
REST OF MASSACHUSETTS	1.040	1.039	1.027	0%	-1%	-1%
REST OF OREGON	0.968	0.950	0.956	-2%	1%	-1%
SAN FRANCISCO, CA	1.198	1.194	1.185	0%	-1%	-1%
WISCONSIN	0.965	0.949	0.955	-2%	1%	-1%
ARIZONA	0.989	0.977	0.979	-1%	0%	-1%
FORT WORTH, TX	0.991	0.981	0.982	-1%	0%	-1%
VERMONT	0.982	0.980	0.974	0%	-1%	-1%
METROPOLITAN ST. LOUIS, MO	0.988	0.971	0.980	-2%	1%	-1%
NORTHERN NJ	1.120	1.105	1.111	-1%	1%	-1%
SOUTHERN MAINE	0.997	0.993	0.990	0%	0%	-1%
MIAMI, FL	1.108	1.100	1.101	-1%	0%	-1%
AUSTIN, TX	0.992	0.979	0.986	-1%	1%	-1%
WYOMING**	1.002	0.994	0.996	-1%	0%	-1%
HOUSTON, TX	1.008	0.992	1.002	-2%	1%	-1%
METROPOLITAN PHILADELPHIA, PA	1.068	1.062	1.062	-1%	0%	-1%
OAKLAND/BERKELEY, CA	1.133	1.136	1.128	0%	-1%	0%
VIRGINIA	0.978	0.971	0.974	-1%	0%	0%
DETROIT, MI	1.060	1.047	1.056	-1%	1%	0%
REST OF NEW JERSEY	1.074	1.066	1.072	-1%	1%	0%
BRAZORIA, TX	0.996	0.977	0.995	-2%	2%	0%
RHODE ISLAND	1.042	1.039	1.041	0%	0%	0%
DC + MD/VA SUBURBS	1.124	1.125	1.123	0%	0%	0%
MARIN/NAPA/SOLANO, CA	1.119	1.127	1.119	1%	-1%	0%
DELAWARE	1.012	1.010	1.013	0%	0%	0%

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Medicare Locality	CY 2011 GAF	CY 2012 GAF (Current law/reg)	CY 2012 GAF (Final Rule)	% Change CY 2011 to CY 2012 (current) Col (C)/ Col (B)-1	% Change CY 2012 (Curr) to CY 2012 (Final) Col (D)/ Col (C)-1	% Change Combined Impact CY 2011 to CY 2012 Col (D)/ Col (B)-1
DALLAS, TX	1.004	0.997	1.005	-1%	1%	0%
FORT LAUDERDALE, FL	1.061	1.062	1.063	0%	0%	0%
VIRGIN ISLANDS	0.998	0.997	1.000	0%	0%	0%
POUGHKPSIE/N NYC SUBURBS, NY	1.037	1.039	1.040	0%	0%	0%
NEW HAMPSHIRE	1.007	1.012	1.010	0%	0%	0%
QUEENS, NY	1.140	1.150	1.144	1%	-1%	0%
CHICAGO, IL	1.081	1.076	1.085	0%	1%	0%
ATLANTA, GA	1.002	0.997	1.006	0%	1%	0%
MINNESOTA	0.969	0.968	0.973	0%	1%	0%
GALVESTON, TX	0.997	0.995	1.002	0%	1%	1%
COLORADO	0.989	0.990	0.994	0%	0%	1%
REST OF CALIFORNIA	1.025	1.038	1.032	1%	-1%	1%
REST OF WASHINGTON	0.987	0.985	0.996	0%	1%	1%
NEVADA**	1.024	1.031	1.036	1%	0%	1%
SUBURBAN CHICAGO, IL	1.061	1.059	1.077	0%	2%	2%
BALTIMORE/SURR. CNTYS, MD	1.052	1.070	1.068	2%	0%	2%
PORTLAND, OR	0.991	0.995	1.007	0%	1%	2%
REST OF MARYLAND	1.004	1.024	1.021	2%	0%	2%
SANTA CLARA, CA	1.156	1.164	1.176	1%	1%	2%
SEATTLE (KING CNTY), WA	1.045	1.056	1.075	1%	2%	3%

*GAF reflects a 1.5 work GPCI floor in Alaska established by the MIPPA.

** GAFs reflect a 1.0 PE GPCI floor for frontier States as required by the Affordable Care Act.