



FACT SHEET

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Proposed policy and payment changes to the Medicare Physician Fee Schedule for calendar year 2013

OVERVIEW

On July 6, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (MPFS) on or after Jan. 1, 2013. The proposed rule also proposes changes to several of the quality reporting initiatives that are associated with MPFS payments – the Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, and the PQRS-EHR Incentive Pilot – as well as changes to the Physician Compare tool on the Medicare.gov website. Finally, the proposed rule includes proposals for implementing the physician value-based payment modifier (Value Modifier) required by the Affordable Care Act that would affect payments to physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare Fee-for-Service program.

This fact sheet discusses the proposed changes to payment policies and payment rates for services furnished under the MPFS. Separate fact sheets, also issued today, discuss the proposed changes to the quality reporting programs and the proposals for implementing the Value Modifier.

BACKGROUND

Since 1992, Medicare has paid for the services of physicians, nonphysician practitioners (NPPs), and certain other suppliers under the MPFS, a system that pays for covered physicians' services

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furnished to a person with Medicare Part B. Under the MPFS, a relative value is assigned to each of more than 7,000 types of services to capture the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice expenses typically involved in furnishing the service. The higher the number of relative value units (RVUs) assigned to a service, the higher the payment. The RVUs for a particular service are multiplied by a fixed-dollar conversion factor and a geographic adjustment factor to determine the payment amount for each service.

PROVISIONS INCLUDED IN THE CY 2013 MPFS PROPOSED RULE

- **Primary Care and Care Coordination:** In recent years, CMS and HHS have recognized primary care and care coordination as critical components in achieving better care for individuals, better health for populations, and reduced expenditure growth. Accordingly, CMS has prioritized the development and implementation of a series of initiatives designed to ensure accurate payment for, and encourage long-term investment, in primary care and care coordination services.

For CY 2013, CMS is proposing to create a new procedure code to recognize the additional resources required for a community physician to coordinate a patient's care in the 30 days following discharge to the community from an inpatient hospital stay, skilled nursing facility (SNF) stay, and specified outpatient services. Medicare already pays separately for care management services for individuals with an inpatient admission who are discharged to SNF, home health, or hospice. Although Medicare traditionally pays for care management services in conjunction with a face-to-face visit, the proposed new procedure code would establish a separate payment for care management services for the beneficiary that occur outside a face-to-face encounter with the community physician.

CMS believes that recognizing the work of community physicians and practitioners with the proposed new code will ensure better continuity of care for these patients and support the agency's readmission reduction initiatives. This care coordination will become increasingly important as Medicare implements the Readmissions Reduction Program beginning Oct. 1, 2012. This program, which was mandated by the Affordable Care Act, reduces payment to hospitals when they have excess readmissions for certain conditions.

The proposed rule also discusses the possibility of other efforts to bolster care coordination for Medicare beneficiaries, and solicits public comment regarding how the program might recognize and pay for advanced primary care medical home services in the fee-for-service setting.

- **Potentially Misvalued Codes:** CMS has been engaged in a vigorous effort over the past several years to identify potentially misvalued codes and when codes are found to be

misvalued to revise the payment accordingly. Last year, CMS finalized a process for the public to recommend potentially misvalued codes to CMS. In addition to reviewing publicly nominated codes, CMS proposes two new categories of potentially misvalued codes for review: “Harvard-valued” CPT codes with Medicare annual allowed charges of \$10 million or more; and services with stand alone practice expense procedure times.

Within this latter category of codes, CMS proposes to reduce the procedure time assumptions used in developing RVUs for intensity modulated radiation treatment (IMRT) delivery and stereotactic body radiation therapy (SBRT) delivery, which would more accurately pay for these radiation therapy services. These services have been identified as potentially misvalued by CMS and the Medicare Payment Advisory Commission (MedPAC). Sometimes Medicare pays free standing IMRT facilities more than hospitals for treatment and delivery. More broadly, a growing body of academic literature has questioned the validity of procedure time assumptions used in established payment rates under the MPFS. Proposed values are derived from procedure time information that better reflects current practice as reported in publicly available patient education materials.

- Interest Rate Assumptions: CMS is also proposing to improve the accuracy of payment rates to reflect current economic conditions by revising interest rate assumptions used to establish payment for practice expense from 11 percent to a range from 5.5 to 8 percent based on the Small Business Administration maximum interest rates for different categories of loan size (equipment cost) and maturity (equipment useful life).

Multiple Procedure Payment Reduction Policy: Medicare has a longstanding policy to reduce payment for the second and subsequent surgical procedures performed on the same patient by the same physician or physician group practice on the same day, largely based on presumed efficiencies in the practice expense (PE) and pre- and post-surgical physician work. For CY 2013, CMS is proposing to apply a multiple procedure payment reduction policy to the technical component of certain cardiovascular and ophthalmology diagnostic services. CMS would make full payment for the highest paid cardiovascular or ophthalmology diagnostic service and reduce the technical component payment for subsequent cardiovascular or ophthalmological diagnostic services furnished by the same physician or group practice to the same patient on the same day by 25 percent.

- DME Face-to-Face: To help combat fraud and reduce improper payments in DME items, CMS is proposing to implement a face-to-face requirement as a condition of payment for certain high-cost DME covered items. This list includes many items that have been historically targets of Medicare fraud as identified by the OIG, MACs, GAO, the HEAT Strike Forces, and our program integrity experts. The requirement is one of the anti-fraud

provisions in the Affordable Care Act and is consistent with similar face-to-face requirements for the Medicare home health and Medicaid DME benefit.

- Elimination of Prepayment Medical Review Limitation: Pursuant to the Affordable Care Act, CMS is proposing to remove a limitation placed on contractors to continue complex prepayment medical review if a provider or supplier has failed to reduce its individual error rate.
- Payment for Molecular Pathology Services: CMS is inviting comments on whether newly created molecular pathology CPT codes should be paid under the MPFS or the Clinical Laboratory Fee Schedule (CLFS). If CMS determines that new molecular pathology CPT codes should be paid under the MPFS for CY 2013, CMS proposes that Medicare contractors would price these codes because the price of tests can vary locally and because this would allow more time for CMS to gather information on these codes to price them nationally. CMS is also inviting discussion at the CLFS Annual Public Meeting of the appropriate payment amounts for these new codes as clinical diagnostic laboratory tests under the CLFS. CMS indicated a notice for the Annual Public Meeting (to be held July 16-17, 2012, at CMS headquarters in Baltimore) that it remains uncertain as to whether these services ordinarily require physician work and thus should be paid under the MPFS, or are clinical diagnostic laboratory tests that would be paid under the CLFS.
- Telehealth Services: In the interest of promoting access to important preventive services intended to help people stay healthy by giving them the tools they need to take charge of their own health, CMS is proposing to add a series of preventive services to the list of Medicare telehealth services for CY 2013. These include: annual alcohol misuse screening, brief behavioral counseling for alcohol misuse, annual face-to-face intensive behavioral therapy for cardiovascular disease, annual depression screening, behavioral counseling for obesity, and semi-annual high intensity behavioral counseling to prevent sexually transmitted infections. In addition, CMS is proposing to add alcohol and/or substance abuse assessment and intervention services to the list of Medicare telehealth services for CY 2013.
- Therapy Data Collection: As required by the Middle Class Tax Relief and Jobs Creation Act of 2012, CMS is proposing to implement a claims-based data collection process for therapy services to gather data about patient function and condition. Under the proposal, therapists will be required to include new codes and modifiers on claims for therapy services that will not affect payment, but will convey information about patients' functional limitations at the outset of therapy, periodically throughout therapy, and at discharge from therapy. Information on therapist-established patient goals will also be collected under this proposal. Proposed frequency of reporting is consistent with existing requirements for therapy progress notes. This system is proposed to be implemented on January 1, 2013. After a six-month

testing period, CMS proposes not to process any claims that do not contain the required information for dates of service beginning July 1, 2013. The data collected will be used primarily to design a new payment system for therapy services. CMS used comments received on a similar data collection effort that was discussed in the CY 2011 proposed rule in developing this proposed rule.

- Removing Barriers to Midlevel Providers: CMS proposes to revise the conditions of coverage and payment regulations to allow nonphysician practitioners (NPPs) and limited-license physicians to order portable x-ray services within the scope of their Medicare benefit and state scope of practice laws. Currently, CMS regulations limit ordering of portable x-ray services to a doctor of medicine or osteopathy. In addition, CMS proposes to clarify that “anesthesia and related care” for purposes of the CRNA benefit means services related to anesthesia that are within the state scope of practice for CRNAs in the state in which the services are furnished.

The proposed rule will appear in the July 30, 2012, Federal Register. CMS will accept comments on the proposed rule until Sep. 04, 2012, and will respond to them in a final rule with comment period to be issued on or about Nov. 1, 2012.

For more information, see: www.federalregister.gov/inspection.aspx#special

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