Medicare’s Proposed Fee Schedules for 2017

The proposed Hospital Outpatient Prospective Payment for 2017 (HOPPS) and the proposed Physician Fee Schedule for 2017 (MPFS) were published by the Centers for Medicare and Medicaid (CMS) in the Federal Register on July 14 and July 15 respectively. The proposed rules and regulations address issues which we have discussed in previous editions of the Washington Watchline. One of the principle issues addressed in the HOPPS is the issue of Provider Based Billing. The proposed MPFS has two sections of interest; new codes proposed for moderate sedation accompanying procedures and new physician billing codes for telemedicine critical care consultations.

Provider Based Billing

When a hospital purchases a physician practice the hospital may claim that practice as an off-campus outpatient department of the hospital or a “Provider Based Department.” When a Medicare beneficiary receives services in an off-campus department of a hospital, the total payment amount for the services made by Medicare is generally higher than the total payment amount made by Medicare when the beneficiary receives those same services in a physician’s office. Medicare pays a higher amount because it receives two separate claims for the service, one under the HOPPS for the institutional services and one under the MPFS for the professional services furnished by a physician. Additionally, the payment methodologies for determining payments for these two categories differ dramatically. Medicare beneficiaries are responsible for the cost-sharing liability, for these claims, often resulting in significantly higher total beneficiary cost-sharing than if the same service had been furnished in a physician’s office. For example, the Medicare Payment Advisory Commission stated in its March 2014 Report to Congress that Medicare paid more than twice as much for a level II echocardiogram in a provider based outpatient facility ($453) as it did in a freestanding physician office ($189).
Hospitals have significant incentives to contract with and purchase independent practices both to build their patient census and the financial plum of provider based billings. This has allowed them to offer generous financial packages to independent practices. The Government Accountability Office engaged in a study of the issue and published a report in December 2015. Through analysis of Medicare billing patterns they found that the number of hospital employed physicians increased significantly from roughly 96,000 in 2007 to 182,000 in 2013.

The issue of billing differentials to Medicare as a result of a hospital claiming that a remote physician’s office was an outpatient department was addressed in the Bipartisan Budget Act of 2015. A provision required that CMS establish criteria for legitimate off campus outpatient departments and identify services that are legitimate to those facilities. CMS begins to address the legislation’s requirements in the proposed 2017 Hospital Outpatient Prospective Payment System. In this document CMS establishes criteria for an off-campus facility to be considered a legitimate Provider Based Department and defines which items and services are legitimate Outpatient Department services.

The off-campus outpatient department must meet certain requirements, including, but not limited to:

- It generally must be located within a 35-mile radius of the campus of the main hospital;
- Its financial operations must be fully integrated within those of the main provider;
- The professional staff at the off-campus outpatient department must have clinical privileges at the main hospital;
- The off-campus outpatient department medical records must be integrated into a unified retrieval system of the main hospital;
- Patients treated at the off-campus outpatient department who require further care must have full access to all services of the main hospital;
- It is held out to the public as part of the main hospital.

CMS identifies the legitimate services by APC code in the proposed rule. Cardiac and pulmonary rehabilitation are included in those services as long as they were provided prior to November 2, 2015. Facilities and services that do not fall within the proposed criteria will not be covered under the OPPS payment. Those items and services will instead be paid through Medicare Part B as if they were delivered in a free standing office beginning January 1, 2017. Because full implementation of the Congressional mandate requires modification of the current rigid payment system, CMS intends the proposed policy to be a temporary, 1-year solution until they can adapt their systems to accommodate payment to legitimate off-campus outpatient departments for items and services that could equally be delivered in an ordinary, independent physician’s office.

These steps by CMS will most likely result in a downward correction in reimbursement to hospital acquired off campus practices. Physician contracts with hospitals that have been based on the higher reimbursement under provider based billing will likely come under pressure as total payment is ratcheted down.

**NOTE:** NAMDRC and other pulmonary societies will be submitting formal comments addressing concerns regarding inclusion of pulmonary rehabilitation (HCPCS code G0424) in the family of codes subject to payment adjustments.

**Telemedicine Codes for Part B Critical Care Services**

Thought leaders in Congress, professional societies and healthcare systems have been taking steps to expand the use of telemedicine technology throughout healthcare. Through the perseverance of the American Telemedicine Association and their efforts to educate policy makers,
implementation of telemedicine has been rising to the top of the healthcare policy agenda in Washington. Over the last five years CMS has received several requests to establish codes to compensate physicians for consultations provided to critically ill patients through telemedicine. CMS has resisted this effort in the past citing a lack of definitive literature to support the benefit. Recent literature has persuaded the Agency that there may be potential benefits of remote care by specialists for critically ill patients. While there are currently codes on the tele-health list that could be reported when consultation services are furnished to critically ill patients, CMS has determined it would be advisable to create a coding distinction between tele-health consultations for critically ill patients relative to tele-health consultations for other hospital patients. CMS has proposed to establish GTT1 and GTTT2 that would be added to the telehealth list and would be subject to the geographic and other statutory restrictions that apply to telehealth services. CMS proposes limiting these services to once per day per patient.

GTTT1 Telehealth consultation, critical care, physicians typically spend 60 minutes communicating with the patient via telehealth (initial) NEW - work RVU 4.00

GTTT2 Telehealth consultation, critical care, physicians typically spend 50 minutes communicating with the patient via telehealth (subsequent) NEW - work RVU 3.86

NOTE: NAMDRC and other pulmonary societies will be submitting formal comments addressing concerns regarding these code descriptors; after all, some critically ill patients may not be able to “communicate” with the physician.

Sedation for Endoscopic Procedures

When establishing the components of procedure codes, the American Medical Association (AMA) CPT Editorial Committee determined that moderate sedation was an inherent part of furnishing most procedures. In developing Relative Value Units (RVUs) for these services, the RUC included the resource costs associated with moderate sedation in the valuation. In the 2015 Physicians Fee Schedule, CMS noted that it appeared that practice patterns for endoscopic procedures were changing. CMS realized that, for services primarily furnished by gastroenterologists, anesthesia services were being separately reported, meaning that the RVU work units associated with sedation were no longer incurred by the practitioner performing the procedure. While the compensation for the physician performing the procedure included a work value for moderate sedation, the anesthesiologist was submitting a claim and being compensated for the same service.

In the 2016 Physician Fee Schedule CMS requested public comment and recommendations on approaches to address the appropriate valuation of moderate sedation related to the
approximately 400 diagnostic and therapeutic procedures for which the CPT Editorial Committee had determined that moderate sedation was an inherent part of furnishing the service. In response to the comments received, the AMA CPT Editorial Panel created CPT codes for separately reporting moderate sedation services accompanying endoscopic procedures. In reviewing the situation, the RUC recommended removing work RVUs for moderate sedation from endoscopy codes. Professional societies and other stakeholders were surveyed to establish the work involved in furnishing the moderate sedation. The GI societies’ survey data reported a median valuation of 0.10 work RVUs for moderate sedation furnished by the same person furnishing the procedure; all other specialty groups reported a median valuation of 0.25 work RVUs.

CMS is proposing to remove the moderate sedation work units from all the endoscopy codes and establish free standing codes for moderate sedation that would be reported in addition to the procedure code. CMS is proposing to remove .25 work units from all the bronchoscopy codes and 0.10 work units from all of the GI endoscopy codes. The agency is establishing separate codes for moderate sedation provided during the procedure. Proposed sedation codes that would be reported with a bronchoscopy code are 991X1 through 991X6. The proposed work values for these codes are: 991X1 0.50 RVU; 991X2 0.25RVU; 991X3 1.90 RVU; 991X4 1.65 RVU; 991X5 0 RVU; 991X6 1.25 RVU. Given the significant difference in RVUs reported in the survey data, CMS has proposed to establish a gastrointestinal endoscopy-specific moderate sedation code GMMM1 that would be used in lieu of the new CPT moderate sedation coding. The GMMM1 has been assigned a work value of 0.10.

### TABLE 21: Moderate Sedation Codes and Descriptors

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<tr>
<th>CPT/HCPCS Code</th>
<th>Descriptor</th>
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<td>991X1</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age</td>
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<td>991X2</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older</td>
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<td>991X3</td>
<td>Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient younger than 5 years of age</td>
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<tr>
<td>991X4</td>
<td>Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older</td>
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<tr>
<td>991X5</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; each additional 15 minutes of intra-service time (List separately in addition to code for primary service)</td>
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<tr>
<td>991X6</td>
<td>Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)</td>
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- Publication of Current Controversies focusing on one specific Pulmonary/Critical Care Issue in each publication;
- Regulatory updates;
- Discounted Annual Meeting registration fees;
- The Executive Office Staff as a resource on a wide range of clinical and management issues; and
- The knowledge that NAMDRC is an advocate for you and your profession.

https://www.namdrc.org/content/issue-advocacy

One of NAMDRC’s primary reasons for existence is to provide both clinicians and patients with the most up-to-date information regarding pulmonary medicine. Bookmark this page!

The complexity of our nation’s health care system in general, and Medicare in particular, create a true challenge for physicians and their office staffs. One of NAMDRC’s key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, NAMDRC members indicate that their #1 reason for belonging to and continuing membership in the Association is its voice before regulatory agencies and legislators. That effective voice is translated into providing members with timely information, identifying important Federal Register announcements, pertinent statements and notices by the Centers for Medicare and Medicaid Services, the Durable Medical Equipment Regional Carriers, and local medical review policies.

ABOUT NAMDRC:

Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

NAMDRC members, all physicians, work in close to 2,000 hospitals nationwide, primarily in respiratory care departments and critical/intensive care units. They also have responsibilities for sleep labs, management of blood gas laboratories, pulmonary rehabilitation services, and other respiratory related services.
# NAMDRC MEMBERSHIP APPLICATION

## TWO EASY WAYS TO BECOME A NAMDRC MEMBER

1. **Go to** [www.namdrc.org](http://www.namdrc.org) **and register for membership online.**

2. **Mail this application to:**

   NAMDRC  
   8618 Westwood Center Drive, Suite 210  
   Vienna, VA  22182-2273

Please print clearly or type:

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| FACILITIES WITH WHICH YOU ARE AFFILIATED |

## MEMBERSHIP DUES SCHEDULE

(Does for first year include $75.00 Initiation Fee)

**Individual and Small Group Dues:** $370.00  
Includes groups of up to 6. Please include contact information for all members.

**GROUP MEMBERSHIP DUES**  
(For larger groups, please attach a list of names. If a group member wishes to receive mailings at an address other than that indicated above, please attach appropriate information.)

- Groups of 7-10: $1,175.00
- Groups of 11-20: $1,560.00
- Groups of 21-30: $1,930.00

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In accordance with IRS Regulations, 95% of your 2016 Annual Dues are tax deductible. NAMDRC’s Federal TAX ID # is 74-2020988.

## FOR MORE INFORMATION, CONTACT NAMDRC

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