

Policy and Payment Changes to the Medicare Physician Fee Schedule for 2015

On Oct. 31, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after Jan. 1, 2015. Medicare primarily pays physicians and other practitioners for care management services as part of face-to-face visits. Last year, CMS finalized separate payment outside of a face-to-face visit for managing the care for Medicare patients with two or more chronic conditions beginning in 2015. Through this year's rule, CMS provided more details relating to the implementation of the new policy, including payment rates. In addition, CMS adopted a new process for establishing PFS payment rates that will be more transparent and allow for greater public input prior to payment rates being set. Under the new process beginning with 2017, public comments will be considered for the vast majority of payment changes before they take effect. CMS also adopted a policy to define screening colonoscopy to include anesthesia so that beneficiaries do not have to pay coinsurance on anesthesia for a screening colonoscopy when furnished separately by an anesthesia professional.

The final rule also makes some changes to several of the quality reporting initiatives that are associated with PFS payments – the Physician Quality Reporting System (PQRS), Medicare Shared Savings Program, and Medicare Electronic Health Record (EHR) Incentive Program, as well as changes to the Physician Compare website. Finally, the rule continues the phased-in implementation of the physician value-based payment modifier (Value Modifier), created by the Affordable Care Act, that would affect payments to physicians and physician groups, as well as other eligible professionals, based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare fee-for-service program.

The Medicare PFS final rule is one of several rules for calendar year 2015 that reflect a broader Administration-wide strategy to deliver better care at lower cost by finding better ways to deliver care, pay providers, and use information. Provisions in these rules are helping to move our health-care system to one that values quality over quantity and focuses on reforms such as measuring for better health outcomes, focusing on disease prevention, helping patients return home from the hospital, helping manage and improve chronic diseases, and fostering a more-efficient and coordinated health care system.

This fact sheet discusses the changes to payment policies and payment rates for services furnished under the PFS, as well as changes to the Open Payments program. Separate fact sheets, also issued today, discuss the changes to the quality reporting programs, the Medicare EHR Incentive Program, implementing the Value Modifier and other CMS programs.

Background

Since 1992, Medicare has paid for the services of physicians, nonphysician practitioners (NPPs), and certain other suppliers under the PFS, a system that pays for covered physicians' services furnished to a person with Medicare Part B. Under the PFS, relative values are assigned to each of more than 7,000 services to reflect the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice expenses typically involved in furnishing that service. Each of these three relative value components is multiplied by a geographic adjustment factor to adjust the payment for variations in the costs of furnishing services in different localities. The resulting relative value units (RVUs) are summed for each service and then are multiplied by a fixed-dollar conversion factor to establish the payment amount for each service. The higher the number of RVUs assigned to a service, the higher the payment.

Provisions included in the CY 2015 PFS Final Rule

Sustainable Growth Rate (SGR)

The Protecting Access to Medicare Act of 2014 provides for a zero percent PFS update for services furnished between January 1, 2015 and March 31, 2015. Current law requires physician fee schedule rates to be reduced by an average of 21.2 percent from the CY 2014 rates. In most prior years, Congress has taken action to avert a large reduction in PFS rates before they went into effect. The Administration supports legislation to permanently change SGR to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

Screening and Diagnostic Digital Mammography

Until now, there have not been separate codes to pay for the higher cost of 3D mammography as compared to 2D mammography. Since 2000, 2D digital mammography has been paid at special payment rates as temporarily provided by a law for digital mammography. To ensure that the higher resources needed for 3D mammography are recognized, CMS is paying for 3D mammography using add-on codes that will be reported in addition to the 2D mammography codes. CMS will revisit payment for 2D and 3D mammography for 2016 when we review coding and payment for all mammography services under our misvalued codes initiative.

Primary Care and Chronic Care Management

Medicare continues to emphasize primary care by making payment for chronic care management (CCM) services – non-face-to-face services to Medicare beneficiaries who have multiple, significant, chronic conditions (two or more) – beginning in 2015. Chronic care management services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management.

CMS has established a payment rate of \$40.39 for CCM that can be billed up to once per month per qualified patient.

CMS is finalizing its proposal to allow greater flexibility in the supervision of clinical staff providing CCM services. The proposed application of the “incident to” supervision rules were widely supported by the commenters.

Payment for CCM is only one part of a multi-faceted CMS initiative to improve Medicare beneficiaries’ access to primary care. Models being tested through the Innovation Center will continue to explore other primary care innovations.

Finally, CMS proposed standards for electronic health records (EHR) – specifically, a 2014-certified EHR. In response to public comments indicating that very few practices have adopted a 2014-certified EHR at this time, CMS will require the version of the certified EHR that is in use on December 31 of the prior calendar year for the EHR Incentive Programs to bill for CCM services.

Application of Beneficiary Cost Sharing to Anesthesia Related to Screening Colonoscopies

The Medicare statute waives the Part B deductible and coinsurance applicable to screening colonoscopy. Increasingly, anesthesia separately provided by an anesthesia professional is becoming the prevalent practice in connection with screening colonoscopies, replacing the previously prevalent practice of moderate sedation provided intravenously by the physician doing the colonoscopy. Currently, when a single physician furnishes the moderate sedation and the screening colonoscopy, payment for the colonoscopy includes both services and coinsurance is waived for the entire procedure. When anesthesia for a screening colonoscopy is provided separately by an anesthesia professional, Medicare does not waive the deductible and coinsurance associated with the anesthesia. In the CY 2015 final rule, by revising the definition of a “screening colonoscopy,” CMS is including separately provided anesthesia as part of the screening service so that the coinsurance and deductible do not apply to anesthesia for a screening colonoscopy, reducing beneficiaries’ cost-sharing obligations under Part B.

Enhanced Transparency in Setting PFS Rates

Since the beginning of the physician fee schedule in 1992, CMS adopted rates for new and revised codes for the following calendar year in the final rule on an interim basis subject to public comment. This policy was necessary because CMS did not receive the codes in time to include in the PFS proposed rule. Until recently, the only services that were affected by this policy were services with new and revised codes. In recent years, CMS began receiving new and revised codes and

revaluing existing services under the misvalued codes initiative. Establishing payment in the final rule for misvalued codes often led to implementation of payment reductions before the public had the opportunity to comment.

CMS proposed to change the process for valuing new, revised and potentially misvalued codes for CY 2016, so that payment for the vast majority of these codes goes through notice and comment rulemaking prior to being adopted. CMS proposed to adopt the new process for 2016 so that the AMA’s CPT Editorial Panel has sufficient time to change its schedule for providing us with codes and recommendations earlier in the year. CMS is finalizing this proposal with a transition in CY 2016 and full implementation in CY 2017. CMS made several adjustments in the policy to minimize the need for Medicare-specific G-codes.

Potentially Misvalued Services

Consistent with amendments to the Affordable Care Act, CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and to make adjustments where appropriate. Below are major misvalued code decisions for 2015:

- **Hip and Knee Replacements:** In the CY 2014 PFS final rule, CMS adopted code and valuation changes that reduced payment for hip and knee replacements. The final payments were higher than recommended by the AMA/Specialty Society Relative Value Update Committee (RUC). While CMS indicated that it would consider further changes, the agency decided further reductions were not warranted after considering the public comments.
- **Radiation Therapy and Gastroenterology:** Consistent with the final rule policy and in response to public comments, CMS is not adopting code changes for gastroenterology and radiation therapy services until they can go through notice and comment rulemaking to propose values for 2016. As a result of this decision, CMS will not recognize some new CPT codes, and will create G-codes in place of CPT codes to continue current payment rates for CY 2015.
- **Radiation Therapy:** CMS proposed to refine the way it accounts for the infrastructure costs associated with radiation therapy equipment, specifically to remove the radiation treatment vault as a direct expense when valuing radiation therapy services. After considering public comments, the agency decided not to finalize this proposal but will reconsider whether the vault is a direct or indirect cost through rulemaking in a future year.
- **Epidural Pain Injections:** CMS reduced payment for these services in 2014 under the misvalued code initiative. In response to concerns from pain physicians regarding the accuracy of the valuation, CMS proposed to raise the values

in 2015 based on their prior resource inputs before adopting further changes after considering RUC recommendations. However, because the inputs for these services included those related to image guidance, we proposed to prohibit separate billing for image guidance for CY 2015. CMS finalized the policy as proposed to avoid duplicate payment for image guidance. The agency has asked the RUC to further review this issue and make recommendations to us on how to value epidural pain injections.

- **Film to Digital Substitution:** CMS finalized its proposal to update the agency's practice expense inputs for X-ray services to reflect that X-rays are currently done digitally rather than with analog film.

Global Surgery

The HHS Office of Inspector General has identified a number of surgical procedures that include more visits in the global period than are being furnished. CMS is also concerned that post-surgical visits are valued higher than visits that were furnished and billed separately by other physicians such as general internists or family physicians. CMS proposed to transform all 10- and 90-day global codes to 0-day global codes beginning in CY 2017. After consideration of all the comments, CMS finalized the proposal beginning with 10-day global services in CY 2017 and following with the 90-day global services in 2018. As the agency begins revaluation of services as 0-day global periods, we will actively assess whether there is a better construction of a bundled payment for surgical services that incentivizes care coordination and care redesign across an episode of care.

Access to Telehealth Services

CMS is adding the following services to the list of services that can be furnished to Medicare beneficiaries under the telehealth benefit: annual wellness visits, psychoanalysis, psychotherapy, and prolonged evaluation and management services.

Adjustments to Malpractice RVUs

As required by the Medicare law, we review and if necessary, adjust malpractice RVUs no less often than every five years. For CY 2015, CMS conducted the third comprehensive review and update of the malpractice RVUs and proposed new malpractice RVUs for all services. CMS is adopting new resource-based malpractice RVUs based on updated professional liability insurance premiums and largely paralleling the methodology used in the CY 2010 update.

Revisions to Geographic Practice Cost Indices (GPCIs)

As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in the cost of operating a medical practice. For CY 2015, CMS is using territory-level wage data to calculate the work GPCI and employee wage component of the PE GPCI for the Virgin Islands. The CY 2015

GPCIs also reflect the application of the statutorily mandated 1.5 work GPCI floor in Alaska, and 1.0 work GPCI floor for all other physician fee schedule areas, and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming). However, given that the statutory 1.0 work GPCI floor is scheduled to expire under current law on March 31, 2015, the GPCIs reflect the elimination of the 1.0 work GPCI floor from April 1, 2015 through December 31, 2015.

Services Performed in off-Campus Provider-Based Departments

CMS will collect data on services furnished in off-campus provider-based departments by requiring hospitals to report a modifier for those services furnished in an off-campus provider-based department of the hospital and by requiring physicians and other billing practitioners to report these services using a new place of service code on professional claims. Data collection will be voluntary for hospitals in 2015 and required beginning on January 1, 2016. The new place of service code will be required for professional claims as soon as it is available, but not before January 1, 2016.

Open Payments

The Open Payments program (Physician Payments Sunshine Act) establishes a system for annually reporting and increasing public awareness of financial relationships between drug and device manufacturers and certain health care providers. The Open Payments program requires applicable manufacturers of covered drugs, devices, biologicals, and medical supplies to report payments or other transfers of value they make to physicians and teaching hospitals to CMS. It also requires applicable manufacturers and applicable group purchasing organizations (GPOs) to report certain ownership or investment interests held by physicians or their immediate family members, and payments or other transfers of value made to physician owners or investors if they held ownership or an investment interest at any point during the reporting year.

In response to questions and experience administering the program, CMS is finalizing four changes in this rule:

1. CMS is deleting the definition of "covered device" as it is duplicative of the definition of "covered drug, device, biological or medical supply" which is already defined in regulation.
2. CMS is deleting the Continuing Education Exclusion in its entirety. Eliminating the exemption for payments to speakers at certain accredited or certifying continuing medical education events will create a more consistent reporting requirement, and will also be more consistent for consumers who will ultimately have access to the reported data.

3. CMS will require the reporting of the marketed name and therapeutic area or product category of the related covered drugs, devices, biologicals, or medical supplies, unless the payment or other transfer of value is not related to a particular covered or non-covered drug, device, biological or medical supply.
4. CMS will require applicable manufacturers to report stocks, stock options or any other ownership interest as distinct categories. This will enable us to collect more specific data regarding the forms of payment made by applicable manufacturers. Based on public comments and manufacturers' need to update their systems according to the new requirements these changes will be implemented for data collection 2016.

For more information about Open Payments, visit:

<http://go.cms.gov/openpayments>.

The final rule can be viewed at

<https://www.federalregister.gov/public-inspection>. Please be mindful this link will change once the rule is published on Nov. 13, 2014 in the Federal Register.

For more information, visit:

<https://www.federalregister.gov/public-inspection>.