2015 Medicare Physician Fee Schedule Final Rule

Overview, Provisions of Interest

October 31, 2014

Sustainable Growth Rate (SGR)

The Protecting Access to Medicare Act of 2014 provides for a zero percent Medicare Physician Fee Schedule (MPFS) update for services furnished between January 1, 2015, and March 31, 2015. CMS currently (subject to change) estimates the SGR payment reduction in 2015 to be -21.2 percent for April 1, 2015 through December 31, 2015. However, it is anticipated that Congress will act to avert the payment cut as it has in the past.

Conversion Factor Update

The conversion factor update for services provided January 1, 2015, through March 31, 2015, is $35.8013. From April 1, 2015, through December 31, 2015, the conversion factor is estimated at $28.2239. Relative Value Units (RVUs) for medical services are multiplied by the conversion factor to determine payment levels for individual services.

Global Bundles for Surgical Services

CMS plans to retain global bundles for surgical services, but to refine bundles by transforming over several years all 10- and 90-day global codes to 0-day global codes. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure. CMS proposes to make this transition for current 10-day global codes in CY 2017 and for the current 90-day global codes in CY 2018, pending the availability of data on which to base updated values for the global codes.

Transparency in Rate Setting

CMS implements changes in 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 in the final rule. CMS is adopting the new process in 2016 so that the AMA's CPT Editorial Panel has sufficient time to change its schedule for providing CMS 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.

Chronic Care Coordination

Medicare will pay 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.

CCM services are to be reported with CPT 99490. This is a new provision as CMS had proposed the use of a G Code for the reporting of services. The requirements for CPT 99490 are:

> Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
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> Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;

Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;

Comprehensive care plan established, implemented, revised, or monitored.

The CCM and non-face-to-face portion of the TCM services provided by clinical staff incident to the services of a practitioner may be furnished under the general supervision of a physician or other practitioner.

Sunshine Act

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.

CMS is finalizing four Sunshine Act 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. CMS argues that 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.

Secondary Interpretation of Images

In the proposed rule CMS solicited comments regarding payment for secondary interpretation of images, to be considered in a future rulemaking process. In the final rule, CMS thanked commenters for their input and again stated that payment for secondary interpretation of images will be addressed time uncertain.

Telehealth

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

Carotid Intima-Media Thickness Ultrasound (CPT Code 93895)

For CY 2015, a new Category I CPT code (93895) takes effect and describes the work of using carotid ultrasound to measure atherosclerosis and quantify the intima-media thickness. However, CMS determined this code is only used for screening and therefore is a non-covered service.

Value Based Modifier Payment Adjustments

In the proposed rule, CMS proposed to increase the maximum downward payment adjustment under the Value Modifier from -2.0 percent in the CY 2016 payment adjustment period to -4.0 percent for the CY 2017 payment adjustment period for all groups and solo practitioners that do not meet the quality reporting requirements for the Physician Quality Reporting System (PQRS).

CMS modified its proposal in the final rule. Under the final rule, CMS will increase the maximum payment penalty from -2.0 percent to -4.0 percent only for groups with ten or more eligible professionals (EPs). That is, for CY 2017 payments, a -4.0 percent Value Modifier adjustment will apply to groups of ten or more EPs subject to the Value Modifier that do not meet PQRS quality reporting requirements.

CMS will increase the maximum downward adjustment under the quality-tiering methodology for groups with ten or more EPs to -4.0 percent for groups of ten or more EPs classified as low quality/high cost and set the adjustment at -2.0 percent for groups classified as either low quality/ average cost or average quality/high cost. CMS will also increase the maximum upward adjustment under the quality-tiering methodology in the CY 2017 payment adjustment period to +4.0x ('x' represents the upward payment adjustment factor) for groups of ten or more EPs classified as high quality/low cost and set the adjustment to +2.0x for groups of ten or more EPs classified as either average quality/low cost or high quality/average cost.

Beginning in CY 2017, CMS will apply a maximum downward adjustment of -2.0 percent for groups with two to nine EPs and solo practitioners, if the group or solo practitioner does not meet the quality reporting requirements for the PQRS. The maximum upward adjustment for groups of two to nine EPs and solo practitioners will be +2.0x ('x' represents the upward payment adjustment factor) if classified as high quality/low cost. Groups of two to nine EPs and solo practitioners classified as either

average quality/low cost or high quality/average cost will receive a +1.0x upward adjustment. Groups of two to nine EPs and solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology for the CY 2017 payment adjustment period.

CMS will apply this policy to non-physician eligible professionals beginning in CY 2018.

PQRS – Removal of Cardiovascular Measures Prevention Group

CMS finalized the removal of the Cardiovascular Prevention measure group from the PQRS and modified its policy regarding support for the Million Hearts campaign via the Physician Compare Website. Specifically, eligible professionals will receive a green check mark indicating support for Million Hearts if they satisfactorily reports all four of the following individual measures:

- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic;
- Preventive Care and Screening: Tobacco Use;
- Controlling High Blood Pressure; and
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented