2015 Proposed Medicare Physician Fee Schedule Analysis
Exclusively for MGMA Members

The Centers for Medicare & Medicaid Services (CMS) published the proposed 2015 Medicare fee schedule for physician services on July 11, 2014. The regulation discusses policies that affect Part B payments for physician services furnished on or after Jan. 1, 2015. CMS will accept public comments on the rule until Sept. 2, 2014, and intends to issue a final rule by Nov. 1, 2014. MGMA will submit formal comments and share them with members through the MGMA Washington Connection newsletter.

Misvalued codes

CMS continues its ongoing efforts to evaluate and modify potentially misvalued codes. This year, the agency plans to review a number of codes affecting various specialties. Below is a summary of three proposals that would have the broadest impact on Medicare providers.

Review high expenditure services across specialties with Medicare allowed charges of $10 million or more

CMS specifies approximately 65 codes listed in Table 10 as potentially misvalued based on the fact that they account for a large portion of Medicare expenditures and have not been reviewed since 2009. CMS plans to assess changes in physician work and update direct practice expense (PE) inputs. Due to the significant impact these codes have on physician fee schedule (PFS) payments at the specialty level, the agency plans to review the relativity of the codes to ensure that the work and PE RVUs are appropriately valued relative to other codes within and across specialties.

Sunset 10 and 90-day global surgery codes

CMS proposes to radically change Medicare payment for surgical care by sunsetting the use of 10 and 90-day global surgical packages. The agency cites concerns regarding potential inaccuracies with the current information used to price these services, including whether current global surgical values accurately represent the number of post-operative visits furnished to beneficiaries. Consequentially, the agency proposes eliminating the use of 10-day and 90-day global surgical codes in 2017 and 2018, respectively. These would be replaced with newly-valued 0-day global surgical codes and would entail physicians billing separately for services such as follow up office visits.

Evaluate services that include moderate sedation as an inherent part of furnishing the procedure

CMS plans to evaluate more than 300 diagnostic and therapeutic procedures in Appendix G of the American Medical Association's (AMA's) CPT Manual, the codes for which CPT determined moderate sedation is an inherent part of furnishing the procedure and that consequentially, only the single procedure code is appropriate. Agency officials are considering establishing a uniform approach for valuing Appendix G services for which moderate sedation is no longer inherent,
rather than continuing to address this issue at the procedure code level. CMS is weighing how to value these codes to ensure accurate payment for moderate sedation when furnished, while avoiding potential duplicative payments when anesthesia is furnished and billed separately.

**Malpractice RVUs**

CMS proposes to implement its third comprehensive five-year review and update of the malpractice (MP) RVUs. The proposed MP RVUs were calculated based on updated MP premium data obtained from state insurance rate filings. The methodology largely parallels the process used in the 2010 update, with MP premium data coming primarily from state departments of insurance. MP RVUs comprise a much smaller portion (4.3%) of Medicare payment in comparison to work or practice expense RVUs, which account for 50.9% and 44.8% of Medicare payment, respectively. If finalized, the MP RVUs would have an approximate +1% impact on three specialties and a negative 1-2% effect on seven specialties. For all other specialties, the estimated impact is 0%. (Table 60) Due to a lack of sufficient data, review of anesthesiology MP RVUs will be postponed until 2016.

**Process for reviewing misvalued codes**

CMS proposes a modified review process for new, revised and potentially misvalued services that would begin with the PFS proposed rule for 2016. The agency acknowledges a number of challenges related to the timing of CMS' rulemaking and that of the AMA CPT Editorial Panel and AMA/Specialty Society Relative (Value) Update Committee (RUC). CMS would include proposed values for all new, revised and potentially misvalued codes for which they have complete RUC recommendations by Jan. 15 of the preceding year. For codes which CMS does not receive RUC recommendations by this date, the agency would delay revaluing for one year and include proposed values in the following year's rule. CMS explains that the new timeline and process would increase transparency and allow for more advance notice of changes by providing more details in the proposed rule, but the new process would significantly delay the inclusion of new codes in the fee schedule. Temporary use of G-codes for some services that are added, revised or deleted as part of annual CPT coding changes is also proposed.

**Collecting hospital outpatient department information**

CMS seeks to better understand the trend of hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments, which affects payments under the PFS and Medicare beneficiary cost-sharing. The proposal outlines that CMS, MedPAC and Congress are all interested in obtaining this information to better evaluate Medicare payments. Therefore, CMS proposes a new HCPCS modifier be reported with every code for physician and hospital services furnished in an off-campus provider-based department of a hospital. Beginning in 2015, the new modifier would be reported on both the CMS-1500 claim form for physicians’ services and the UB-04 (CMS form 1450) for hospital outpatient claims. CMS explains that this information may help the agency develop proposals affecting CMS’ PE methodology or data that would better account for the different resource costs among traditional office, facility and off-campus provider-based settings.
Medicare telehealth services

CMS proposes to make the following additions to the 2015 approved telehealth services list:

- Annual wellness visit (AWV) HCPCS codes G0438 and G0439 (to view AWV criteria, download MGMA’s analysis of the 2011 Medicare physician fee schedule)
- Psychotherapy services CPT codes 90845, 90846 and 90847
- Prolonged service office CPT codes 99354 and 99355

If finalized, all coverage guidelines specific to these services would continue to apply when furnished via telehealth.

Chronic care management services

CMS finalized plans to establish a new Medicare service, Chronic Care Management (CCM), in 2014, proposing payment begin in 2015. The specific elements finalized in 2014 can be viewed in our 2014 Final Medicare Physician Fee Schedule Analysis. CCM would be furnished to patients with two or more chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. In order to bill for this non face-to-face service, at least 20 minutes of services must be furnished per 30 days. CMS proposes the following RVUs:

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Description</th>
<th>Physician Work RVUs</th>
<th>Non-Facility PE RVUs</th>
<th>Facility PE RVUs</th>
<th>Mal-Practice RVUs</th>
<th>Total Non-Facility RVUs</th>
<th>Total Facility RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>GXXX1</td>
<td>Chronic care management</td>
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<td>0.57</td>
<td>0.26</td>
<td>0.04</td>
<td>1.22</td>
<td>0.91</td>
</tr>
</tbody>
</table>

CMS proposes a new scope of service requirement for the use of certified electronic health record technology (CEHRT), which would have to be certified to at least 2014 Edition certification criteria and would need to include an electronic care plan. Changes related to incident to billing for CCM are also being proposed. Specifically, services provided by clinical staff under general (rather than direct) supervision would be eligible to be counted for the purposes of incident to billing of the CCM service. Additionally, rather than only allowing the use of general supervision under incident to billing outside of regular business hours, CMS proposes to allow this during business hours as well. The same requirements are also being considered for equivalent purposes in relation to Medicare transitional care management services.
**Definition of colorectal cancer screening tests**

Screening colonoscopies are one of several recognized procedures within the definition of a “colorectal cancer screening test.” Currently, a screening colonoscopy includes payment for moderate sedation. This bundling prevents the physician providing the service from also reporting additional sedation codes, requiring anesthesia services beyond moderate sedation to be billed by a second physician.

Citing recent studies that suggest an increase in the percentage of colonoscopies and upper endoscopy procedures furnished using an anesthesia professional, as well as an analysis of 2013 Medicare claims data, CMS concluded that the prevailing standard of care for colonoscopies is undergoing a transition and that anesthesia separately provided by an anesthesia professional is becoming the prevalent practice. Therefore, CMS proposes to revise the definition of “colorectal cancer screening tests” to include anesthesia that is separately furnished in conjunction with screening colonoscopies.

Colorectal cancer screening tests are preventative services for which both coinsurance and deductibles are waived under section 4104 of the Patient Protection and Affordable Care Act (ACA). By including related anesthesia within the definition of colorectal cancer screening test, the proposed revision would relieve Medicare beneficiaries of cost-sharing obligations for such services.

CMS notes that if finalized, the agency would establish a modifier for use when billing the relevant anesthesia codes and will provide “appropriate and timely information” to facilitate correct billing of these services.

**Open Payments Program**

CMS proposes to remove the existing Open Payments Program exemption for reporting payments or transfers of value provided as compensation for speaking at continuing medical education programs. If finalized, these payments would be reported unless the situation qualifies for another reporting exclusion. Under a related existing exclusion, CMS does not require reporting for indirect payments or other transfers of value where the applicable manufacturer/group purchasing option (GPO) is unaware of the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year. CMS also proposes to make stock, stock options and any other ownership interests distinct categories, rather than one combined category. Finally, CMS proposes requiring the marketed name of devices and medical supplies, as is currently required for drugs and biologics. If finalized, these proposed changes would impact data collection requirements beginning Jan. 1, 2015.

**Physician Compare**

CMS continues to add material to the Medicare Physician Compare website, which contains information about individual physicians and group practices. Table 19 contains a list of changes
made in recent years, some of which will go into effect later this year and in 2015. CMS proposes to make 2015 PQRS group practice reporting option (GPRO) performance across group reporting mechanisms – GPRO web interface, registry, and EHR – available for public reporting on Physician Compare in 2016. Similarly, all measures reported by Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) would be available for reporting on Physician Compare. CMS also announced plans to display 2015 Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) performance for certain groups and Medicare ACOs.

In addition to increasing available information about groups, CMS also outlines plans to add additional data on individual physicians, including information regarding the 2015 PQRS Qualified Clinical Data Registry (QCDR) and 20 PQRS measures from 2013. CMS would also make available on Physician Compare all 2015 PQRS measures for individual eligible professionals (EPs) using claims, registry and EHR-based reporting, but is considering only displaying certain measures, or grouping measures into composites. The use of selective measure reporting and composites is also being considered for group reporting.

**Physician Quality Reporting System (PQRS)**

CMS proposes that EPs and group practices who do not satisfactorily report PQRS quality measures receive a 2% payment reduction under Medicare in 2017 based on data reported in 2015. Incentive payments will also no longer be available in the program, as 2014 is the last year to earn a bonus in PQRS.

CMS proposes the following changes to reporting criteria for individual EPs to avoid the 2017 PQRS penalty:

**Claims and Registry** – EPs would report at least nine measures covering at least three National Quality Strategy (NQS) domains for at least 50% of Medicare Part B fee-for-service patients seen during the reporting period to which the measure applies. Additionally, if the EP has seen at least one Medicare patient in a face-to-face encounter, the EP would report on at least two of the 18 measures contained in the proposed cross-cutting measure set (Table 21). These two cross-cutting measures would count toward the nine measures required to avoid the 2017 PQRS penalty.

For the purposes of these two reporting options, CMS proposes to determine whether an EP had a face-to-face encounter by seeing whether the EP billed for services under the PFS that are associated with face-to-face encounters, such as whether the EP billed general office visit codes, outpatient visits and surgical procedures. CMS would not include telehealth visits as face-to-face encounters.

**Qualified Clinical Data Registry (QCDR)** – EPs would report at least nine measures covering at least three NQS domains for at least 50% of the EP’s patients. CMS also proposes to increase the number of outcomes measures that EPs report from one to three out of the nine total measures. These three outcomes measures would be counted toward the nine measures required to avoid the 2017 PQRS penalty. If three outcomes measures are not available, the EP would report on
two outcomes measures and at least one of the following types of measures: resource use, patient experience of care and/or efficiency/appropriate use.

CMS proposes the following changes to reporting criteria for those in GPRO to avoid the 2017 PQRS penalty:

**Registry** (available to group practices with two or more EPs) – Group practices would report at least nine measures, covering at least three NQS domains. If the group practice has seen at least one Medicare patient in a face-to-face encounter, then at least two of the nine measures reported must be contained on the cross-cutting measures list (Table 21).

**GPRO web interface** (available to group practices with 25 or more EPs) – Group practices would report on all measures included in the web interface and populate data fields for the first 248 consecutively assigned beneficiaries. CMS proposes to align the web interface beneficiary attribution method with the Value-Based Payment Modifier’s proposed method of attribution.

**CMS-certified survey vendor** (available to group practices with 25 or more EPs) – CMS proposes the following three options for satisfactory reporting:

- **Registry** – Group practices would report all CAHPS for PQRS survey measures via a certified vendor and at least six additional measures covering at least two NQS domains using a qualified registry. If any EP in the group practice sees at least one Medicare patient in a face-to-face encounter, then at least one of the six measures reported via registry must be contained on the cross-cutting measures list (Table 21).

- **EHR** – Group practices would report all CAHPS for PQRS survey measures via a certified vendor and at least six additional measures covering at least two NQS domains using direct EHR or an EHR data submission vendor.

- **GPRO web interface** – Group practices would report all CAHPS for PQRS survey measures via a certified vendor and all measures included in the web interface and populate data fields for the first 248 consecutively assigned beneficiaries.

CMS proposes that all groups selecting this reporting option will be required to bear the cost of administering the surveys in 2015. Furthermore, beginning with the reporting period for the 2018 PQRS penalty, group practices with 25 or more EPs participating in the GPRO would be required to report and pay for the collection of CAHPS for PQRS survey measures using a CMS-certified survey vendor.

The agency also proposes changing the GPRO self-nomination deadline to June 30 during the applicable reporting period.

**Proposed changes to the PQRS informal review process**

CMS proposes a modified deadline for requesting an informal review of a PQRS penalty, lowering the window from within 90 days of the release of feedback reports to within 30 days.
CMS explains this would expedite informal review decisions and as a result, EPs and group practices would have a brief period to make limited corrections to their PQRS data.

If finalized, CMS would allow EPs and group practices to make corrections to their PQRS data if the data was previously submitted by a third-party vendor using the qualified registry, EHR data submission vendor or QCDR reporting options. This resubmitted data could then be used to make corrections to value modifier calculations, when appropriate.

**Proposed changes to individual measures**

CMS proposes to add 28 new measures (Table 22) and retire 73 existing measures (Table 24) beginning in 2015. A number of modifications to existing PQRS measures and measures groups were also proposed, including NQS domain changes (Table 23) and alterations to the available reporting options (Table 25).

**Proposed changes to measures groups**

CMS proposes raising the minimum number of measures that may be included in a PQRS measures group from four to six measures. The change would include adding two new measures groups and retiring six current measures groups, beginning in 2015 (Tables 26-47).

**Proposed changes to GPRO web interface measures**

CMS proposes to make available nine new web interface measures beginning in 2015 (Table 48) and to retire or replace eight web interface measures (Table 49). If finalized, the GPRO web interface measure set would contain a total of 21 measures. To view the current PQRS reporting criteria, download MGMA’s analysis of the 2014 Medicare physician fee schedule.

**Accelerating health information technology (HIT)**

CMS reiterates its commitment to accelerating health information exchange (HIE) through the use of EHRs and other types of health information technology (HIT) through a number of initiatives including:

- Alignment of incentives and payment adjustments to encourage provider adoption and optimization of HIT and HIE services through Medicare and Medicaid payment policies;
- Adoption of common standards and certification requirements for interoperable HIT;
- Support for privacy and security of patient information across all HIE-focused initiatives; and
- Governance of health information networks.

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Medicare Shared Savings Program (MSSP)

MSSP and the Value-Based Payment Modifier (VBPM)

CMS proposes to make physicians and nonphysician EPs participating in a MSSP ACO subject to the VBPM in 2017. Please see the VBPM section of this analysis for more details.

Aligning EHR meaningful use clinical quality measure (CQM) reporting

CMS proposes to better align MSSP with meaningful use group reporting requirements by allowing EPs participating in an ACO to satisfy the CQM reporting component of meaningful use when the ACO reports GPRO web interface measures. CMS reiterates that EPs would still have to individually satisfy the other objectives and associated measures for their respective stages of meaningful use.

Specifically, CMS proposes to allow EPs participating in an MSSP ACO to satisfy the CQM reporting component of meaningful use when:

1) the EP extracts data necessary for the ACO to satisfy its GPRO quality reporting requirements from CEHRT,

2) the ACO satisfactorily reports the ACO GPRO measures through a CMS web interface.

While CMS is not proposing any new EHR reporting requirements for ACOs, the agency states its intention to “take steps in the future to better align and integrate EHR use into quality reporting under the MSSP.”

Revisions to quality measures used in establishing quality performance standards

CMS proposes to retire, add and revise a number of quality measures used to establish quality performance standards that ACOs must meet to be eligible for shared savings in the MSSP. Under these proposed changes, the number of quality measures ACOs would be assessed on for the 2015 reporting period would increase from 33 to 37 measures (Table 52). CMS notes however that these changes would not increase an ACO’s reporting burden since the total number of measures that an ACO would be required to report using the GPRO web interface would actually decrease by one, from 22 to 21. The increased number of proposed measures would be calculated by CMS using administrative claims data or patient surveys.

Modifications to MSSP benchmarking methodology

CMS proposes modifications to its benchmarking methodology to address stakeholder concerns with “topped out” measures, meaning that all but a very few organizations achieved near perfect performance on a measure. It also proposes to update benchmarks every two years to allow ACOs a longer period of time to gain experience with performance measures and provide a more stable target for measuring quality improvement.
Rewarding quality improvement

Finally, CMS proposes to recognize ACOs that improve their quality performance on a year-to-year basis by adding a quality improvement measure similar to the Medicare Advantage Five Star Quality Rating System. ACOs would be eligible to earn up to two bonus points for each of the four quality domains if they achieve statistically significant levels of quality improvement for the measures within the domain.

Value-based payment modifier (VBPM) and Physician Feedback Program

The ACA requires the Secretary of Health and Human Services to apply a VBPM, first to specific physicians and groups of physicians that the Secretary deems appropriate and ultimately to all Medicare Part B physicians by Jan. 1, 2017. The VBPM assesses both quality of care furnished and the cost of providing that care under the Medicare PFS.

CMS proposes to complete the phase-in of the VBPM in 2017 by applying it to all physicians and other providers who were previously exempt. The 2017 VBPM would be based on 2015 quality and cost performance.

To view current VBPM criteria, download MGMA’s analyses of the 2013 and 2014 Medicare physician fee schedules.

Proposed application of the VBPM in 2017

For 2017, CMS proposes to apply the VBPM to all physicians and non-physician EPs, including those participating in the MSSP, Pioneer ACO Model, Comprehensive Primary Care (CPC) Initiative and other similar Innovation Center models or CMS initiatives (Tables 56-57).

VBPM adjustment based on PQRS participation

The VBPM relies on PQRS participation for the purposes of reporting quality. The 2017 VBPM quality score would be based on 2015 PQRS reporting.

CMS proposes to designate two categories of physicians and nonphysician EPs for the purposes of applying the VBPM in 2017.

Category 1: This would include solo practitioners who satisfactorily report PQRS quality measures as individuals and group practices that satisfactorily report PQRS quality measures through the GPRO for the purposes of avoiding the 2017 PQRS payment adjustment (2015 reporting year). This category would include groups that do not self-nominate in GPRO under PQRS, but at least 50% of the group’s EPs meet the criteria for satisfactory PQRS reporting as individuals for the purposes of avoiding the 2017 PQRS payment adjustment.

Category 2: This would include all groups and solo practitioners subject to the 2017 VBPM that do not fall under category 1.
If finalized, solo practitioners and group practices in Category 1 would receive a positive, neutral or negative adjustment based on their practice size and quality-tiering score. EPs who fall in category 2 would receive a 4% payment reduction.

**Quality-tiering**

Quality-tiering allows those in Category 1 an opportunity to earn upward payment adjustments for providing high quality, low cost care to Medicare beneficiaries as compared with national benchmarks. Conversely, it puts certain groups at risk of receiving downward adjustments for providing low quality, high cost care.

Currently, only VBPM impacted groups with 100 or more EPs are at risk for potential downward payment adjustments in 2016 based on their 2014 performance under mandatory quality-tiering. Under the proposal, based on how they perform in 2015, groups with 10 or more EPs would be subject to downside risk in 2017 resulting from quality-tiering, while groups with 2-9 EPs and solo practitioners could only receive neutral or positive adjustments. CMS signals its intent to make all groups and solo practitioners subject to downside risk in 2018 through future rulemaking.

For the 2017 VBPM, CMS proposes to apply a maximum 4% penalty under the quality-tiering methodology. Upward payment adjustments earned under quality-tiering would be established by the agency based on the projected aggregate amount of downward payment adjustments determined under budget neutrality requirements.

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+0.0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-2.0%</td>
<td>+0.0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

*Groups and solo practitioners are eligible for an additional +1.0x if reporting PQRS quality measures and their average beneficiary risk score is in the top 25% of all beneficiary risk scores.

**Quality measures**

CMS proposes to include all of the quality measures and reporting mechanisms available under PQRS for the 2015 reporting period (both individual and GPRO).

**Clarification Regarding Treatment of Non-Assigned Claims for Non-Participating Physicians**

CMS clarifies that in 2015 the VBPM would only be applied to assigned services and not to non-assigned services to Medicare beneficiaries.

**Physician feedback and Quality and Resource Use Reports (QRURs)**

CMS plans to make another round of QRURs available in late August or September 2014 for all physicians and groups to measure the resources involved in furnishing care to Medicare fee-for-
service beneficiaries, as well as to provide feedback on 2013 quality performance. The QRURs will display a group practice’s performance on quality and cost measures used to score the VBPM. For group practices of 100 or more EPs who elected the quality-tiering option, CMS has indicated that QRURs will display the group’s 2015 value modifier payment adjustment.

Expansion of the informal inquiry process to allow corrections for the VBPM

CMS proposes to expand the informal inquiry process in 2015 (based on the CY 2013 reporting period) to align with the PQRS information review process. Specifically, the agency is proposing to establish a deadline of Jan. 31, 2015 for a group or solo practitioner to request correction of a perceived error made by CMS in the determination of its CY 2015 VBPM payment adjustment. The agency is seeking comment on an alternative deadline of no later than then Feb. 28, 2015.

For the CY 2016 payment adjustment period, CMS proposes a 30-day review period that would start after the release of the applicable QRURs for groups or solo practitioners to request correction of a perceived error in the 2016 VBPM calculation.

Potential methods to address National Quality Forum (NQF) concerns regarding the total per capita cost measures

To address NQF concerns regarding CMS’ current “two step” attribution method under the VBPM, the agency proposes to move nurse practitioners, physician assistants and clinical nurse specialists from Step 2 of the attribution method to Step 1 and to remove the “pre-step.” If finalized, the agency believes these changes would streamline the attribution process and ensure that beneficiaries can be assigned to group practices comprised of nonphysician EPs.

Additionally, CMS proposes to include certain part-year Medicare fee-for-service beneficiaries not currently considered under the VBPM’s attribution process.