The Final 2014 Medicare Physicians Fee Schedule

The Centers for Medicare and Medicaid Services (CMS) released the final 2014 Medicare Physicians Fee Schedule on November 27, one month late due to the government shutdown in October. The proposed 2014 fee schedule, discussed in the August Watchline, contained several significant changes to CMS policies and the regulatory environment. The final document includes the comments received from interested parties and the CMS responses revealing a great deal about evolving CMS policy. Major topics include the effort to address inequities in the Resource Based Relative Value Scale (RBRVS), alterations to the Physicians Quality Reporting System (PQRS), implementation of the Value Based Modifier (VBM), anomalies in reimbursement for office based services and an effort to recognize care outside of routine office visits.


CMS Transitions Away From AMA RUC CPT Code Values

With the constant urging of the Government Accountability Office (GAO), Office of Inspector General (OIG), the Medicare Payment Advisory Commission (MedPAC) and Congress, CMS has been taking steps to uncouple their valuation of codes from the American Medical Association/Specialty Society Relative Value Scale Update Committee (AMA RUC) valuation methodology. Because changes in RVUs must be budget neutral, the AMA RUC process of determining physician reimbursement has been competitive and dominated by procedural specialties. Recognizing this, legislators included a section in the Affordable Care Act requiring CMS to establish a process to validate RVUs of physician fee schedule services and explicitly authorized CMS to conduct the validation through surveys, studies or other analyses that would facilitate validation. CMS has acknowledged the concerns expressed by MedPAC over the structure of the AMA RUC and has expressed concerns about the AMA RUC use of a methodology that employs the incremental difference in codes to determine values for many of these services. This methodology uses a base code or other comparable code and considers what the difference should be between that code and another code by comparing the differentials to those for other similar codes.

"NAMDRC will directly affect your practice more than any other organization to which you belong."
In the proposed fee schedule CMS revealed that it had entered into two contracts with outside entities to develop validation models for RVUs, the RAND Corporation and The Urban Institute, and would no longer rely solely on the updates from the AMA RUC. During a 2-year project, the RAND Corporation will use available data to build a validation model to predict work RVUs and the individual components of work RVUs, time and intensity. The Urban Institute will also focus on the highly influential time estimates by focusing its efforts on collecting data from several practices for specific services selected by the contractor. Robert Berenson, M.D., will serve as Clinical Director for the Urban Institute project, providing clinical and policy expertise as well as recruiting and training the physicians who will lead the clinical panels. Dr. Berenson, a former vice-chair of MedPAC, has been a vocal critic of the AMA RUC methodology. The codes currently selected for review are primarily procedure codes.

CMS received a great deal of criticism on this step. A number of societies, including the American Thoracic Society, opposed any unilateral action on the part of CMS to reduce reimbursement for codes that it feels are over-valued. Several commenters believe that the identification of misvalued codes should be carried out only through the AMA RUC process.

CMS responded:

As discussed in section II.B.1. of this final rule with comment period, each year we develop and propose appropriate adjustments to the RVUs, taking into account the recommendations provided by the American Medical Association/Specialty Society Relative Value Scale Update Committee (AMA RUC), the Medicare Payment Advisory Commission (MedPAC), and others. For many years, the AMA RUC has provided us with recommendations on the appropriate relative values for new, revised, and potentially misvalued PFS services. We review these recommendations on a code-by-code basis and consider these recommendations in conjunction with analyses of other data, such as claims data, to inform the decision-making process as authorized by the law. We may also consider analyses of physician time, work RVUs, or direct PE inputs using other data sources, such as Department of Veteran Affairs (VA), National Surgical Quality Improvement Program (NSQIP), the Society for Thoracic Surgeons (STS) National Database, and the Physician Quality Reporting System (PQRS) databases. We conduct a clinical review to assess the appropriate RVUs in the context of contemporary medical practice.

For further information on this new process:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/RVUs-Validation-Model.pdf

Hospital Outpatient Department vs Independent Office Billing

As part of the CMS effort to address issues of “misvalued CPT codes” they have identified two anomalies related to ambulatory patient billing and are making these a priority for action. The first relates to hospital acquisition of physician offices and the second to examples of independent office compensation exceeding that of a hospital facility for certain services.

When a Medicare beneficiary receives outpatient services in a hospital, the total payment amount for outpatient services made by Medicare is generally higher than the total payment amount made by Medicare when a physician furnishes those same services in a freestanding clinic or in a physician’s office. When a service is furnished in an independent clinic or physician office, only one payment is made under the fee schedule; however, when a service is furnished in a hospital-associated office, Medicare pays a “facility fee” in addition to the payment for the physician’s service. With the increased trend toward hospital acquisition of physician practices previously independent offices can now bill both Medicare Part A and Medicare Part B resulting in higher costs to Medicare and the patient without a change in the service. The beneficiary pays coinsurance for both the physician payment and the hospital outpatient payment (facility fee). MedPAC has questioned the appropriateness of increased Medicare payment and beneficiary cost-sharing when physicians’ offices become hospital outpatient departments and has recommended that Medicare pay selected hospital outpatient services
at the same rates they pay independent offices. CMS stated in the CY 2014 proposed rules that in order to better understand the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments, they were considering collecting information that would allow them to analyze the frequency, type, and payment of services furnished in off-campus provider-based hospital departments. Most commenters agreed on the need to collect information on the frequency, type, and payment for services furnished in off-campus provider-based departments of hospitals, but opinions differed on how to best collect this data. CMS responded:

We appreciate the public feedback in response to our comment solicitation in the proposed rules. We will take the comments received into consideration as we continue to consider approaches to collecting data on services furnished in off-campus provider-based departments.

On the other hand, Medicare has noted that there are codes for which the payment under the current fee schedule is higher in the free standing clinic than the hospital outpatient department due to an elevated practice expense (PE) component. The PE component relies heavily on the voluntary submission of information by individuals furnishing the service and who are paid at least in part based on the data provided. Currently, CMS has little means to validate whether the information is accurate or reflects typical resource costs. In the CY 2014 proposed rule with comment period, CMS identified nearly 200 codes that fell into this group. The great majority of these codes are for procedures. CMS has proposed to limit the nonfacility practice expense RVUs for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting.

While the overwhelmingly majority of commenters, including the ATS objected to the proposed policy. The Association of American Medical Colleges (AAMC) urged CMS to work with stakeholders to review results of a survey currently being conducted by the Department of Health and Human Services Office of Inspector General (OIG). In their comments, MedPAC has encouraged CMS to seek legislative authority to equalize the total payment rates for E&M office visits across settings. The CMS response to the objections:

At this time, we do not believe that our standard process for evaluating potentially misvalued codes, including the use of the AMA RUC is an effective means of addressing these codes.

We also continue to believe that if the total Medicare payment when a service is furnished in the physician office setting exceeds the total Medicare payment when a service is furnished in an HOPD or an ASC, this is generally not the result of appropriate payment differentials between the services furnished in different settings. Rather, we continue to believe that it is primarily due to anomalies in the data we use under the PFS and in the application of our resource-based PE methodology to the particular services.

We are not finalizing our proposed policy in this final rule with comment period. We expect to develop a revised proposal for using OPPS and ASC rates in developing PE RVUs which we will propose through future notice and comment rulemaking.

Expanding the Physician Quality Reporting System


For 2014, satisfactorily reporting data on PQRS quality measures will result in an incentive equal to 0.5 percent of the total estimated Medicare Part B allowed charges for all covered professional services furnished by the eligible professional or group practice. Those that do not meet the reporting criteria will experience a negative adjustment in their total Medicare compensation of 2%. The incentive payment and penalties will be applied to the 2016 compensation.

Individual Measures:

In the final rule CMS increased the number of quality measures that an individual is required to report via claims, EHR and qualified registry from three to nine covering at least 3 of the National Quality Strategy (NQS) domains while
while decreasing the percentage of patients that must be reported from 80 percent to 50 percent. If less than 9 measures are available, a provider must report those that are for at least 50 percent of the applicable patients. Of the measures reported via a qualified clinical data registry a provider must include at least 1 outcome measure. A provider who reports fewer than 9 measures will be subject to the Measures Applicability Validation (MAV) process which will determine whether the individual should have reported quality data codes for additional measures and/or covering additional NQS domains. Details of the MAV process may be found:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html

The majority of commenters opposed the proposal to increase the number of measures to be reported for a variety of reasons. The American Association of Medical Colleges (AAMC) raised two important issues. The reporting mechanisms may not have comparable results and there may be biases between individual reporting and group reporting. In the former, a null value in a GPRO Web measure might count against a group’s performance, while a null value in EHR reporting is simply ignored. Both are reporting the same measure, but the results are different. As an example of the latter, if a group practice decides to collect diabetes measures, then all patients with an active diabetes problem list will be selected from the EHR, even if a patient is seen in the practice for something unrelated to diabetes care. If comprehensive diabetes care is not typically part of the workflow of the clinician who sees that patient, lab tests related to diabetes care will not be ordered or recorded in the system, thus penalizing the group practice. It was recommended that CMS validate the quality data results that come from different reporting mechanisms and from individual and group reporting to ensure they are comparable. AAMC also recommended that CMS analyze whether a systematic discrepancy exists between reporting mechanisms or between group and individual reporting that could affect the comparability of the data. CMS responded:

We believe that we have provided eligible professionals with enough time to familiarize themselves with the reporting options for satisfactory reporting under the PQRS, particularly for the PQRS incentives.

Measures Groups:

CMS has previously defines a measures group as a subset of four or more Physician Quality Reporting System measures. Consistent with the increase the number of individual measures to be reported via claims and registry, CMS proposed to increase the number of measures that would be reported in a measures group to six or more. Unlike reporting individual measures, where a provider would be able to report on any 9 measures, a provider would be required to report on ALL the measures contained in a measures group. CMS received numerous objections to this proposal and responded:

Although we still plan to increase the minimum number of measures in a measures group in the future, we are not finalizing this proposal at this time. We will work with the measure developers and owners of these measures groups to appropriately add measures to measures groups that only contain four measures within the measures group.

The Value Based Payment Modifier

Despite increasing concern and criticism of the methodology, CMS continues to phase in implementation of the Value Based Payment Modifier (VBM) and will apply it to small groups of physicians and increase the amount of payment at risk. In the final Physicians Fee Schedule for 2013 CMS established calendar year 2013 as the performance period that would be applied to payments for physicians in groups of 100 or more eligible professionals during 2015. In the new rule CMS will apply the modifier to groups of physicians with 10 or more eligible professionals in CY 2016. Payments or penalties in CY 2016 would be based on performance in CY 2014. It is estimated that this proposal would affect approximately 17,000 groups and nearly 60 percent of physicians. Under current rules, the modifier will apply to all physicians for their calendar year 2017 compensation (a 2015 performance period). CMS is increasing the amount of payment at risk under the value-based payment modifier from 1.0 percent to 2.0 percent in 2016.

Many societies continue to express concern over the accuracy of the methodology behind the Value Based Modifier. The AMA has repeatedly argued that the Value Based Modifier is a flawed concept that cannot be equitably applied across
the board to all physicians. The AAMC has expressed the opinion that both the PQRS and Value Modifier programs are complex with many moving parts. Most commenters felt that it is premature to move to a full pay-for-performance program before CMS can ensure the accuracy and stability of the performance scoring of the cost and quality measures and that the results are comparable for individuals, groups, and across the various reporting mechanisms. CMS responded:

Based on an analysis of our CY 2012 Quality and Resources Use Reports the PQRS quality measures and the cost measures used for the value-based payment modifier have high average statistical reliability.

CMS is finalizing its proposals to apply the Physician Value Modifier to groups of physicians with 10 or more eligible professionals, and to apply upward and downward payment adjustments based on performance to groups of physicians with 100 or more eligible professionals. However, only upward adjustments based on performance (not downward adjustments) will be applied to groups of physicians with between 10 and 99 eligible professionals.

The Effort to Shift Reimbursement from Procedures to Cognitive Services

CMS policy continues to evolve in regards to approving compensation for preventative services and non face to face care. Medicare has traditionally paid for primary care management services only as part of a face-to-face visit. Under current policy, pre and post-encounter evaluation and decision making is included in calculating the total work for the typical evaluation and management (E/M) service. CMS recognizes that the current E/M office visit CPT codes reflect an overall orientation toward episodic treatment and has now been persuaded that the resources required to furnish care management services to beneficiaries with multiple chronic conditions are not adequately reflected in the existing E/M codes. In the 2013 Physicians Fee Schedule, CMS adopted a policy to pay separately for management involving the transition of a beneficiary from care furnished by a treating physician during a hospital stay to care furnished by the beneficiary’s primary physician in the community. In this rule, CMS proposed to make a separate payment for non-face-to-face chronic care management services for Medicare beneficiaries who have two or more chronic conditions to be effective in 2015.

Chronic Obstructive Pulmonary Disease (COPD) is one of the most common chronic conditions on the CMS list and was diagnosed in 12% of Medicare beneficiaries making it ninth out of fifteen conditions in frequency. Almost half of the patients with COPD had five or more conditions. Patients with stroke and COPD or renal failure and COPD were among the top five most costly combinations. The great majority of our patients with COPD will be eligible for billing under this new code. Only one physician may bill this code and while CMS expects the chronic care management code to be billed most frequently by primary care physicians they confirm that specialists who meet the requirements may also bill for these services.

CMS currently plans to establish a G code for this service but has not yet proposed relative values or offered any payment information related to the service. The AMA comments reminded CMS that current CPT contains codes for chronic care, CPT codes 99487-99489. The CMS response again underlines their plan to reduce reliance on the AMA RUC although they did leave the door open for the AMA RUC to comply with the CMS definition of complex chronic care.

The current CPT codes do not meet our policy requirements (for example, the eligible patient population, the time required for the code); therefore, we are not adopting these codes in this final rule.

In summary, to recognize the additional resources required to provide chronic care management services to patients with multiple chronic conditions, we will be creating one new separately payable alphanumeric G-code for CY 2015.

As currently described, billing for this service will impose a significant administrative and documentation burden on providers and the level of compensation has yet to be determined.

Medicare Hospital Outpatient Final Regulations Posted

Simultaneous with the publication of the Physician Fee Schedule, Medicare has posted its final regulations for hospital outpatient services for 2014. The rule addresses in detail the proposal that shifts payment for pulmonary rehabilitation services
This decision by CMS creates a puzzling anomaly, with CMS paying for 15 minutes of service for pulmonary rehabilitation type services for non COPDers (codes G0237 and G0238) the same amount as it will pay for up to 90 minutes of service for pulmonary rehabilitation services for COPD beneficiaries.

Here is a link http://www.ofr.gov/OFRUpload/OFRData/2013-28737_PI.pdf

CMS rejected the comments from NAMDRC and its sister societies. Rather than highlight the reasons CMS has identified, it is important for NAMDRC members involved with pulmonary rehabilitation to understand what all of this means:

1. As long as hospitals do not adjust their charges on Medicare claims for G0424, payment will continue to be woeful. CMS has clearly signaled that their payment rates are dependent on two primary sources of information PROVIDED by hospitals – the Medicare claims form UB 04 and the annual hospital cost report. The Pulmonary Rehabilitation Toolkit guides you through the process for determining charges as well as the political process within hospitals that members should follow to secure accurate payment for pulmonary rehabilitation (now approximately 36% of what cardiac rehabilitation receives).

2. The codes G0237, G0238, G0239 and G0424 all crosswalk to the same APC, which pays approximately $39+. So, 15 minutes of one-on-one time for codes G0237 and G0238 will warrant the same payment for up to 90 minutes of pulmonary rehabilitation services, despite CMS’ statement that pulmonary rehab does include some one-on-one services.
PRODUCT AND TECHNOLOGY NEWS!

NAMDRC is providing this space to our benefactors and patrons who provide us with information about new products and innovations related to pulmonary medicine. NAMDRC reserves the right to edit this copy as appropriate.
A Bout 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 Benefits at a Glance…

- Monthly publication of the Washington Watchline, providing timely information for practicing physicians;
- 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.

http://www.namdrc.org/coding.html

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.
NAMDR C MEMBERSHIP APPLICATION

Two Easy Ways to become a NAMDR C member
1. Go to www.namdr.org and register for membership online.
2. Mail this application to

NAMDR C
8618 Westwood Center Drive, Suite 210
Vienna, VA 22182-2222

Please print clearly or type:

Name (Last) (First) (MI)

Degree

Address

City State Zip

Telephone Fax

E-mail

Facilities with which you are affiliated

Please indicate the areas that apply to your practice:

☐ Respiratory Care Management
☐ Anesthesiology
☐ Sleep Disorders
☐ Pulmonary Rehabilitation
☐ Skilled Nursing Facility
☐ Hyperbaric Oxygen Therapy
☐ Critical Care
☐ Home Health Services
☐ Physiology Assessments

Membership Dues Schedule
(Dues for the first year includes $75.00 Initiation Fee)

Individual and Small Group Membership Dues $350.00
Can include groups of up to 6. Please include contact information for additional 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 $1,100.00
Groups of 11-20 $1,460.00
Groups of 21-30 $1,805.00
TOTAL PAYMENT DUE $____________

Payment
☐ Enclosed is a check payable to NAMDR C (US Dollars)
☐ Charge my credit card for total payment due
   ☐ VISA
   ☐ MasterCard

Credit Card Number Expiration Date

Name as it appears on Credit Card

Billing Address (If different from registration)

E-mail

Signature

In accordance with IRS Regulations, 95% of your 2014 Annual Dues are tax deductible. NAMDR C’s Federal TAx ID # is 74-2020988.

For more Information, Contact NAMDR C
Phone: 703-752-4359
Fax: 703-752-4360
E-mail: ExecOffice@namdrc.org
Web Site: www.namdr.org

NAMDR C’s primary mission is to improve access to quality care for patients with respiratory disease by removing regulatory and legislative barriers to appropriate treatment.