2015 Medicare Physician Fee Schedule Final Rule and Impact Analysis

December 4, 2014

2015 Medicare Physician Fee Schedule Final Rule

<u>3 Webinars on 2015 Medicare PFS</u>

- Nov 18 - Webinar on PQRS/Value Modifier Provisions
- Dec 5 – (Today) – Impact Analysis
- Dec 11 - Webinar on FPSC Quality & Efficiency Module

  Webinar link has been sent to FPSC Q&E Participants

<u>References</u>

- Displayed on Oct 31; published in Federal Register 11/13
  https://www.federalregister.gov/articles/2014/11/13/2014-26183/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory

- Supplemental materials (including RVU data)
  www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html

© 2014, AAMC-UHC-FPSC®

Agenda

- The Big Picture
- Payment Update, Conversion Factor
- RVU and GPCI Changes
- Off-Campus Reporting Requirements
- Chronic Care Management Code
- Transition to 0-day Global Codes
- Other Policies of Interest
  - Expansion of Telehealth Services
  - Open Payments/ “Sunshine Act”

© 2014, AAMC-UHC-FPSC®

The Big Picture: Payment Policies

- **Physician Update Stable through March**
  - Jan-Mar 2015: 0% update
    - BUT CF changes from $35.8228 to $35.8013 due to budget neutrality adjustments
  - Apr-Dec 2015: 22.2% reduction
    - Requires congressional action to avoid reduction
- **Payment/RVU Changes**
  - Work RVUs stable, Updates for PE, MP RVUs and GPCIs
  - New chronic care management code
  - Transition of 10- and 90-day global codes to 0-day global codes
  - Expanded telehealth

© 2014, AAMC-UHC-FPSC®

Top Payment Changes by Specialty

Most Positive Changes	Variance
Transplant Surgery: Kidney	1.9%
Surgery: Neurological	1.9%
Transplant Surgery: General	1.5%
Orthopedic Surgery: Spine	1.3%
Surgery: Vascular	1.1%
Transplant Surgery: Liver	1.1%
Emergency Medicine	0.9%
Pain Management	0.9%
MOHS Surgery	0.8%
Neurology: Neuromuscular	0.8%

Most Negative Changes	Variance
Ophthalmology: Retinal	-4.1%
Ophthalmology: Glaucoma	-3.4%
Ophthalmology: Oculo / Rec	-3.0%
Ophthalmology: General / Comp	-2.7%
Ophthalmology: Corneal / Ref	-2.5%
Ophthalmology: Optometry	-1.7%
Neurology: Epilepsy / EEG	-1.3%
Ophthalmology: Neuro	-1.2%
Uro-Gynecology	-1.0%
Psychology	-0.9%

This variance was calculated from the mix of facility and non-facility work performed at FPSC members and considers all work performed across the membership. Both RVU changes and Conversion Factor changes are evaluated. Data are not GPCI-Adjusted. Assumes conversion factor of $35.8013 for 2015.

© 2014, AAMC-UHC-FPSC®

Medicare Physician Fee Schedule Proposed Rule CY2015

PAYMENT UPDATE/ CONVERSION FACTOR

Reminder: Regulation v. Legislation

Regulation (CMS)	Legislation (Congress)

• Regulations implement existing law
 	
• **Example:**
  • CMS can modify the RVUs and the GPCI weights
  • Changes to PQRS or EHR measures
  • Modifying non-statutory policies related to payment
 	
• Medicare PFS Proposed Rule is part of the regulatory process
  • Law requires comment on proposals and agency to respond to comments
  • Final rule in November
	• Congress creates new laws and can use legislation to change existing laws or policies. President must sign bill; if bill vetoed by President only becomes law if Congress overrides veto (2/3 House and Senate)
	
	• **Example:**
	  • Physician update formula (SGR) is written in law. It requires Congressional action to overturn the 22.2% reduction scheduled for April 1, 2015
	  • Extending the GPCI work floor also requires legislation
	
	• SGR repeal or patches determine the "size" of the pot and any potential savings to pay for increased update
	  • Potential "savings" could include cuts to academic enterprise: IME, HOPD cuts

© 2014, AAMC-UHC-FPSC®

Calculating the Conversion Factor

Two Major Reasons the Conversion Factor Changes

RVU Changes

- Increases/Decreases in RVU values and new codes can change CF
  - Any change > $20M requires a budget neutrality adjustment
- Most RVUs are finalized in **REGULATION**

Example: New CCM code increases RVUs and requires a slight reduction to CF

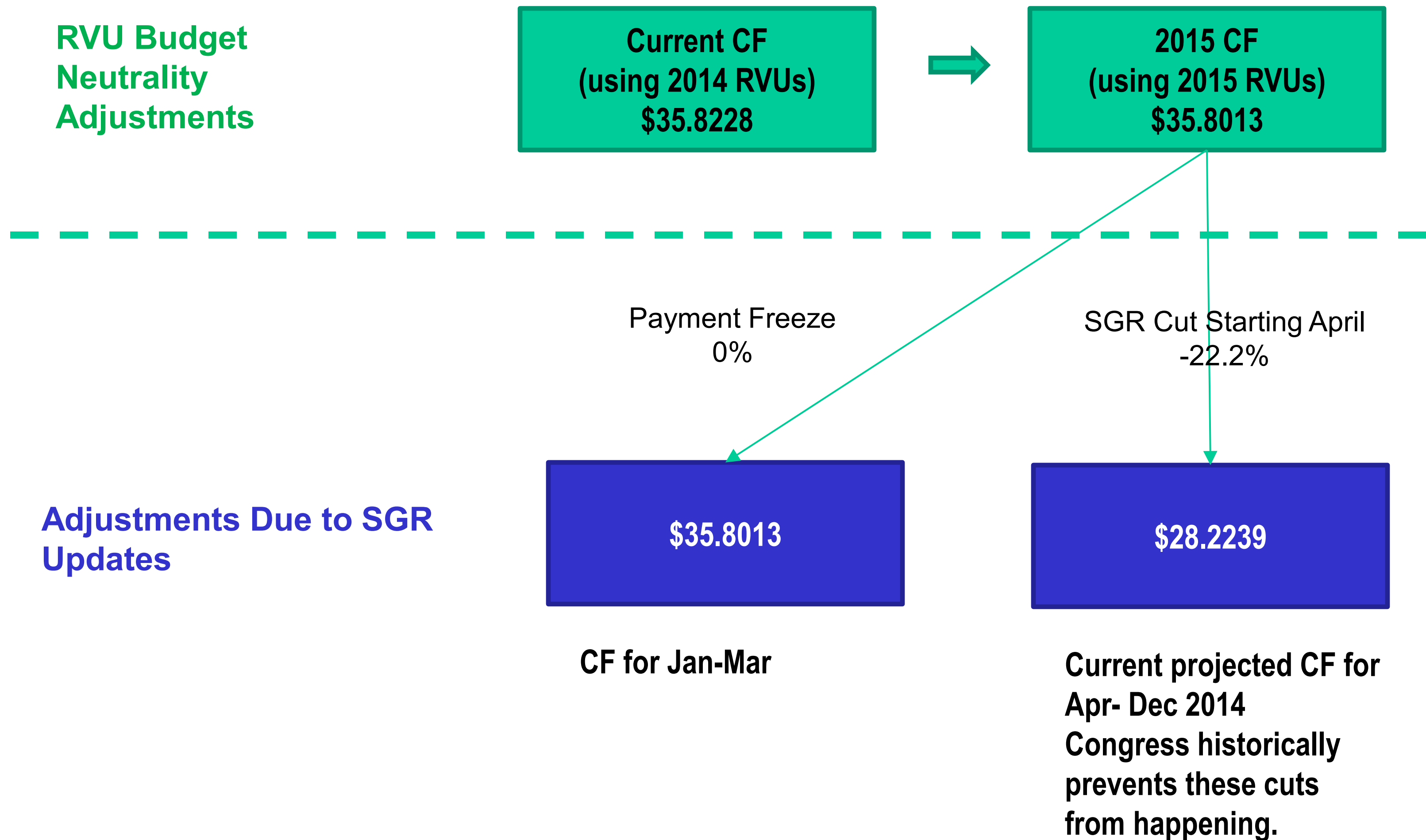
Physician Update

- Annual update calculated by “Sustainable Growth Rate” formula
- Overturning SGR requires **LEGISLATIVE** action

Congress passed a patch that maintains the current update through the end of March 2015.

© 2014, AAMC-UHC-FPSC®

Conversion Factor in Impact Analyses



© 2014, AAMC-UHC-FPSC®

SGR Update

- Deadline: April 1, 2015
  - Avert 22.2% cut
  - Extend GPCI work floor (and other extenders)
- Push for lame duck repeal and replace of SGR
  - Cost $140B; No offsets in existing bill
  - Congress expected to end by Dec 11
- New Congress in 2015 –
  - Getting agreement on SGR with new Congress before April unlikely
  - Freeze until the end of 2015 = ~$20B
  - Watch for offsets that affect other parts of the clinical enterprise

© 2014, AAMC-UHC-FPSC®

Medicare Physician Fee Schedule Proposed Rule CY2015

RVU/GPCI ADJUSTMENTS

© 2014, AAMC-UHC-FPSC®

RVUs and GPCIs

- Continued push to identify “misvalued RVUs”
  - Each year CMS will review subset of codes
  - New process to provide comments on code changes
- PE RVUs
  - Adjusted clinical labor time for moderate sedation
  - Adopted recommendation to shift radiology inputs from film to digital
- Malpractice RVUs updated
  - Corrected error in ophthalmology data → decrease in aggregate ophthalmology $$
- GPCIs
  - 2nd year of implementing 2014 GPCI update
  - New codes for Virgin Islands

© 2014, AAMC-UHC-FPSC®

WRVUs Largely Unchanged

- 76 CPT Codes with Work RVU changes
  - 29 WRVUs increased with average gain of .6 WRVUs
  - 47 WRVUs decreased with average loss of 1.3 WRVUs
- Changes within clinical specialties were often dampened by a mix of loss and gains

© 2014, AAMC-UHC-FPSC®

Cardiology WRVU Gains

- Cardiology specialties, particularly Noninvasive Cardiology, will see small gains with changes to the ECHO Transeosophageal (TEE) Work RVUs
  - Gains of ~10 to 30 WRVUs per 1.0 CFTE*

Code	Description	2014 WRVU	2015 WRVU	Difference
93312	Echo transesophageal	2.20	2.55	+0.35
93313	Echo transesophageal	0.95	0.51	-0.44
93314	Echo transesophageal	1.25	2.10	+0.85
93315	Echo transesophageal	2.78	2.94	+0.16
93316	Echo transesophageal	0.95	0.85	-0.10
93317	Echo transesophageal	1.83	2.09	+0.26
93318	Echo transesophageal intraop	2.20	2.40	+0.20

Source: CPT Values come from the 2014/2015 Medicare Physician Fee Schedule
*Change in specialty WRVUs derived from the FPSC Clinical Fingerprint and PFS changes.

© 2014, AAMC-UHC-FPSC®

Pain Management WRVU Gains

- Pain Management specialists, and some Physiatrists, will see modest gains due to WRVU increases in WRVUs for spinal injections
  - Gains of ~80 WRVU per 1.0 cFTE

Code	Description	2014 WRVU	2015 WRVU	Difference
62310	Inject spine cerv/thoracic	1.18	1.91	+0.73
62311	Inject spine lumbar/sacral	1.17	1.54	+0.37
62318	Inject spine w/cath crv/thrc	1.54	2.04	+0.50
62319	Inject spine w/cath lmb/scrl	1.50	1.87	+0.37

Source: CPT Values come from the 2014/2015 Medicare Physician Fee Schedule
*Change in specialty WRVUs derived from the FPSC Clinical Fingerprint and PFS changes.

© 2014, AAMC-UHC-FPSC®

Ophthalmology Losses

- The Glaucoma subspecialty is likely to see a drop in Work RVUs due to reductions in the WRVUs for codes 66180 and 67255
  - Decrease of ~**-162 WRVUs per 1.0 cFTE** for Glaucoma
- Retinal subspecialists will see a greater reduction in WRVUs, primarily due to codes 67040, 67041 and 67042.
  - Decrease of ~**-278 WRVUs per 1.0 cFTE** for Retina.

Code	Description	2014 WRVU	2015 WRVU	Difference
66180	Aqueous shunt eye w/graft	16.3	15	-1.3
66185	Revise aqueous shunt eye	9.58	10.58	+1.0
67036	Removal of inner eye fluid	13.32	12.13	-1.19
67039	Laser treatment of retina	16.74	13.2	-3.54
67040	Laser treatment of retina	19.61	14.5	-5.11
67041	Vit for macular pucker	19.25	16.33	-2.92
67042	Vit for macular hole	22.38	16.33	-6.05
67043	Vit for membrane dissect	23.24	17.4	-5.84
67255	Reinforce/graft eye wall	10.17	8.38	-1.79

Source: CPT Values come from the 2014/2015 Medicare Physician Fee Schedule
*Change in specialty WRVUs derived from the FPSC Clinical Fingerprint and PFS changes.

© 2014, AAMC-UHC-FPSC®

Pathology Coding Changes

- Codes for *Fluorescent in situ hybridization (FISH)* and *immunohistochemisty services (IHC)* change for 2015
- IHC
  - CMS deleted code 88242 and replaced it with codes G0461 (1st IHC stain per site) and G0462 (additional IHC stain per site) in 2014
  - For 2015, CMS won't recognize the G-codes nor the CPT Code 88343 (each additional antibody per slide) and has reinstated the 88342 code.
  - CMS has also introduced two new codes 88341 and 88344 for 2015
- FISH
  - The work components of 88365, 88367, and 88368 have been reduced but the definitions have been changed from one probe to one specimen with add-on codes for additional specimens.
- Changes are difficult to model due to the nature of add-on codes, but the pathology community believes these changes will result in a small net gain in RVUs and payments.

© 2014, AAMC-UHC-FPSC®

Practice Expense Changes

- Many specialties will see small changes in the practice expense component and Medicare payments.
  - On average across specialties, organizations will see just a 1% gain on non-facility practice expense RVUs and near zero on facility practice expense RVUs.
- Facility-based Ophthalmology practices are most negatively affected.

Specialty	**Facility Practice Expense Change**
Ophthalmology: Corneal / Refractive Surgery	-3%
Ophthalmology: General / Comprehensive	-3%
Ophthalmology: Glaucoma	-4%
Ophthalmology: Neuro	-2%
Ophthalmology: Oculoplastic / Reconstructive Surgery	-4%
Ophthalmology: Optometry	-2%
Ophthalmology: Pediatric	-3%
Ophthalmology: Retinal	-5%

© 2014, AAMC-UHC-FPSC®

Geographic Practice Cost Indices (GPCI)

- 2nd year of phasing in most recent update
  - Trend from last year will continue for this year
- Work component of GPCI was unchanged with the exception of 3 areas: Chicago, Suburban Chicago, and Detroit had -1% change each
- 50 areas received slight increases in the PE component, 29 decreased
  - Among the membership, no organization gained or lost more than 1%
- Changes were greater for the malpractice component
  - The upcoming organization-level reports should give us an idea of the effect on payments.

© 2014, AAMC-UHC-FPSC®

Billing Modifier Changes on 1/1/2015

- Not part of PFS, but important to know
- The -59 modifier is used for several situations including the identification of a separate encounter, separate service or separate anatomic site
- To clarify the usage, CMS is establishing four new HCPCS modifiers to define specific subsets of the -59 modifier
  - XE Separate Encounter
  - XS Separate Structure
  - XP Separate Practitioner
  - XU Unusual Non-Overlapping Service
- FPSC processing will accept the new codes and treat them as Modifier -59 is handled today.

© 2014, AAMC-UHC-FPSC®

Medicare Physician Fee Schedule Proposed Rule CY2015

REPORTING FOR OFF-CAMPUS PROVIDER-BASED SERVICES

© 2014, AAMC-UHC-FPSC®

Data Collection: Off-Campus Provider-Based Facilities

- Off-Campus Data collection
  - Reference to MedPAC concerns about higher payments to hospital-based facilities than freestanding clinics
  - CMS cannot distinguish between services provided close to the main campus versus services that are further away.
- Finalized new policy on data collection – not payment change
  - Physicians to use new place of service codes
  - Hospitals to use a modifier
    - Voluntary reporting in 2015
    - Mandatory in 2016

© 2014, AAMC-UHC-FPSC®

Definition of Off-Campus Provider-Based Facilities

- Does not include remote location of a hospital, a satellite facility, or emergency departments
- Does include provider-based departments located more >250 yards from main campus of hospital
  - Formal definition of on-campus at §413.65
  - CMS regional office can review on a case-by case basis if a site >250 yards from main campus should be classified "on-campus"

© 2014, AAMC-UHC-FPSC®

Off-Campus Reporting: Physicians

- Creating 2 new place of service codes for on-campus/off-campus outpatient departments

- No transition phase; CMS will do a one-time switch to the new POS codes
  - CMS has started process to create new POS codes
  - CMS will give prior notice before the switch
  - After switch, POS "22" will no longer be valid for Medicare

© 2014, AAMC-UHC-FPSC®

Off-Campus Reporting: Hospitals

- FINAL RULE: optional for January 1, 2015, REQUIRED for January 1, 2016
- Use HCPCS modifier "PO" with every code for outpatient hospital services furnished in off-campus provider-based department, reported on UB-04 (CMS Form 1450)
- Services furnished on- and off-campus on same day?
  - "The location where the service is actually furnished would dictate the use of the modifier, regardless of where the order for services initiated."
  - Use modifier if hospital "expends resources" to furnish the service in an off-campus setting
- CMS will issue subregulatory guidance

© 2014, AAMC-UHC-FPSC®

Medicare Physician Fee Schedule Proposed Rule CY2015

CHRONIC CARE MANAGEMENT (CCM) CODE

© 2014, AAMC-UHC-FPSC®

Chronic Care Management (CCM)

CPT 99490 –
Services furnished to patients with two or more chronic conditions expected to last at least 12 months; 20 minutes or more; per calendar month.

$42.60 per patient per month

Required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- Comprehensive care plan established, implemented, revised, or monitored)

© 2014, AAMC-UHC-FPSC®

CCM requirements

- Must document at least 20 minutes of clinical time to bill
- Patients required to pay a copay; must be informed in advance
- Scope of service elements
  - 24/7 access
  - Continuity of care with a designated practitioner or member of the care team
  - Care management (including assessments, preventative care, medication reconciliation, etc).
  - Patient-centered care plan
  - Management of care transitions
  - Coordination with home and community-based providers
  - Enhanced opportunities for the beneficiary/caregiver to communicate with provider through secure messaging
- Additional billing requirements
  - Inform beneficiaries in advance
  - Document in the medical record that all elements were explained and offered
  - Provide the beneficiary a written or electronic copy of the care plan
  - Inform the beneficiary the right to stop the CCM service
  - Inform the beneficiary that only practitioner can furnish the service
- No restriction on which specialties can bill the service

© 2014, AAMC-UHC-FPSC®

Important Changes to CCM

Changes to Counting Clinical Time

- Clinical staff can perform services under “general” supervision instead of “direct” at any time
  - Previously time was only counted if the service was outside normal business hours
  - Clinical staff must still meet all other “incident to” provisions
- Clinical staff do not need to be direct employees

New EHR requirement

- EHR must meet CEHRT standards as of Dec 31 of previous year
- Several scope requirements must be documented in CEHRT

© 2014, AAMC-UHC-FPSC®

How Common Are Multiple Chronic Conditions?

The Medicare County Level Multiple Chronic Conditions (MCC) table can provide an estimate of Medicare beneficiaries patients with multiple chronic conditions.

Percentage of Medicare Beneficiaries by Number of Chronic Conditions

2 to 3 Conditions	4 to 5 Conditions	6+ Conditions	>=2 Conditions
31%	20%	13%	**63%**

Nationally, 63% of Medicare beneficiaries have 2 or more chronic conditions.

Source: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.html

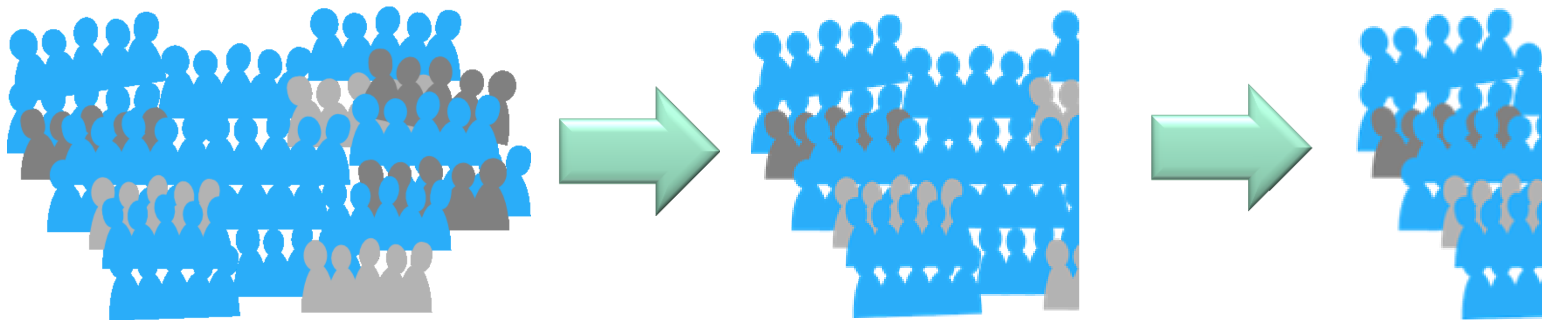
© 2014, AAMC-UHC-FPSC®

CCM Payments Offer Revenue Opportunity

Average FPSC practice sees 8,000 Medicare beneficiaries by primary care physicians

63% with 2 or more Chronic Conditions

Assume 50% of eligible beneficiaries sign up for CCM and practice spends 20 min working on care plan



= $107,352 per month

© 2014, AAMC-UHC-FPSC®

Medicare Physician Fee Schedule Proposed Rule CY2015

TRANSITION TO 0-DAY GLOBAL CODES

© 2014, AAMC-UHC-FPSC®

Transition to 0-Day Global Codes

- Concerns that 10- and 90-day global codes are "misvalued"
  - Transition 10-day global codes to 0-day in 2017
  - Transition 90-day global codes to 0-day in 2018
  - Additional details in 2016 PFS proposed rule

- "0-day global" maintains "same day" packaging of pre- and post-op services
  - Bill separately for each E/M visit and service outside day of surgery (including administering patient cost-sharing)

© 2014, AAMC-UHC-FPSC®

Why Globals?

- CMS identified the following concerns with global codes
  - Codes were established over 20 years ago and unlike other systems the rates are not automatically reset
  - Variation in long post-op period could lead to some providers being paid more
  - Physicians do not provide the estimated number of E/M visits, or beneficiary receives services from another providers
  - More post-op visits are performed in facilities and the codes assume RVUs for non-facility sites
  - Distortion in global codes affect all other PFS services

© 2014, AAMC-UHC-FPSC®

Unbundling Post-operative Care

- About 4,000 surgery codes are currently associated with 10 and 90-day global periods.
- General estimate of post-operative care
  - 7% to 23% of the allowed payment (based on modifier 54 - when it is known the post-op care will be transferred to another provider)
  - Post-op care will be the portion of the service that will be billed differently and be at risk

© 2014, AAMC-UHC-FPSC®

Change to Global Codes Will Impact Some Departments

Specialty Groups	% of Medicare TRVUs from 10-Day Global Codes	% of Medicare TRVUs from 90-Day Global Codes	% of Medicare TRVUs from Other Codes
Orthopedics	1%	66%	34%
Surgery	2%	54%	44%
Ophthalmology	4%	46%	50%
Otorhinolaryngology	3%	38%	60%
Urology	2%	30%	69%
MOHS Surgery	18%	21%	61%

© 2014, AAMC-UHC-FPSC®

Are Follow-ups after Surgery Routinely Performed?

- We selected patients based on their having a procedure using the global surgical code
- We removed instances where the surgeon billed the intraoperative portion only
- Significant numbers of surgical patients do not appear to be receiving a post-op office visit
  - Patients not receiving follow-up
    - Mean: 15% / Median: 12%
    - Range 5% to 58%
  - **Is this a real phenomena, or just lack of documentation?**

© 2014, AAMC-UHC-FPSC®

Teaching Guidelines

- Final rule does not address teaching physician documentation rules
  - *Current guidelines:*
    The teaching surgeon determines which <u>postoperative visits are considered key or critical and require his or her presence</u>. If the postoperative period extends beyond the patient's discharge and the teaching surgeon is not providing the patient's follow-up care, then instructions on billing for less than the global package in §40 apply

© 2014, AAMC-UHC-FPSC®

Medicare Physician Fee Schedule Proposed Rule CY2015

OTHER POLICIES

Expansion Telehealth Services

- CMS adds 7 CPT and HCPCS Codes
  - Psychoanalysis, family psycho therapy, prolonged services in office, and wellness visits

- Full list of Medicare codes and descriptors available at www.cms.gov/telehealth

- FPSC has done recent analyses looking at telemedicine payment and denials
  - Contact Dave Troland, troland@uhc.edu for more information

© 2014, AAMC-UHC-FPSC®

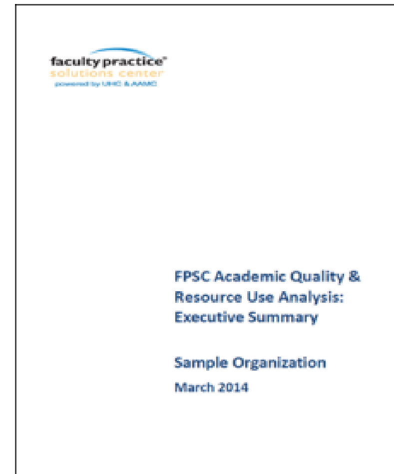
"Sunshine Act" Regulations

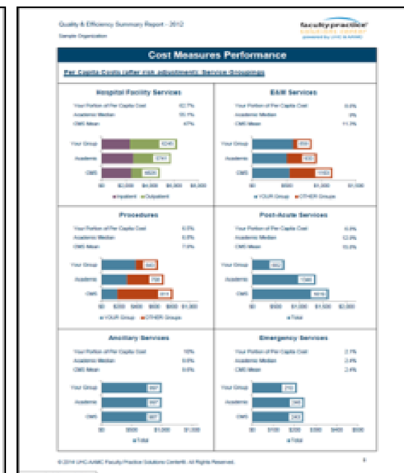
- Applicable to manufacturers and group purchasing organizations (GPOs)
  - Must report payments and other transfers of value to physicians and teaching hospitals, and ownership or investment interests held by physicians
- 4 changes
  - Remove definition of "covered device" because it is duplicative of another defined term (§403.902)
  - Remove the entire subsection exempting reporting of payments to speakers at an accredited CME event if certain conditions are met (§403.904(g))
  - Revising a section to require reporting of a marketed name of a product when applicable (§403.904(c)(8))
  - Creating distinct reporting categories for stock, stock option, and any other ownership interest (§403.904(d)(3))

© 2014, AAMC-UHC-FPSC®

FPSC Quality & Efficiency Module Helps Groups Be Successful with PQRS and VM

- Almost 50 participants
- Interpretation and diagnosis of performance on CMS QRUR & PQRS GPRO Web reporting
- Management reports and comparative data on a variety of QRUR quality, cost and efficiency measures
- Networking opportunities
- Feedback to CMS





Upcoming Events for FPSC Quality & Efficiency Module Participants

- Week of December 10: Final 2013 Academic GPRO Web and 2013 QRUR Analysis
- December 17: Networking Session for FPSC Quality & Efficiency Participants
- December 19: Launch of FPSC Quality & Efficiency Collaboration Site
- Q1 - Q2 2015: Networking Webinars
- Spring/Summer 2015: In-person networking event

© 2014, AAMC-UHC-FPSC®

Questions/Feedback

Questions about PFS Proposals

Mary Wheatley, mwheatley@aamc.org, 202-862-6297

FPSC Projects Related to PFS

Dave Troland, troland@uhc.edu, 312-775-4357

Will Dardani, dardani@uhc.edu, 312-775-4510

FPSC Projects Q&E Projects

Shaifali Ray, ray@uhc.edu, 312-775-4305

Jake Langley, langley@uhc.edu, 312-775-4239

© 2014, AAMC-UHC-FPSC®