NATIONAL ASSOCIATION OF EPILEPSY CENTERS
NAEC

2014 Medicare Physician Fee Schedule Final Rule Summary

On Wednesday, November 27, 2013, the Centers for Medicare and Medicaid Services (CMS) released the final Medicare Physician Fee Schedule (PFS) for 2014. The proposed 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 Shared Savings Program (ACOs), the EHR meaningful use program, and the physician value-based payment modifier.

The rule in its entirety and the addenda, 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, 2014 unless stated otherwise.

The following summarizes the major provisions of the final rule, including the PQRS program.

SGR and Conversion Factor (CF) Impact

In December Congress passed a short term 0.5% increase in the Medicare conversion factor, preventing the 24% reduction being driven by the Sustainable Growth Rate (SGR) formula. The CF in effect from January 1, 2014 – March 31, 2014 is $35.82.

It is anticipated that Congress will return to working on legislation to permanently repeal the SGR and reform Medicare physician payment policy early in 2014. Late last year, the Senate Finance Committee passed a bill to eliminate the SGR formula replacing it with a 10 year freeze in the CF and the House Ways and Means Committee's passed bill included a 3 year 0.5% increase in the CF followed by a 7 year freeze. Both these Committees, along with the House Energy and Commerce Committee which passed its bill earlier in the year, also authorize a Value Based Performance (PBP) program that will further determine physician payment. The VBP program would assess eligible professionals' performance in four categories: 1) Quality (PQRS); 2) Resource Use; 3) Clinical Practice Improvement Activities; and 4) EHR Meaningful Use. It is anticipated that Congress will attempt to finalize these bills prior to the expiration of the short-term fee fix in April.

Specialty Impact

Table 93 (see Attachment 1), extracted from the rule, provides a summary of the impact of the final changes in the rule by specialty. This chart does not include the impact of any reductions caused by the SGR. The changes in the rule are budget-neutral in the aggregate which explains why the impact for all physicians (i.e., total row) is shown as zero. Most specialties will see changes in the range of plus or minus 3%. The specialties which see a change in excess of 5 percent include: pathology (-6%), psychiatry (+6%), clinical psychologist and clinical social worker (+8%), chiropractor (+12 %), and diagnostic testing facility (-11%).

Impact on Neurological Services - CMS estimates a net overall change of minus 1 percent for neurology without regard to any SGR reduction for all physicians. Attached to this summary are several charts comparing payment for evaluation and management services (E/M) and neurology procedural services in 2013 to 2014.

The impact of the rule on neurologists will be as follows. Office-based E/M services would see minimal changes – the lower level services would be slightly reduced while the higher levels of office visits would see slight increases. The professional component values for most neurophysiology services also will increase slightly as will hospital visits. The values for most procedures performed in the physician office

setting are being reduced with some of the short term EEGs (95816 – 95822), muscle tests (95867 – 95869), and nerve function and evoked potential services seeing reductions around 20% or greater. Most of these changes are due to the proposed shifting of relative values from practice expense to professional physician work due to the recalibration of the medical economic index (discussed below).

Mis-valued Codes

Caps on Practice Expense RVUs for office-based services – In the proposed rule, CMS planned to cap the practice expense RVUs assigned to certain codes provided in the non-facility (office) setting using the hospital outpatient prospective payment system (HOPPS) as a limit. This would have had a large adverse impact on many neurology services. ACNS and AAN, along with many other specialty societies commented on this proposal pointing out its flaws. Based on these comments, CMS decided not to finalize this proposal at this time.

Medicare Economic Index (MEI)

CMS is revising the calculation of the MEI, which is the price index used to update physician payments for inflation by changing the relative RVU weights assigned to physician work and practice expense, resulting in a redistribution of payment from PE to physician work as shown below:

	Current	2014
Physician Work	48.266%	50.866%
Practice Expense	51.734%	49.134%
Total MEI	100%	100%

This change is generally beneficial to services performed in a hospital setting with relatively lower practice expense shares as compared with the share assigned to professional work. Thus, specialties such as anesthesiology were advantaged by the change while specialties with relatively higher practice expense shares such as diagnostic testing facilities, allergy and dermatology were cut significantly. For neurologists, services performed in hospital settings such as hospital visit codes and procedural services done in a facility setting generally benefited by the change while it is disadvantageous to office-based services.

Geographic Practice Expense Index (GPCI)

The GPCI is an adjustment CMS calculates and applies to both the work and practice expense relative value units for each code to reflect differences in labor, rent and other cost elements based on geographic areas. CMS changed its GPCI policies for 2014 using updated data and changed the weights assigned to each GPCI consistent with the proposed MEI change. These changes will be phased in over 2014 and 2015. A complete listing of the changes can be found in Addenda D and E.

Incident-to Requirements

Currently when a service is billed by a non-physician practitioner (e.g. physician assistant, nurse practitioner) the regulations require that the practitioner meet any State law requirements to be eligible to provide the service. However, the same requirement does not exist when services are performed in whole or in part by auxiliary personnel but billed in the name of the physician under Medicare's "incident to" requirements. CMS is modifying the "incident to" rules to specify that all services and supplies must be furnished in accordance with applicable State law and that auxiliary personnel performing "incident to" services must meet any applicable State requirements, including State licensure, to perform the service.

Complex Chronic Care Management Services

As part of CMS ongoing effort to enhance payment for primary care, for CY 2015, CMS is establishing a separate payment for complex chronic care management services furnished to patients with multiple (two or more) complex chronic conditions that are expected to last at least 12 months or until death, and that

place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Complex chronic care management services include physician development and revision of a plan of care, communication with other treating professionals, and medication management.

In the final rule, CMS decided to establish a single code defined as follows: GXXX1 Chronic care management services furnished to patients with multiple (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; 20 minutes or more; per 30 days. The service could be provided by the physician and/or by staff under the physician's direction. CMS is not proposing any suggested RVUs for these codes at this time but invites comments on the work and PE that might be assigned to these codes.

All of the complex chronic care management services, described in the rule, that are relevant to the patient must be furnished in order to bill this code. If a face-to-face visit is provided during the 90-day period by the practitioner who is furnishing complex chronic care management services, the practitioner should report the appropriate evaluation and management code in addition to the chronic care management code.

CMS indicates that complex chronic care management services include transitional care management services (CPT 99495, 99496), home health care supervision (HCPCS G0181), and hospice care supervision (HCPCS G0182). To avoid what it considers duplicate payment, CMS stated that these services may not be billed separately during the same 30 day period of time. In addition, multiple practitioners cannot bill for chronic care management for the same period of time.

CMS proposed the following as potential requirements:

- Practitioner must be using a certified Electronic Health Record (EHR) for beneficiary care that is integrated into the practice to support access to care, care coordination, care management and communication.

- Practitioner must employ one or more advanced practice registered nurses or physicians assistants whose responsibilities include providing complex chronic care management.

- Written protocols must be established that describe:
  - methods for furnishing complex chronic care management services
  - strategies for systematically furnishing health risk assessments to identify all eligible beneficiaries
  - procedures for informing eligible beneficiaries about complex chronic care management services and obtaining their consent
  - steps for monitoring the medical, functional and social needs of all beneficiaries receiving complex chronic care management services
  - system based approaches to ensure timely delivery of all recommended preventive care services to beneficiaries; communicating common and anticipated clinical and non-clinical issues to beneficiaries
  - care plans for beneficiaries post-discharge from an emergency department or other institutional health care setting
  - a systematic approach to communicate and electronically exchange clinical information with and coordinate care among all service providers involved in the ongoing care of a beneficiary receiving complex chronic care management services

- a systematic approach for linking the practice and a beneficiary receiving complex chronic care management services with long-term services
- a systematic approach to the care management of vulnerable beneficiary populations such as racial and ethnic minorities and people with disabilities
- patient education to assist the beneficiary to self-manage a chronic condition

Several societies raised questions about the necessity for some of the proposed requirements such as the need to employ advanced practice nurses. CMS responded to most of the comments by indicating that they would be considered for future rulemaking. CMS did accept the suggestion to make it clear that specialists can utilize this code in addition to primary care physicians. However, they did not accept the suggestion that management of a single chronic condition could qualify for use of the code - 2 or more chronic conditions must be present.

Physician Quality Reporting System (PQRS)

Those who successfully report quality measures in 2014 will receive a bonus payment of 0.5 percent of total allowed charges for services provided during the reporting period. 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 in 2014. As mandated by Congress, those providers who do not report quality measures in CY 2014 will have their payments adjusted in CY 2016. The initial penalty will be -2.0 percent.

In the final rule, CMS takes steps to align reporting requirements across its quality programs, including the PQRS, the Medicare Shared Savings Program (ACOs), the EHR Incentive Program and the value-based payment modifier.

Reporting Mechanisms. PQRS continues to provide eligible professionals with reporting mechanism options. The program retained the claims, registry, EHR, administrative claims and the GPRO web-interface options and added a new certified survey vendor reporting mechanism for the purposes of reporting CG CAHPS measures and a qualified clinical data registry reporting mechanism.

- *Clinical Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) Survey*. CMS is proposing the option of completing CG CAHPS survey to satisfy the 2014 incentive and to avoid the 2016 payment adjustment.

- *Qualified Clinical Data Registries.* This new reporting mechanism will allow eligible professionals to use the measures in a clinical data registry to satisfy the PQRS reporting requirements. Eligible professionals would report on all patients, regardless of whether they are Medicare Part B patients. To receive the 2014 PQRS incentive payment, providers participating in qualified registries must report at least 9 measures covering at least 3 of the National Quality Strategy (NQS) domains and report each measure for at least 50% of the provider's applicable patients. To avoid the penalty in 2016, providers must report3 measures covering 1 NQS domain for 50% of applicable patients. These registries will be held to stringent standards; specifically, they must be capable of benchmarking

Criteria to Satisfactorily Report. All eligible professionals who satisfy the requirements to earn an incentive payment in 2014 will not be subject to the payment adjustment in 2016. To earn the incentive and avoid the payment adjustment, eligible providers are required to report at least 9 measures covering 3 of the National Quality Strategy domains for 50 percent of the Medicare Part B patients they see during the reporting period. Complete details on the reporting requirements by reporting method can be found in the table below. CMS will continue to allow eligible professionals using the claims-based reporting mechanism to report 3 measures on 50 percent of their applicable patients to avoid the payment adjustment.

Reporting for Individual Eligible Professionals

Claims-Based Reporting	
Reporting Criteria	Reporting Period
- Report at least 9 PQRS measures covering at least 3 of the National Quality Strategy domains, OR, - If less than 9 measures apply to the eligible professional, 1-8 measures, AND - Report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. - Measures with 0% performance rate will not be counted.	12 month (January 1 - December 31)
Registry-Based Reporting	
Reporting Criteria	Reporting Period
- Report at least 9 PQRS measures, covering at least 3 of the National Quality Strategy domains, AND - Report each measure for at least 50% of Medicare Part B FFS patients to which the measure applies. - Measures with a 0% performance rate will not be counted	12 month (January 1 - December 31)
Qualified Clinical Data Registry	
Reporting Criteria	Reporting Period
- Report at least 9 PQRS measures available for reporting under a qualified clinical data registry covering at least 3 of the National Quality Strategy domains, AND - Report each measure for at least 50% of the eligible professional's patients. - Of the measures reported via a clinical data registry, at least one reported measure must be an outcomes measure.	12 month (January 1 - December 31)

Reporting for Group Practices

Qualified Registry – 2+ Eligible Professionals	
Reporting Criteria	Reporting Period
- Report at least 9 PQRS measures covering at least 3 of the National Quality Strategy domains, AND - Report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. - Measures with 0% performance rate will not be counted.	12 month (January 1 - December 31)
Certified Survey Vendor + Qualified Registry, Direct EHR Product, EHR Data Submission Vendor or GPRO Web Interface – 25+ Eligible Professionals	
Reporting Criteria	Reporting Period
- Report all CG CAHPS survey measures via certified survey vendor, AND - Report all 6 measures covering at least 2 of the National Quality Strategy domains	12 month (January 1 - December 31)

Quality Measures. CMS finalized an additional 57 new individual measures and 2 measures groups, as well as retired some claims-based measures to encourage reporting via registry and EHR.

All proposed measures have been classified into 1 of 6 domains based on the National Quality Strategy's six priorities:

1. Person and Caregiver-Centered Experience and Outcomes
2. Patient Safety
3. Communication and Care Coordination
4. Community/Population Health
5. Efficiency and Cost Reduction
6. Effective Clinical Care

Maintenance of Certification Program Incentive. CY 2014 is the final year for which this program is authorized, and CMS is keeping the self-nomination process and standards for this program consistent. The MOC program requires eligible professionals to:

1. Maintain a valid and unrestricted license in the United States;
2. Participate in educational and self-assessment programs;
3. Demonstrate through a formalized secure examination that the physician has fundamental diagnostic skills, medical knowledge and clinical judgment to provide care in his specialty; and
4. Successfully complete a qualified maintenance of certification program practice assessment.

CMS requires an eligible professional to participate more frequently than is required in at least one of the four parts of the MOC program, not all four. CMS will look to the specific requirements of Board certification to determine if the "more frequently" requirement is met. However, CMS will interpret the statute to require the participation and successful completion in at least one MOC program practice assessment for each year the physician participates in the MOC Program Incentive.

More information on PQRS can be found here.

TABLE 93: CY 2014 PFS Final Rule with Comment Period Estimated Impact Table: Impacts of Work, Practice Expense, and Malpractice RVUs, and the MEI Adjustment*

(A)	(B)	(C)	(D)	(E)	(F)
Specialty	Allowed Charges (mil)	Impact of RVU Changes		Impact of Adjusting the RVUs to Match the Revised MEI Weights	Combined Impact
		Impact of Work & MP RVU Changes	Impact of PE RVU Changes		
TOTAL	$87,552	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$214	0%	0%	-3%	-3%
ANESTHESIOLOGY	$1,871	0%	0%	1%	1%
CARDIAC SURGERY	$357	0%	0%	2%	2%
CARDIOLOGY	$6,461	0%	2%	-1%	1%
COLON AND RECTAL SURGERY	$159	0%	0%	0%	0%
CRITICAL CARE	$276	0%	0%	2%	2%
DERMATOLOGY	$3,123	-1%	1%	-2%	-2%
EMERGENCY MEDICINE	$2,946	0%	0%	2%	2%
ENDOCRINOLOGY	$449	0%	0%	0%	0%
FAMILY PRACTICE	$6,402	0%	0%	0%	0%
GASTROENTEROLOGY	$1,909	-1%	-1%	0%	-2%
GENERAL PRACTICE	$536	0%	0%	0%	0%
GENERAL SURGERY	$2,254	0%	0%	0%	0%
GERIATRICS	$235	0%	0%	1%	1%
HAND SURGERY	$151	0%	0%	-1%	-1%
HEMATOLOGY/ONCOLOGY	$1,896	0%	0%	-2%	-2%
INFECTIOUS DISEASE	$639	0%	0%	2%	2%
INTERNAL MEDICINE	$11,503	0%	0%	1%	1%
INTERVENTIONAL PAIN MGMT	$644	-1%	-2%	-1%	-4%
INTERVENTIONAL RADIOLOGY	$221	-1%	0%	-1%	-2%
MULTISPECIALTY CLINIC/OTHER PHY	$80	0%	-1%	1%	0%
NEPHROLOGY	$2,134	0%	0%	1%	1%
NEUROLOGY	$1,509	0%	-1%	0%	-1%
NEUROSURGERY	$718	0%	0%	0%	0%
NUCLEAR MEDICINE	$51	0%	0%	0%	0%
OBSTETRICS/GYNECOLOGY	$693	0%	2%	-1%	1%
OPHTHALMOLOGY	$5,609	0%	0%	0%	0%
ORTHOPEDIC SURGERY	$3,702	-1%	-1%	0%	-2%
OTOLARNGOLOGY	$1,133	0%	-1%	-1%	-2%
PATHOLOGY	$1,141	-4%	-2%	0%	-6%
PEDIATRICS	$64	0%	0%	0%	0%
PHYSICAL MEDICINE	$1,007	0%	-1%	0%	-1%
PLASTIC SURGERY	$372	0%	0%	0%	0%
PSYCHIATRY	$1,181	4%	1%	1%	6%
PULMONARY DISEASE	$1,783	0%	0%	1%	1%
RADIATION ONCOLOGY	$1,788	0%	3%	-2%	1%
RADIOLOGY	$4,655	0%	-2%	0%	-2%
RHEUMATOLOGY	$553	0%	-2%	-2%	-4%

THORACIC SURGERY	$335	0%	0%	1%	1%
UROLOGY	$1,864	0%	-1%	0%	-1%
VASCULAR SURGERY	$931	0%	-1%	-1%	-2%
AUDIOLOGIST	$57	0%	1%	-1%	0%
CHIROPRACTOR	$729	5%	6%	1%	12%
CLINICAL PSYCHOLOGIST	$587	6%	-1%	3%	8%
CLINICAL SOCIAL WORKER	$414	6%	-2%	4%	8%
DIAGNOSTIC TESTING FACILITY	$790	0%	-6%	-5%	-11%
INDEPENDENT LABORATORY	$818	-2%	0%	-3%	-5%
NURSE ANES / ANES ASST	$1,061	0%	0%	3%	3%
NURSE PRACTITIONER	$1,954	0%	0%	1%	1%
OPTOMETRY	$1,116	0%	0%	-1%	-1%
ORAL/MAXILLOFACIAL SURGERY	$45	0%	1%	-2%	-1%
PHYSICAL/OCCUPATIONAL THERAPY	$2,818	0%	1%	-1%	0%
PHYSICIAN ASSISTANT	$1,414	0%	0%	0%	0%
PODIATRY	$1,998	0%	0%	-1%	-1%
PORTABLE X-RAY SUPPLIER	$113	0%	2%	-4%	-2%
RADIATION THERAPY CENTERS	$63	0%	5%	-6%	-1%
OTHER	$25	0%	0%	1%	1%

* Table 93 shows only the payment impact on PFS services. These impacts use a constant conversion factor and thus do not include the effects of the January 2014 conversion factor change required under current law.