Physician & Freestanding Center Regulatory Update

Since 1992, Medicare has paid for the services of physicians, non-physician practitioners, and certain other providers under the Medicare Physician Fee Schedule (PFS). For reimbursement purposes, relative values are assigned to each of more than 7,000 services to reflect the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice expenses typically involved in furnishing that specific service. After applying a geographic practice cost indicator, the resulting relative value units (RVUs) are summed for each service and multiplied by a fixed-dollar conversion factor to establish the payment amount for each visit or procedure.

The Sustainable Growth Rate (SGR) is a formula adopted by the Balanced Budget Act of 1997 to determine the conversion factor that may result in steep across-the-board reductions in fee schedule reimbursement. The CY 2015 conversion factor (CF) will remain at $35.80 from January 1 through March 31 as mandated by the Protecting Access to Medicare Act. Without a change in the law, effective April 1, 2015, the conversion factor will be $28.22 representing a 21.2 percent decrease. The President's budget calls for averting these cuts and finding a permanent solution to this annual problem. Table 7 (below) shows estimated CY 2015 payment increases or decreases by specialty (without considering the potential conversion factor change).

Radiation Vault

CMS did not finalize its proposal to remove the radiation treatment vault from the direct Practice Expense (PE) input and treat it as part of the infrastructure. The 2015 Final Rule states:[2]

Table 7. Estimated CY 2015 Payment Increases or Decreases by Specialty*

SPECIALTY	ALLOWED CHARGES (MILLIONS)	IMPACT OF WORK RVU CHANGES	IMPACT OF PE RVU CHANGES	IMPACT OF MP RVU CHANGES	COMBINED IMPACT
Hematology and Oncology	$1,811.00	0%	1%	0%	1%
Radiation Oncology	$1,794.00	0%	0%	0%	0%
Radiation Therapy Centers	$57.00	0%	0%	0%	1%

1. Specialty: The Medicare specialty code as reflected in the physician/supplier enrollment files.
2. Allowed Charges: The aggregate estimated PFS allowed charges for the specialty based on CY 2013 utilization and CY 2014 rates.
3. Impact of Work RVU Changes: The estimated CY 2015 impact on total allowed charges of the changes in the work RVUs, including the impact of changes due to new, revised, and misvalued codes.
4. Impact of Practice Expense (PE) RVU Changes: The estimated CY 2015 impact on total allowed charges of the changes in PE RVUs, including the impact due to new, revised, and misvalued codes and miscellaneous minor provisions.
5. Impact of Malpractice (MP) RVU Changes: The estimated CY 2015 impact on total allowed charges of the changes in the MP RVUs, which are primarily driven by the required five-year review and update of MP RVUs.
6. Combined Impact: The estimated CY 2015 combined impact on total allowed charges of all the changes in the previous columns.

* Does not consider the potential conversion factor change.

In previous rulemaking, we indicated that we included the radiation treatment vault as a direct PE input for several recently reviewed radiation treatment codes for the sake of consistency with its previous inclusion as a direct PE input for some other radiation treatment services, but that we intended to review the radiation treatment vault input and address whether or not it should be included in the direct PE input database for all services in future rulemaking. Specifically, we questioned whether it was consistent with the principles underlying the PE methodology to include the radiation treatment vault as a direct cost given that it appears to be more similar to building infrastructure costs than to medical equipment costs.

CMS stated that it understands the essential nature of the vault in the provision of radiation therapy services and its uniqueness to a particular piece of medical equipment, but the agency is not convinced that either of these factors leads to the conclusion that the vault should be considered medical equipment for purposes of the PE methodology under the PFS. Although, CMS did not finalize the proposal at this time, the agency "intends to further study the issues raised by the vault and how it relates to our PE methodology."[2]

Off-Campus Provider-Based Departments

CMS had proposed creating a new modifier to be reported on all services performed in an off-campus provider-based department (PBD), but based on comments received, it has decided to use a new place of service (POS) code for physician claims and a new modifier for hospital claims. This means that CMS will delete POS code 22 (outpatient hospital department) and request two new POS codes from the POS Workgroup. One will be for outpatient services furnished in on-campus, remote, or satellite locations of a hospital. The other will be for services in an off-campus hospital PBD setting that is not a remote location of a hospital, a satellite location of a hospital, or a hospital emergency department. The new POS codes must be used as soon as they are available, but CMS does not expect this to be until July 1, 2015. Providers will be notified prior to the implementation date.

Potentially Misvalued Codes

Consistent with amendments made by the Affordable Care Act (ACA), CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes and make adjustments where appropriate. CMS and the RUC (Relative Value Update Committee) have taken several steps to improve the review process, examining potentially misvalued services in the following seven categories:

1. Codes and families of codes for which there has been the fastest growth
2. Codes and families of codes that have experienced substantial changes in PEs
3. Codes that are recently established for new technologies or services
4. Multiple codes that are frequently billed in conjunction with furnishing a single service
5. Codes with low relative values, particularly those that are often billed multiple times for a single treatment
6. Codes which have not been subject to review since the implementation of the Resource-based Relative Value Scale (RBRVS, the so-called "Harvard-valued codes")
7. Other codes determined to be appropriate by the Secretary.

Section 220(c) of the Protecting Access to Medicare Act of 2014 further expanded the categories of codes to be examined by adding nine additional categories:

1. Codes that account for the majority of spending under the PFS
2. Codes for services that have experienced a substantial change in the hospital length of stay or procedure time
3. Codes for which there may be a change in the typical site of service since the code was last valued
4. Codes for which there is a significant difference in payment for the same service between different sites of service
5. Codes for which there may be anomalies in relative values within a family of codes
6. Codes for services where there may be efficiencies when a service is furnished at the same time as other services
7. Codes with high intra-service work per unit of time
8. Codes with high PE RVUs
9. Codes with high cost supplies.

After considering the comments received, CMS stated that it is appropriate to finalize the high-expenditure screen as a tool to identify potentially misvalued codes. However, given the resources required over the next several years to revalue the services with global periods, CMS will concentrate its efforts on these valuations. Therefore, the agency is not finalizing the codes identified through the high-expenditure screen as potentially misvalued at this time. This means that codes **77263** (Complex clinical treatment plan), **77334** (Complex treatment device), **96372** (Therapeutic injection), **96375** (Therapeutic intravenous push, each additional drug), **96401** (Chemotherapy injection, non-hormonal antineoplastic), and **96409** (Chemotherapy push, each additional drug) will not be reviewed at this time. CMS will re-run the high-expenditure screen at a future date, and at that time will propose the specific set of codes to be reviewed that meet the high expenditure criteria.

After publication of the CY 2014 Physician Fee Schedule final rule with comment period, CMS was made aware that, due to a clerical error, the clinical labor type for CPT code **77293** (Respiratory Motion Management Simulation [list separately in addition to code for primary procedure]) was entered as L052A (Audiologist) instead of L152A (Medical Physicist), which has a higher cost per minute. CMS has corrected the clinical labor type for this service.

Stereotactic Radiosurgery

In the CY 2014 PFS final rule, CMS summarized comments received about whether CPT codes **77372** and **77373** would accurately reflect the resources used in furnishing the typical SRS delivery if there were no coding distinction between robotic and non-robotic delivery methods. SRS services furnished using robotic methods were billed in the non-hospital setting using contractor-priced HCPCS Level II G-codes **G0339** (Image-guided robotic linear accelerator based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment) and **G0340** (Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment). Last year, CMS indicated that it would consider deleting these codes in future rulemaking. However, after considering comments regarding the appropriate inputs to use in pricing the SRS services, CMS concluded that it lacks sufficient information to make a determination about the appropriateness of deleting the G-codes and paying for all SRS/SBRT services using the CPT codes. Therefore, CMS will not delete the G-codes for CY 2015, but will instead work with stakeholders to identify an alternate approach and again reconsider this issue in future rulemaking.

Establishing RVUs

CMS is going to adopt a new process for publicly sharing the proposed values for new and revised procedure codes prior to implementation, but this process will not begin until CY 2016. To allow an opportunity for public input into the values for the 2015 CPT code sets for radiation therapy, CMS will not adopt these new codes under the PFS until CY 2016. CMS describes the implementation of the new process as follows:[2]

As suggested by some commenters, we will use CY 2016 as a transition year. In the PFS proposed rule for CY 2016, we will propose values for the new, revised, and potentially misvalued codes for which we receive the RUC recommendations in time for inclusion in the CY 2016 proposed rule. We will also include proposals for the two code sets delayed from CY 2015 in the CY 2016 proposed rule, as discussed above. For those new, revised, and potentially misvalued codes for which we do not receive RUC recommendations in time for inclusion in the proposed rule, we anticipate establishing interim final values for them for CY 2016, consistent with the current process. Beginning with valuations for CY 2017, the new process will be applicable to all codes. In other words, beginning with rulemaking for CY 2017, we will propose values for the vast majority of new, revised, and potentially misvalued codes and consider public comments before establishing final values for the codes; use G-codes as necessary in order to facilitate continued payment for certain services for which we do not receive RUC recommendations in time to propose values; and adopt interim final values in the case of wholly new services for which there are no predecessor codes or values and for which we do not receive RUC recommendations in time to propose values.

This means that while hospitals will use the new CPT procedure codes for radiation treatment delivery and image guidance, physicians and freestanding radiation treatment centers will use HCPCS Level II G-codes referenced in Table 1, page 11. CMS further states:[2]

There is substantial work to be done to assure the new valuations for these codes accurately reflect the coding changes. Accordingly we are delaying the use of the revised radiation therapy code set until CY 2016 when we will be able to include proposals in the proposed rule for their valuation. We are maintaining the inputs for radiation therapy codes at the CY 2014 levels. [Note: Due to budget neutrality adjustments and other system-wide changes, the payment rates may change.] Since the code set has changed and some of the CY 2014 codes are being deleted, we are creating G-codes as necessary to allow practitioners to continue to report services to CMS in CY 2015 as they did in CY 2014 and for payments to be made in the same way. All payment policies applicable to the CY 2014 CPT codes will apply to the replacement G-codes. The new and revised CY 2015 CPT codes that will not be recognized by Medicare for CY 2015 are denoted with an "I" (Not valid for Medicare purposes). [Table 1, page 11] *lists the G-codes that we are creating and the CY 2014 CPT codes that they are replacing.*

CMS also finalized the interim RVUs for hyperthermia and HDR brachytherapy, and increased the equipment time from 86 minutes to 104 minutes for codes **77373** (SBRT), **77422**, and **77423** (neutron treatment). Last, the RUC made a recommendation regarding the practice expense inputs for digital imaging services. CMS accepted the RUC recommendations to remove the film supply and equipment items and to allocate minutes for a desktop computer as a proxy for the PACS (Picture Archiving and Communication System) workstation as a direct expense. This policy impacts new brachytherapy isodose plan codes **77316**, **77317**, and **77318**.

Locum Tenens

In the 2015 proposed PFS rule CMS indicated concern about the operational and program integrity issues that result from the use of substitute physicians to fill staffing needs or to replace a physician who has permanently left a medical group or employer. There are concerns that a physician who has left a group may still have claims filed in his or her name and NPI (national provider identification) number, as well as the SSA requirement for the locum tenens identifying information to be submitted with each claim. As a result, CMS solicited comments on the policy for substitute physician billing arrangements. Through this solicitation, the agency hoped to understand better current industry practices for the use of substitute physicians and the impact that policy changes limiting the use of substitute physicians might have on beneficiary access to physician services. CMS received a few comments on the issues raised in this

solicitation and will carefully consider these comments in any future rulemaking on this subject.

Concerns with the 10-day and 90-day Global Packages

CMS supports bundled payments as a mechanism to incentivize high-quality, efficient care. Although on the surface, the PFS global codes appear to function as bundled payments similar to those Medicare uses to make single payments for multiple services to hospitals under the Inpatient and Outpatient Prospective Payment Systems, CMS believes that these global codes function significantly differently than other bundled payments. Another concern is that payment for the PFS global packages relies on valuing the combined services together. This means that there are no separate PFS values established for the procedures or the follow-up care, making it difficult to estimate the costs of the individual global code component services. After consideration of all the comments received regarding this proposal, CMS finalized the proposal to transition and revalue all 10- and 90-day global surgery services with 0-day global periods, beginning with the 10-day global services in CY 2017 and following with the 90-day global services in CY 2018. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure. This change will affect some brachytherapy procedures and related surgical services.

Open Payments Update

The Open Payments program establishes a system for annual reporting and increasing public awareness of financial relationships between drug and device manufacturers and certain healthcare providers. The Open Payments program requires applicable manufacturers to report payments or other transfers of value they make to physicians and teaching hospitals to CMS. In its final rule, CMS finalized four changes to this program:[2]

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. According to CMS, eliminating the exemption for payments to speakers at certain accredited or certifying continuing medical education (CME) 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 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. This will enable the collection of more specific data regarding the forms of payment made by applicable manufacturers.

Based on public comments and manufacturers' need to update their systems according to the new requirements, these changes will be implemented for data collection in CY 2016.

Other Issues

In addition to the specific topics listed above, CMS also provided details on the Physician Compare Website, the Electronic Health Record Incentive Program, the Medicare Shared Savings Program, value-based modifiers, the Physician Self-Referral Prohibition, and Physician Quality Reporting Systems. OI

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2. 2015 Medicare PFS Final Rule. Available online at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html?DLPage=1&DLSort=2&DLSortDir=descending. Last accessed Dec. 9 2014.