2013 Medicare Physician Fee Schedule
Final Rule Summary

On Friday, November 16, 2012, the Centers for Medicare and Medicaid Services (CMS) published the final Medicare Physician Fee Schedule (PFS) Rule for 2013 in the Federal Register. The final rule updates payment policies and payment rates for services furnished under the PFS and includes changes to the quality reporting initiatives associated with the PFS – the Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, and the physician value-based payment modifier.

The rule in its entirety can be found here. The addenda to the rule, including Addendum B, which lists the proposed RVUs for each CPT code, can be found here. The provisions of the rule will be effective January 1, 2013 unless stated otherwise. For those provisions subject to comment, comments may be submitted by COB December 31, 2012.

The following summarizes the major provisions of the proposed rule.

SGR and Conversion Factor (CF) Impact

The current CF, which expires on December 31, 2013, is $34.0376. Without congressional action, the CF will be reduced by 26.5 percent to $25.0008 due to the SGR formula. Congress has prevented reductions in the CF due to the SGR formula for a number of years and it is anticipated that it will once again take action to prevent the scheduled 26.5 percent reduction from taking effect. Whether this involves another short term "fix" such as freezing the current CF for a period of time or a more substantial revision of the SGR formula is not at all clear. Because of policy and payment changes made in this rule, the current CF must be adjusted to $34.0230 to preserve budget neutrality. For that reason, the charts accompanying this summary utilize a CF of $34.0230 for purposes of projecting the impact of this rule on services provided by epilepsy centers.

Impact on Epilepsy Center Services

Table 134 (see Attachment 1), extracted from the rule, provides a summary of the impact of the proposed changes in work and practice expense values by specialty. All of these changes are budget neutral in the aggregate which explains why the impact for all physicians is shown as zero. The overall impact of the 2013 final rule on neurology is shown as minus 7 percent. There are significant changes to the motor and sensory nerve conduction tests occurring in 2013, which is the cause of this reduction. We do not believe that epileptologists will face such a reduction. In fact, payment for almost all diagnostic services provided by epilepsy centers will increase in 2013 with some services provided in physician offices increasing substantially. The professional component payments for most of diagnostic services and epilepsy surgery services are remaining relatively stable.

Overall, E/M services will see little change. Lower level office visits will be slightly reduced while the highest levels of office visits commonly billed by neurologists will see modest increases. Hospital visits and critical care E/M services will see minimal increases.

TABLE 134: CY 2013 PFS Final Rule Estimated Impact on Total Allowed Charges by Specialty*

(A)	(B)	(C)	(D)	(E)
Specialty	Allowed Charges (mil)	Impact of Work & MP RVU Changes	Impact of PE RVU Changes	Combined Impact

TOTAL	$86,558	0%	0%	0%
NEUROLOGY	$1,604	-2%	-5%	-7%
NEUROSURGERY	$687	0%	0%	0%

Post-Discharge Transitional Care Management Services.
CMS has proposed payment for two new codes for transitional care management (TCM) services provided to patients being discharged from acute, rehabilitation, or long-term acute hospital stays or skilled nursing facility (SNF), or community mental health center stays into the community. Primary care providers and specialists (including the discharging physician) can bill these for new services within 30 days following discharge. CMS stated that any physician who is enrolled in Medicare may bill for the TCM service. Transitional care management requires a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames.

The new CPT codes 99495 and 99496 established to report TCM services beginning in 2013 are defined in the rule as follows:

Code 99495 Transitional Care Management – moderate complexity:
- Communication (direct contact, telephone, electronic with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity in the service period
- Face-to-face visit within 14 days of discharge

Code 99496 Transitional Care Management – high complexity:
- Communication (direct contact, telephone, electronic with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity in the service period
- Face-to-face visit within 7 days of discharge

CMS expects that that the services in the following two lists of non-face-to-face services will be routinely provided as part of a TCM service unless the practitioner's reasonable assessment of the patient indicates that a particular service is not medically indicated or needed.

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, and may include:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Communication with home health agencies and other community services utilized by the patient.
- Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living.
- Assessment and support for treatment regimen adherence and medication management.
- Identification of available community and health resources.
- Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provide and may include:
- Obtaining and reviewing the discharge information (for example, discharge summary, as available, or continuity of care documents).
- Reviewing need for or follow-up on pending diagnostic tests and treatments.

- Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems.
- Education of patient, family, guardian, and/or caregiver.
- Establishment or reestablishment of referrals and arranging for needed community resources.
- Assistance in scheduling any required follow-up with community providers and services.

Code 99495 has been assigned a total value of 4.82 relative value units and Code 99496 a total value of 6.79 relative value units. Using a CF of $34.0066, the national payment rate for these codes would be $163.91 and $230.56, respectively. Please note that the initial face-to-face visit within the 14-day period for Code 99495 and within the 7-day period for Code 99496 is not separately billable but rather is bundled into the TCM code. However, all other medically necessary visits after that initial post discharge visit are payable.

CMS clearly intended this change to benefit primary care physicians; however, the proposal was not written in a way to restrict the use of the code only to family physicians and other primary care providers. CMS states in the rule that any physician who is enrolled in Medicare may bill for the TCM service and that while they expect that most community physicians who furnish TCM services will be primary care physicians and practitioners, they recognize that there will be circumstances in which "cardiologists, oncologists or other specialists" will be in the best position to provide transitional care.

Surgeons whose post discharge care is included in their 10-day or 90-day global fee are not eligible to bill the TCM codes. In addition, physicians who bill home health or hospice care plan oversight codes (G0181 and G0182) cannot bill for TCM since that would be considered duplicative services. CMS will allow a physician billing for hospital discharge codes (99238 or 99239) to bill TCM services.

A number of technical questions issues were raised in the comments and CMS provided guidance as follows:

- A TCM code can only be billed once in a 30-day period following discharge even if the patient has a second admission and discharge. Presumably if the second discharge occurred more than 30 days after the initial hospital stay, a TCM code could be billed a second time assuming of course that all the requirements have been met.

- Only one physician can bill a TCM code for a single discharge. While CMS expects that conflicts will be worked out between physicians on who can bill the TCM code, if bills for multiple physicians are received, the first one received will generally be paid.

- In general, CMS expects the TCM code to be billed at the end of 30 days post discharge. (Note, it is not totally clear how this will be coordinated with the requirement that the initial post discharge visit is included in the TCM payment.

- A physician or other qualified health care professional who reports codes 99495, 99496 may not report care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), anticoagulant management (99363, 99364), medical team conferences (99366-99368), education and training (98960-98962, 99071, 99078), telephone services (98966-98968, 99441-99443), end stage renal disease services (90951-90970), online medical evaluation services (98969, 99444), preparation of special reports (99080), analysis of data (99090, 99091), complex chronic care coordination services (99481X- 99483X), medication therapy management services (99605-99607), during the time period covered by the transitional care management services codes

CMS will be issuing manual instructions amplifying the requirements for billing the TCM codes and physicians will presumably also receive guidance from their Medicare contractor.

Payment for Molecular Pathology Services In the proposed rule, CMS invited comments on whether newly created molecular pathology CPT codes should be paid under the MPFS or the Clinical Laboratory Fee Schedule (CLFS). CMS decided to include the molecular pathology CPT codes under the CLFS because the services do not ordinarily require interpretation by a physician to produce a meaningful result. CMS accepted the argument that non-physician geneticists can provide the necessary interpretation for a meaningful test result of a molecular pathology test if some interpretation is required and that physician interpretation currently is not typical across molecular pathology services.

CMS did state that they recognize that there may be situations where a physician interpretation of a molecular pathology test might be needed and they established a new HCPCS code G0452 (molecular pathology procedure; physician interpretation and report) to describe medically necessary interpretation and written report of a molecular pathology test, above and beyond the report of laboratory results.

RUC Review of Potentially Misvalued Codes

At the direction of CMS, the AMA's Relative Value Update Committee (RUC) has reviewed the relative values assigned to various categories of services. CMS has typically identified for review, codes with substantial growth in utilization, codes billed in multiple units, and codes for which the site of service had changed. In this rule, CMS is proposing two new categories of potentially misvalued codes for review: CPT codes that have not been valued since the implementation of the fee schedule, (known as "Harvard-valued" codes) with Medicare annual allowed charges of $10 million or more; and CPT codes without physician work values with stand-alone practice expense procedure times.

In reviewing the list of "Harvard-valued" codes that CMS is directing the RUC to review next year, we have not identified any of interest to NAEC. Under the second new category of potentially misvalued codes, CMS is finalizing their proposal to significantly reduce the RVUs for two radiation therapy services: intensity modulated radiation treatment (IMRT) and stereotactic body radiation therapy (SBRT).

Pharmacy Billing for Part B Drugs

CMS clarifies in the final rule that only physicians not pharmacies or DME suppliers are allowed to bill Medicare for drugs administered to beneficiaries in physician offices. Due to some miscommunication by one or more Medicare contractors, it was erroneously assumed by some physicians and pharmacies that it was acceptable for pharmacies to bill for Part B drugs provided to patients "incident to" the physician service.

DME Requirement for Face-to-Face Contact by Physicians

CMS is finalizing its proposal to require that a physician (or a PA or NP) must have evaluated a beneficiary and have conducted a needs assessment no more than 90 days before writing an order for certain items of durable medical equipment. Among the designated items of DME are hospital beds, wheelchairs, seat lift chairs, ventilation assist devices, nebulizers, and TENS units

Telemedicine

CMS has added a number of preventive screening services to the list of services that can be provided as a telehealth services. This includes alcohol, drug and depression screening.

Multiple Procedure Payment Reduction

Currently there is a reduction in the practice expense payment for multiple imaging and therapy services provided on the same day. The rationale is that there are economies when more than one procedure is

performed on the same day such as reduced pre-service activities like greeting and gowning the beneficiary, obtaining the vital signs, providing pre-education/obtaining consent, preparing the room and equipment, and preparing the patient and post-service activities like cleaning the room and providing home care instructions to the beneficiary. CMS is now expanding this concept to multiple ophthalmology and cardiovascular diagnostic tests.

Therapy Service Reporting

For a number of years, CMS, MedPAC and the Congress has been very concerned about the growth of spending for physical, occupational and speech therapy services. An annual per beneficiary cap was established as a limit on expenditures, which could be exceeded only if documentation was maintained to establish medical necessity for services in excess of the cap. As a first step to establishing an improved payment system that would provide incentives for the efficient delivery of therapy services, therapists will begin reporting in 2013 a series of non-payable codes describing the treatment goals and the patient's functional progress.

Physician Quality Reporting System (PQRS)

CMS finalized its proposed policies for PQRS. There are two ways an eligible professional can participate in PQRS: 1) as an individual or 2) as part of a group practice participating in the PQRS group practice reporting option (GPRO). Individuals who successfully report quality measures in 2013 and 2014 will receive a bonus payment of 0.5 percent of total allowed charges for services provided during the reporting period. Eligible professionals must report at least 3 measures or if less than 3 apply to the professional 1 or 2, AND report each measure for at least 50% of the Medicare Part B patients seen during the reporting period. If reporting by registry, at least 3 measures must be reported for 80% of patients. Tables 90 and 91 (pg. 69196-69194) and 92 and 93 for group practices (pg. 69199-69200) provide a summary of the final criteria for reporting in 2013 and 2014. Like last year, an additional 0.5 percent will be available for those who participate in a maintenance of certification (MOC) program required for board certification by a recognized physician specialty organization.

The reporting period for the 2015 incentive payment is calendar year 2013 or if reporting by registry, the reporting period is the 6-month period of July 1, 2013 – December 31, 2013. The reporting period for 2016 follows a similar timeframe in CY 2014. For payment adjustments starting in 2017, the 6-month reporting period is being eliminated.

Providers who do not report quality measures in 2013 will be subject to a payment adjustment in 2015 of -1.5 percent and -2.0 percent in 2016. To avoid the payment adjustment in 2015, CMS is proposing that individual eligible professionals successfully report 1 PQRS measure or measure group for at least 1 applicable patient using the claims, registry, or EHR reporting and group practices successfully report 1 measure or measure group by registry. Individuals that meet the criteria for the 2015 or 2016 incentive payments would not be subject to the adjustment.

CMS proposes to include 264 individual measures and 26 measure groups for individuals and group practices to report in CY 2013 and 2014. There are three epilepsy measures approved by CMS for 2013. They are:

- Documentation of Current Seizure Frequency(ies) of each current seizure type (#266)
- Documentation of Epilepsy Etiology or Epilepsy Syndrome (#267)
- Counseling for Women of Childbearing Potential with Epilepsy (#268)

For determining payment adjustments in 2015 only, CMS will allow individuals and group practices to use an administrative claims reporting mechanism. Through this mechanism, participants do not submit quality data codes. Rather, CMS analyzes the individual eligible professional's or group practice's claims during the reporting period (CY 2013) to determine whether any of the clinical quality actions listed in

Tables 123 and 124 (pg. 69287-29287) have been performed. To avoid the payment adjustment in 2015 all measures in Tables 123 and 124 must be reported for 100 percent of the cases in which the measures apply.

CMS finalized its proposal to expand the definition of a group practice to include groups of at least 2 eligible professionals (groups were previously > 25), who reassign their billing rights to the group's tax ID number (TIN). Groups must send a self-nomination letter to CMS and declare the reporting mechanism they will use for the reporting period. Self-nomination must occur before October 15 of the reporting year. Groups of 2-99 eligible professionals may use of claims, registry, and EHR reporting (starting in 2014) or the administrative claims option. Groups participating in Medicare's Shared Savings Program as ACOs and other programs are subject to different requirements. Groups of 25 or more eligible professionals may use the GPRO web interface.

More information on PQRS can be found here.

Electronic Prescribing (eRx) Incentive Program

CMS uses a combination of incentive payments and penalties to encourage electronic prescribing. Through 2013, successful e-prescribers are provided incentive payments of 0.5%. In 2013, CMS will apply a payment adjustment of -1.5% for non-successful e-prescribers, which will increase to -2% in 2014. Eligible professionals are identified by NPI or TIN. CMS is finalizing its proposal to define group practices under the eRx program as including groups of 2 – 24 similar to the definition of groups under PQRS. In addition, CMS finalized two additional hardship exemptions for eligible professionals participating in the EHR Incentive Program. Tables 125 and 126 in the rule summarize the hardship exemptions in 2013 and 2014, respectively.

To successfully participate in the eRx program, eligible professionals must submit e-prescribing measures for at least 25 unique electronic prescribing events in 2013. CMS changed its proposal for group practices with 2-24 professionals to only require the reporting of 75 measures (the proposed rule had required 225 measures). Group practices of 25-99 must report 625 measures; and groups of 100 or more must report 2,500 unique measures. Eligible professionals can report via claims, qualified registry or qualified EHR; however, the requirement must be met by reporting through a single mechanism.

More information on the eRx incentive program, including the informal review process, can be found here.

Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program

The establishment of a value-based payment modifier (VBM) was mandated by the ACA in order to provide differential payment to physicians and group practices based upon the quality of care furnished to Medicare beneficiaries compared to the cost of that care during a specific performing period. The statute requires the VBM be implemented in a budget neutral manner. In the final rule, CMS decided to limit the VBM in CY 2015 to groups of physicians with 100 or more eligible professionals. CMS is proposing to apply the VBM at the TIN level for the group practice; meaning if a physician moves from one group to another between 2013 and 2015 his/her payment will be adjusted based on the 2013 TIN. CY 2014 will be the performance period for VBM in 2016. The VBM will apply to all physicians in CY 2017.

In CY 2015, the VBM will be based on the group's participation in the PQRS program. Groups that participate in the PQRS GPRO and report at least 1 measure or groups that elect the administrative claims option in 2013 will not be penalized under the VBM program (their PQRS payments would not be affected). Groups can also choose to participate in the quality tiering option, which would allow the group to earn a positive payment adjustment for high performance. Under the quality tiering approach CMS will establish national benchmarks for the PQRS quality measures and grade practices against these

benchmarks. Groups participating in Medicare Shared Savings Program (ACOs) cannot participate in the quality tiering option. Groups that do not participate in PQRS or didn't qualify for a PQRS incentive payment in 2013 would receive a VBM adjustment of -1.0%.

Since 2010, CMS has provided confidential physician feedback reports to certain physicians and group practices. The reports compare quality of care and costs among the physicians and groups. Starting in 2013, CMS will include the value-based modifier score in these reports.

More information on the value-based modifier program can be found here.

Physician Compare Website

Physician Compare is a website with information on physicians and other providers who bill Medicare. The website was launched in 2010 and more information on participating providers has been added each year. CY 2013 is the first year for which CMS is required to publish information on physician performance on quality and patient experience measures.

For 2013, CMS will use data reported under existing CMS reporting systems, such as the Physician Quality Reporting System (PQRS), PQRS Group Practice Reporting Option (GPRO), Medicare EHR Incentive Program and Shared Savings Program, for those providers who participate in these programs. For the Medicare EHR Incentive Program and the PQRS Cardiovascular Prevention measures group, CMS will just report the names of providers who participate, while CMS will report data on specific quality measures for the other programs. For all data sources, CMS will only post data that is technically feasible, available, that meet a minimum sample size and that are statistically valid and reliable.

More information on the Physician Compare initiative is available here.

APPENDIX A

TABLE 134: CY 2013 PFS Final Rule Estimated Impact on Total Allowed Charges by Specialty*

(A)	(B)	(C)	(D)	(E)
Specialty	**Allowed Charges (mil)**	**Impact of Work & MP RVU Changes**	**Impact of PE RVU Changes**	**Combined Impact**
TOTAL	$86,558	0%	0%	0%
ALLERGY/IMMUNOLOGY	$200	0%	3%	3%
ANESTHESIOLOGY	$1,923	0%	1%	1%
CARDIAC SURGERY	$369	0%	-1%	-1%
CARDIOLOGY	$6,733	-1%	-2%	-2%
COLON AND RECTAL SURGERY	$153	0%	2%	2%
CRITICAL CARE	$263	0%	1%	1%
DERMATOLOGY	$3,024	0%	0%	0%
EMERGENCY MEDICINE	$2,839	0%	0%	0%
ENDOCRINOLOGY	$437	0%	1%	1%
FAMILY PRACTICE	$5,943	2%	4%	7%
GASTROENTEROLOGY	$1,896	0%	0%	0%
GENERAL PRACTICE	$587	0%	1%	1%
GENERAL SURGERY	$2,283	0%	1%	0%
GERIATRICS	$220	1%	3%	5%
HAND SURGERY	$135	0%	1%	1%
HEMATOLOGY/ONCOLOGY	$1,909	0%	2%	2%
INFECTIOUS DISEASE	$629	0%	1%	1%
INTERNAL MEDICINE	$11,163	2%	3%	4%
INTERVENTIONAL PAIN MGMT	$539	0%	1%	1%
INTERVENTIONAL RADIOLOGY	$204	0%	-2%	-3%
MULTISPECIALTY CLINIC/OTHER PHY	$81	0%	0%	-1%
NEPHROLOGY	$2,080	0%	0%	0%
NEUROLOGY	$1,604	-2%	-5%	-7%
NEUROSURGERY	$687	0%	0%	0%
NUCLEAR MEDICINE	$49	0%	-2%	-3%
OBSTETRICS/GYNECOLOGY	$704	0%	0%	0%
OPHTHALMOLOGY	$5,645	-3%	0%	-3%
ORTHOPEDIC SURGERY	$3,643	0%	0%	0%
OTOLARNGOLOGY	$1,076	0%	2%	2%
PATHOLOGY	$1,210	0%	-6%	-6%
PEDIATRICS	$65	1%	3%	3%
PHYSICAL MEDICINE	$999	-1%	-3%	-4%
PLASTIC SURGERY	$356	-1%	1%	1%

PSYCHIATRY	$1,170	-1%	3%	2%
PULMONARY DISEASE	$1,703	0%	1%	1%
RADIATION ONCOLOGY	$1,988	0%	-7%	-7%
RADIOLOGY	$4,818	0%	-3%	-3%
RHEUMATOLOGY	$548	0%	0%	0%
THORACIC SURGERY	$343	0%	-1%	-1%
UROLOGY	$1,918	0%	-1%	-1%
VASCULAR SURGERY	$888	0%	-2%	-2%
AUDIOLOGIST	$57	0%	-4%	-4%
CHIROPRACTOR	$746	0%	1%	1%
CLINICAL PSYCHOLOGIST	$575	1%	-3%	-2%
CLINICAL SOCIAL WORKER	$406	1%	-3%	-2%
DIAGNOSTIC TESTING FACILITY	$888	0%	-7%	-7%
INDEPENDENT LABORATORY	$1,073	0%	-14%	-14%
NURSE ANES / ANES ASST	$1,104	0%	1%	1%
NURSE PRACTITIONER	$1,623	1%	3%	4%
OPTOMETRY	$1,061	-1%	1%	1%
ORAL/MAXILLOFACIAL SURGERY	$45	0%	1%	1%
PHYSICAL/OCCUPATIONAL THERAPY	$2,636	0%	4%	4%
PHYSICIAN ASSISTANT	$1,229	1%	2%	3%
PODIATRY	$1,925	0%	2%	2%
PORTABLE X-RAY SUPPLIER	$106	0%	5%	5%
RADIATION THERAPY CENTERS	$72	0%	-9%	-9%
OTHER	$19	0%	1%	1%

* Table 134 shows only the proposed payment policy impact on PFS services. We note that these impacts do not include the effects of the negative January 2013 conversion factor change under current law.