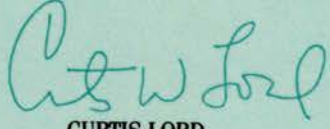
UNDERSTANDING

Physician Payment Reform

INTRODUCTION

s the popular song from the sixties goes: "The times they are a changing." And boy are they! Not since the inception of the Medicare program over twenty-five years ago, have physicians been faced with such far-reaching changes to federal health care policy. The changes are coming in the form of Physician Payment Reform (PPR) which was enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989). Medicare Part B is committed to helping physicians in Florida understand and cope with the many provisions of PPR. This booklet is just a small part of a PPR education and training plan that will be executed by our Provider Education Department over the next several months. Please pay particular attention to pages 21-22 to learn about the many other PPR educational activities we have planned. Together we can make the implementation of PPR a success in Florida. Hope to see you at a seminar or a Professional Association meeting soon! ▲



CURTIS LORD
Director,
System/Program Change Management
Medicare Part B

What Is Physician Payment Reform?

The term "Physician Payment Reform" (PPR) is commonly used to refer to various provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1989 which was passed by Congress in December, 1989. Together these provisions will make sweeping changes to the way payment for physician services is determined by Medicare Part B. There are four general components of PPR:

1 Payment for physician services will be based on a fee schedule. The fee schedule will be established using a resource based relative value system.

2 Medicare Volume Performance Standards (MVPSs) have been established to monitor annual increases in Medicare Part B benefit payments for physician services and, where necessary, adjust payment levels for future years.

3 Various beneficiary financial protections have been established.

4 The reimbursement and medical policies utilized by Medicare carriers will be substantially more standardized.

These four components, including important implementation dates, are addressed in considerable detail within the remainder of this booklet.

Why Physician Payment Reform?

Ever heard the saying: "If it ain't broke, don't fix it"? Well, the current way Medicare pays for physician services was considered by many to be very broken. Fundamental reform was considered necessary to harness the high and rising cost of Medicare Part B. Paying a physician largely based on his historical customary charges and the prevailing charges in his locality — the current system — has been criticized because:

- It created an incentive for physicians to raise their charges. Raising your charges one year, after all, could increase your Medicare reimbursement the next.
- It created wide, and sometimes unexplainable, fluctuations in payment levels for the same service in different geographic localities. These variations occurred not only from one part of the country to another but sometimes within a single state.
- In states where payment has been based on the specialty of the physician, wide fluctuations in payment levels have also occurred for the same service performed by physicians of different specialties. This has generally not occurred in Florida because we have not traditionally considered a physician's specialty in determining payment amounts.

- It was complex and, therefore, difficult for carriers to administer and for physicians and beneficiaries to understand. This created negative perceptions of the Medicare program and possibly caused some physicians to refuse to accept Medicare assignment.
- It distorted Medicare payments by not considering the time and intensity of effort of the physician rendering the service. For example, a physician may invest substantial time and effort providing a service but be paid much less than a physician providing a more technically focused service that required less time and effort.
- Beneficiaries have not been adequately protected against excessive balance billing. Maximum Allowable Actual Charges (MAACs) have limited balance billing by nonparticipating physicians to some extent. However, MAACs were extremely difficult to understand and in some cases left beneficiaries with substantial out of pocket expenses.
- Some physicians may have countered the government's attempts to control increases in payment levels by simply rendering a greater volume of services. Remember, price × volume = payout.

Criticisms like those above not only fueled the Physician Payment Reform movement but also helped shape the reforms ultimately enacted in OBRA 1989.

Where Did The Payment Concepts Adopted by Physician Payment Reform Originate?

PPR did not just happen. Several years ago Congress began looking at alternative ways to pay physicians. Congress required the Health Care Financing Administration (HCFA) to devote considerable effort to the development of a relative value based fee schedule for physician services. HCFA was assisted in this task by a number of experts both inside and outside the government. The most notable was Harvard University's School of Public Health led by William Hsiao, Ph.D. In cooperation with HCFA, the Harvard research team produced a report on a resource based relative value scale for physician services in September, 1988. In addition, HCFA submitted three reports to Congress in October, 1989. These reports summarized the research and analysis related to the implementation of a Medicare fee schedule for physician services based on a resource based relative value system. The Physician Payment Review Commission (PPRC), an advisory body created by Congress, also provided considerable input to Congress on PPR including the recommendation that payment be based on a fee schedule.

Tell Me More About PPR Component #1

FEE SCHEDULE REIMBURSEMENT

BACKGROUND

Fee schedule reimbursement is the cornerstone of PPR. Beginning January 1, 1992 the Medicare fee schedule will replace the complex customary/prevailing charge based reimbursement system now in place. While all physician services will be paid on the basis of a fee schedule beginning January 1, 1992, the fee schedule amounts for certain services will be subject to a five-year transition policy designed to prevent extreme changes in Medicare payment amounts. This will be explained in more detail later.

ATTRIBUTES OF THE MEDICARE FEE SCHEDULE

In simple terms, the Medicare fee schedule amounts will be based on the costs physicians incur in rendering a service — not the charges they have typically billed for the service. Variations in practice costs between areas will be recognized through application of geographic practice cost indices (GPCI, pronounced "Gypsies"). There will be no payment differentials for a service based on the specialty of the rendering physician. The 1992 Medicare fee schedule must also, by Congressional mandate, be "budget neutral." That is, total payments under the fee schedule must approximate the total payments that would have been made under the current system. Obviously, however, payment amounts for many individual services will be very different in 1992 than current payment amounts.

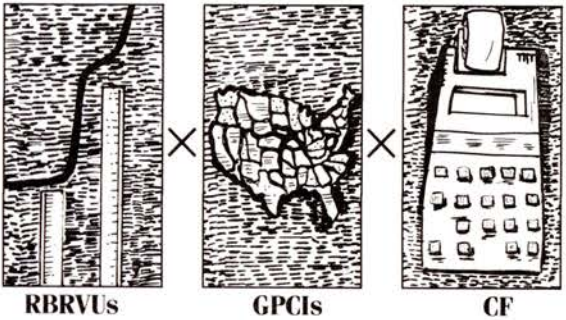
PAYMENTS UNDER A MEDICARE FEE SCHEDULE

The fee schedule amount (or allowable charge) for a service in 1992 will be the product of three numbers:

- the **resource based relative value units** (RBRVUs) for the service. This is established nationally for each procedure code and will not vary between carriers
- the **geographic practice cost indices** (or GPCIs) for the locality where the service was rendered. We will have different GPCIs for each of our four current prevailing charge localities. Thus, these are established locally, and
- the national **conversion factor** (CF) used with the fee schedule. This is a single national number that is used by all carriers in calculating payments under the Medicare fee schedule.

For those of you into formulae, the above can be summarized as follows:

FEE SCHEDULE AMOUNT



RBRVUs **GPCIs** **CF**

Payment will be made at 80% of the fee schedule amount, subject to the annual Medicare Part B deductible.

RESOURCE BASED RELATIVE VALUE UNITS

The resource based relative value unit (RBRVU) for a service will be the sum of the relative value units associated with:

- the **physician work** required for the service. These units were developed by William Hsiao and his colleagues at Harvard. The work component of the RBRVU was based on the time required to render the service, the mental effort (or intensity) of the service, the technical skills required and the relative risk to the patient
- **practice overhead expenses** such as office rent, salaries of office staff, supplies and the like, and
- **malpractice premiums.**

Again, the national RBRVU for a procedure will be the sum of the relative value units assigned to the procedure for each of the above three components.

GEOGRAPHIC PRACTICE COST INDICES

As mentioned earlier Medicare Fee Schedule amounts will be adjusted to accommodate the variation in practice costs from area to area. A geographic practice cost index (GPCI) will be established for each of the three components of a procedure's RBRVU (work, overhead and malpractice) in each of our four prevailing charge localities. These adjustment factors were determined by the Urban Institute using relative prices in metropolitan service areas and nonmetropolitan areas that correspond to the prevailing charge localities currently recognized by carriers, including our four. Prices were analyzed for physician work (or income), employee wages, office rents, medical equipment, supplies and malpractice insurance.

THE FIVE YEAR TRANSITION POLICY

HCFA estimates that approximately one-third of all physician services will be paid on the basis of the full Medicare fee schedule in 1992; the other two-thirds will be paid on the basis of a transitional

fee schedule and moved to the full fee schedule amount over the next five years. By 1996, therefore, all physician services will be paid off the full Medicare fee schedule.

A service will be moved to the full fee schedule in 1992 if the average allowed charge (AAC) for the service in 1991 is within 15% of the full fee schedule amount. This determination will be made for a service in each of our four prevailing charge localities. Thus, a procedure might go to the full fee schedule in 1992 in one locality but not in another.

If the AAC in a locality exceeds or is less than the full fee schedule amount by more than 15% the service will be transitioned to the full fee schedule over a five year period as outlined below:

- For 1992, if the 1991 AAC is more than 15% greater than the full fee schedule, 15% of the fee schedule amount is deducted from the AAC; if the 1991 AAC is less than the full fee schedule by more than 15%, 15% of the fee schedule amount is added to the AAC
- In 1993, 25% of the fee schedule amount is added to 75% of the 1992 payment rate
- In 1994, 33% of the fee schedule amount is added to 67% of the 1993 payment rate
- In 1995, 50% of the fee schedule amount is added to 50% of the 1994 payment rate
- In 1996, all physician services will be paid on the full fee schedule

The following charts illustrate how to determine whether a service will be subject to the five year transition policy and how to determine the 1992 fee schedule amount for transitioned services.

HOW TO DETERMINE WHETHER A SERVICE IS SUBJECT TO THE 5 YEAR TRANSITION RULE

If the 1991 AAC in a locality is . . .	And the locality fee schedule amount is. . .	The locality fee schedule amount ± 15% is . . .	Is service subject to the transition rules in that locality?
$110	$100	$85 to $115	No
$120	$100	$85 to $115	Yes (see chart below)
$ 90	$100	$85 to $115	No
$ 80	$100	$85 to $115	Yes (see chart below)

HOW TO DETERMINE 1992 FEE SCHEDULE AMOUNTS FOR SERVICES SUBJECT TO TRANSITION RULES

If the 1991 AAC in a locality is . . .	And the locality fee schedule amount is. . .	15% of the locality fee schedule amount is. . .	And the 1991 locality AAC adjusted by 15% of the locality fee schedule amount is. . .
$120	$100	$15	$105 ($120 - $15)
$ 80	$100	$15	$95 ($80 + $15)

Tell Me More About PPR Component #2

THE ESTABLISHMENT OF MEDICARE VOLUME PERFORMANCE STANDARDS

BACKGROUND

The establishment of Medicare Volume Performance Standards (MVPSs) was the most debated and controversial provision of the PPR legislation. This is true, we think, because MVPSs represent the government's first significant effort to address inappropriate annual increases in the **volume** of physician services received by Medicare beneficiaries. Previous efforts by the government to control increases in Medicare benefit payments were focused on the **price** Medicare pays for covered services. The principle underlying MVPSs is rather simple: the volume of physician services must be carefully monitored because physicians may make up their lost fees by seeing Medicare beneficiaries more frequently or performing more procedures.

EXACTLY WHAT IS A MVPS?

A MVPS is best thought of as an estimate or projection. It projects a reasonable percentage increase in the volume of physician services for the upcoming fiscal year. The projection covers items or services commonly performed by a physician, or in a physician's office, including the services of nonphysician practitioners who are considered physicians for Medicare purposes. Actually two MVPSs are established for each fiscal year, one for surgical services performed by surgical specialists, including podiatrists, and another for nonsurgical services. For fiscal year 1991, which began October 1, 1990, the surgical MVPS was set at 3.3% and the nonsurgical MVPS was set at 8.6%. The overall MVPS was

set at 7.3%. HCFA is presently studying whether MVPSs for other groups of physicians or types of services would be feasible.

HOW IS A MVPS DETERMINED?

The MVPSs for a fiscal year are established through a series of recommendations to Congress which Congress can either accept or modify. In general terms, the process goes like this:

- By April 15 the Secretary of the Department of Health and Human Services must make his MVPS recommendations for the upcoming fiscal year. The Secretary must consider the anticipated rate of inflation, Medicare enrollment changes, the utilization of physician services, increases in technology and certain other factors.
- By May 15 the PPRC must make its MVPS recommendations for the upcoming fiscal year.
- Congress has until October 15 (two weeks into the fiscal year) to establish the MVPSs for the fiscal year, by either accepting or modifying the DHHS and PPRC recommendations described above.
- If Congress does not act by October 15, the MVPSs for the fiscal year are established using a default mechanism. The default mechanism considers the anticipated growth in benefit payments due to fee schedule increases, enrollment changes, the volume and intensity of services and the impact of program changes for the year. For fiscal year 1992, MVPSs arrived at through the default mechanism will be reduced by 1.5%; for subsequent fiscal years such MVPSs will be reduced by 2%.

HOW IS A MVPS ACTUALLY USED?

Herein lies the controversial nature of a MVPS. The annual "inflation adjustment" to the Medicare fee schedule — scheduled for January 1 of each year — will be directly influenced by how the actual percentage increase in physician services two fiscal years ago compares to the MVPS that was estab-

lished for that year. For example, the "inflation adjustment" to the Medicare fee schedule that is scheduled for January 1, 1993 will be established, in part, based on actual performance against the fiscal year 1991 MVPS. When DHHS (on April 15) and PPRC (on May 15) make their annual recommendations to Congress regarding the "inflation adjustment" to the Medicare fee schedule for the upcoming calendar year, they will be strongly considering performance against previous MVPSs. Congress, again, has until October 15 to accept or modify the recommended increase to the Medicare fee schedule. If Congress takes no action, another default mechanism comes into play. This default mechanism will set the "inflation adjustment" for the upcoming calendar year at the Medicare Economic Index (MEI) established by HCFA, adjusted for MVPS performance two fiscal years ago.

A couple of hypothetical examples of the default mechanism should clear this up a bit:

Example where physicians did not meet the MVPS:

MVPS for fiscal year 1993 = 9%

Actual expenditure increase for fiscal year 1993 = 10%

MEI for calendar year 1995 = 5%

Actual fee schedule update using the default mechanism = 4% (5% less 1% overage in expenditures against the MVPS)

NOTE: Negative, or downward, adjustments to the fee schedule like that illustrated in this example are limited to 2% for 1992 and 1993; 2.5% for 1994 and 1995 and 3% for 1996 and subsequent years.

Example where physicians outperformed the MVPS:

MVPS for fiscal year 1993 = 9%

Actual expenditure increase for fiscal year 1993 = 7%

MEI for calendar year 1995 = 5%

Actual fee schedule update using the default mechanism = 7% (5% plus 2% underage in expenditures against the MVPS)

NOTE: Positive, or upward, adjustments to the fee schedule like that illustrated in this example are not limited.

Remember, however, that the default mechanism illustrated above only comes into play when Congress fails to take action to establish an "inflation adjustment" to the Medicare fee schedule. Where Congress does take such action they will likely have considered the recommendations of DHHS and PPRC which would have been based in part on actual performance against previous MVPSs.

COMPARATIVE PERFORMANCE REPORTS AND MVPSs

By now you have probably heard of Comparative Performance Reports (CPRs). CPRs are informational reports mailed to physicians whose patterns of practice appear aberrant compared to their peer group. The reports, which are mailed annually, are designed to help ensure compliance against MVPSs by alerting physicians who may need to make modifications to their practice patterns.

Tell Me More About PPR Component #3

BENEFICIARY PROTECTIONS

The enhanced beneficiary protections included in PPR are essentially two-prong:

- Effective September 1, 1990 all providers are required to file claims for Medicare beneficiaries without charge — even if they do not accept assignment. Penalties have been established for providers choosing not to do so.
- New balance billing limits, known as limiting charges, became effective January 1, 1991 for unassigned claims filed by nonparticipating physicians. These new limiting charges are simpler and generally more favorable to beneficiaries than the MAACs they replaced. In general terms, a nonparticipating physician can not charge more than the following amounts on unassigned claims:

  During 1991, the 1991 nonparticipating locality prevailing charge increased by the percentage by which the physician's 1990 MAAC exceeded the 1990 nonparticipating prevailing charge, up to 25% (40% in the case of certain evaluation and management services).

  During 1992, the 1992 nonparticipating fee schedule increased by the percentage by which the physician's 1991 limiting charge exceeded

the 1991 nonparticipating locality prevailing charge, up to 20%.

During 1993 and subsequent years, 115% of the nonparticipating fee schedule. At this point legal charge limits will no longer be physician-specific but rather the same for all nonparticipants.

- Note that beginning in 1993 the difference between Medicare's fee schedule amount and the amount a nonparticipant may legally charge a beneficiary will be only 9.25%! This is because nonparticipants will only be able to legally charge 115% of the nonparticipating fee schedule amount which is 95% of the fee schedule amount paid to participants. The narrowing of this gap is a key provision of PPR.
- If you are a nonparticipant and have questions about your limiting charges for 1991 please consult the disclosure form we mailed you in late January, 1991.

Tell Me More About PPR Component #4

THE STANDARDIZATION OF MEDICAL AND REIMBURSEMENT POLICIES

In order to implement the national reimbursement system included in PPR equitably, a considerable degree of Medicare program standardization must be achieved before January 1, 1992. All physicians and carriers across the country must be speaking the "same Medicare language" for the various components of PPR to work as envisioned by Congress. Standardization will take several shapes and forms, including the following:

- Physicians file claims to Medicare using various codes. The most notable such codes

are **diagnosis** codes, **procedure** codes, **procedure code modifier** codes and **place of service** codes. These codes form the language that physicians use to file claims to Medicare and carriers use to issue payment to physicians and beneficiaries. Diagnosis codes used by physicians are already standardized because they are selected from the ICD-9-CM coding structure which is used nationally. The other three codes are selected from coding structures that vary somewhat around the country. This local variation must be greatly minimized if not eliminated in the following respects:

The **procedure code** structure must be standardized by eliminating virtually all the "locally assigned" codes presently utilized by carriers. (Locally assigned procedure codes begin with a W, X, Y or Z.) HCFA's intent is to drive substantially all of the coding for physician services to the CPT-4 coding structure. A relatively small number of HCFA assigned (alpha-numeric) codes will still be used; locally assigned codes will be used very infrequently.

Procedure code modifiers, two-digit codes affixed to the end of a procedure code, must also be standardized where they affect reimbursement. This will occur through the elimination of many locally assigned modifiers. (Locally assigned modifiers also begin with a W, X, Y or Z.) Only the procedure code modifiers contained in CPT-4, created by HCFA or utilized locally by carriers for informational purposes will be retained.

Place of service codes describe **where** the service was rendered. This is an important piece of data that impacts reimbursement and medical policy to a large degree. Thus, these codes must also be standardized for all physicians. HCFA will establish the single coding structure to which all carriers/physicians must migrate.

- Every service processed by a Medicare carrier is assigned a type of service code. These codes typically identify services as surgical services, medical services, radiology services and the like. They

are not as familiar to physicians because they are not required to use them in filing claims. Nevertheless, carriers will migrate to a standard type of service code structure mandated by HCFA, primarily to ensure consistency in the processing of claims and the reporting of payment data to HCFA.

- How the procedure codes for visits are defined is another key aspect of standardization. In simple terms, the meaning of an "intermediate" office visit, for example, must be common to physicians in Tallahassee, Florida; Salt Lake City, Utah; Buffalo, New York, etc. for a national reimbursement system to function properly. HCFA, in conjunction with various expert advisors, intends to help promote this common understanding of visit code terminology by:

  improving the narrative descriptors of the visit codes

  including more specific examples, including specialty specific examples, of the service contemplated by each of the visit codes

  considering whether more generic descriptors of level of care would be useful; for example, "level 1" rather than "brief" visit

  developing explicit medical record documentation requirements for the various levels of visit codes

  revisiting the issue of how many levels of visit codes should be used

  determining whether the definition of visit codes should include time. This, as you might imagine, is a controversial policy issue.

- Many reimbursement and medical policies must be standardized nationally. The most significant of these policies involve surgical procedures. The services included in Medicare fee schedule reimbursement for a gallbladder operation must be the same whether the procedure is done in Florida or some other state. Other surgical standardization issues involve identifying the minor surgical procedures that are included in a major surgical procedure and determining whether the

global payment concept should be applied to minor surgeries such as CPT-4 starred and endoscopic procedures. HCFA is formulating the national approach on these issues by studying the policies presently in place around the country. HCFA has already made considerable progress on these issues and recently published a proposed definition of the services included in a surgical fee in the **Federal Register** for public comment.

Again, these, and other less significant, standardization issues must be addressed by January 1, 1992 when the Medicare fee schedule will be utilized for the first time.

So What Will All This Mean To Me and My Practice?

The coach of a major college football team once said: "When it is all said and done, more is said than done." That won't be the case with PPR . . . plenty will be done! The impact of what is done on a physician's practice will vary a great deal depending on his specialty of practice, where he practices, his participation status, his current customary/prevailing based reimbursement and, for a nonparticipant, his current limiting charge. Generally, however, the impacts of PPR on a physician can be summarized as follows:

- When you accept assignment, **the amount Medicare pays you will be different** beginning January 1, 1992. I say different because in some cases reimbursement may go up under the

Medicare fee schedule; in other cases reimbursement may go down. Remember, the general intent is to **redistribute** the same money Medicare would have paid for physician services under the current system. There has been much speculation that the "winners" in PPR will be physicians who presently practice in rural areas and/or have primary care specialties; and the "losers" will be physicians who presently practice in large metropolitan areas and/or have procedural specialties such as surgery. HCFA published a model fee schedule in the **Federal Register** in September 1990 for public comment. A second, and more detailed, proposal is scheduled for the spring of 1991. These publications will give us more insight into the actual impact of PPR on payment levels in Florida.

- If you do not participate, when you elect not to accept assignment **the amount you can legally charge your Medicare patient is changing and in many cases dropping.** The new limiting charges implemented for 1991 are more favorable to beneficiaries than the Maximum Allowable Actual Charges (MAACs) they replaced. And as time goes on limiting charges will become even more favorable to beneficiaries. The physicians most impacted by these new legal charge limits are those who previously had MAACs substantially higher than Medicare's payment amounts. The gap between what Medicare pays and what nonparticipating physicians can legally charge is narrowing sharply.
- **How you file your claims to Medicare is changing** due to the many standardization issues being worked by HCFA. As codes and policies change to support standardization, your office staff must be able to react quickly and accurately. Be sure your staff understands the magnitude of the change we are going through and how it will impact them. They need to be alert to Medicare Part B publications because most of the change will be announced through those publications.

Again, how PPR will impact your practice is a function of several variables. Should you be impacted to a substantial degree, however, you may want to change your Medicare participation status during an upcoming open enrollment . . . either to begin participating or to withdraw from the participation program. A substantial amount of data will be mailed to you during the next open enrollment to help you in this regard. That enrollment period is presently scheduled for November/December 1991 to be effective January 1, 1992.

How Can I and My Office Staff Learn More About PPR?

Easy! Take advantage of the many PPR educational services offered by Medicare Part B's Provider Education Department. They include:

- This booklet. It is the cornerstone of a good understanding of PPR. Share it with anyone you wish. You might even want to prepare a pop quiz for your office staff to keep them on their toes.
- Presentations to County Medical Societies. Check with your county officials to see when a visit by Medicare Part B representatives is planned. If one has not been planned let them know you are interested in such a session.

- Presentations to professional associations. We have plans to speak at several such meetings over the next several months. Check the agenda of your association's meeting to see if we are on it.
- From time to time PPR Notices will appear in the ***Medicare Part B Update***, our bimonthly publication. Look for these notices. Special PPR bulletins will also be released on an as needed basis.
- Visits to physicians' offices. While the number of such visits the Provider Education Department can make is limited, we have assigned a representative to work with physicians in each part of Florida.
- The seminars sponsored by Medicare Part B have been modified to incorporate discussion on PPR issues. Check the ***Medicare Part B Update*** for the locations and dates of upcoming seminars.
- As always our provider telephone lines are ready to answer your general questions about PPR. The phone numbers are also published in the ***Medicare Part B Update.***

A Final Word About PPR

If you got this far and are still clearheaded you are probably a PPR expert. However, if some things do not quite make sense, please take advantage of the educational services described in this booklet. We have included a timeline of key PPR events to help you understand what you need to know. We truly want to make PPR something that every Florida physician understands!

CHRONOLOGY OF MAJOR TASKS ASSOCIATED WITH IMPLEMENTATION OF PHYSICIAN PAYMENT REFORM (PPR)

	PPR TASK	DATE
1.	Mandatory assignment for Medicare/ Medicaid eligibles.	April 1, 1990
2.	Mandatory claim filing for all providers.	Sept. 1, 1990
3.	HCFA issues Model Fee Schedule in Federal Register.	Sept. 4, 1990
4.	MVPS projection for fiscal year 1991 finalized.	Oct. 15, 1990
5.	First Comparative Performance Reports released by carriers.	Nov. 15, 1990
6.	New limiting charges for nonparticipating physicians implemented. These new limits replaced MAACs and other special charge limits previously used; limiting charges for nonparticipants cannot exceed 125% of nonparticipating prevailing charges for 1992 (140% for evaluation and management services). Some physicians' limiting charges for 1991 are lower than these amounts.	Jan. 1, 1991
7.	Phase I payment policy standardization implemented by carriers. This phase of standardization addressed the improper "unbundling" of surgical procedures.	Feb., 1991
8.	Phase II payment policy standardization implemented by carriers. This phase of standardization addressed such issues as the elimination of local procedure codes and procedure code modifiers.	Mar. 1, 1991
9.	HCFA issues proposed rule for fee schedule in Federal Register.	April 1, 1991 (tentative)
10.	Carriers identify procedures subject to transition fee schedule reimbursement in 1992.	Jul./Aug., 1991
11.	Phase III payment policy standardization implemented. This phase of standardization will address such issues as the global surgery concept, payment for minor surgeries and the "unbundling" of surgical procedures.	July, 1991 (tentative; could be scheduled for January 1, 1992)
12.	MVPS projection for fiscal year 1992 finalized.	Oct. 15, 1991

	PPR TASK	DATE
13.	HCFA issues final PPR regulations in Federal Register.	Oct. 16, 1991
14.	Material necessary to make 1992 participation decision released to physicians.	Nov. 18, 1991
15.	Phase IV payment policy standardization implemented. This phase of standardization will address such issues as coding of visit services and other outstanding fee schedule issues.	Jan. 1, 1992
16.	Implementation of first year (or transition) fee schedule; limiting charges for nonparticipants cannot exceed 120% of nonparticipating prevailing charges for 1992 (some physicians' limiting charges for 1992 will be lower than this amount).	Jan. 1, 1992
17.	MVPS projection for fiscal year 1993 and the fee schedule adjustment for calendar year 1993 finalized.	Oct. 15, 1992
18.	Implementation of second year (or 75%/25% blended) fee schedule; limiting charges for nonparticipants cannot exceed 115% of nonparticipating prevailing charges for 1993.	Jan. 1, 1993
19.	MVPS projection for fiscal year 1994 and the fee schedule adjustment for calendar year 1994 finalized.	Oct. 15, 1993
20.	Implementation of third year (or 67%/33% blended) fee schedule; limiting charges for nonparticipants cannot exceed 115% of nonparticipating prevailing charges for 1994.	Jan. 1, 1994
21.	MVPS projection for fiscal year 1995 and the fee schedule adjustment for calendar year 1995 finalized.	Oct 15,1994
22.	Implementation of fourth year (or 50%/50% blended) fee schedule limiting charges for nonparticipants cannot exceed 115% of nonparticipating prevailing charges for 1995.	Jan. 1, 1995
23.	MVPS projection for fiscal year 1996 and the fee schedule adjustment for calendar year 1996 finalized.	Oct. 15, 1995
24.	Implementation of fifth year (or final) fee schedule; limiting charges for nonparticipants cannot exceed 115% of nonparticipating prevailing charges for 1996.	Jan. 1, 1996

Medicare Part B
Provider Education Department
P.O. Box 2078
Jacksonville, FL 32231

Condon, Bill
3T