Reimbursement Changes: Understanding the 2015 Physician Fee Schedule
Agenda

- What is the Medicare Physician Fee?
- Key Provisions of 2015 Ruling
- Impact by Specialty
- PQRS and Value-Based Modifiers
- Additional Changes by CMS
- Resources
What is the Medicare Physician Fee?

- Established in 1992 replacing CPR charge system
- CMS uses formula to determine reimbursement amount
- Funded by Medicare Part B

\[
\text{Payment} = (\text{Work RVU} \times \text{Work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI}) \times CF
\]
How is MPFS Calculated?

- 3 resource costs
  - Physician work, practice expenses, malpractice insurance
- Each resource is assigned a Relative Value Unit (RVU) for each CPT
- RVUs adjusted based on Geographical Practice Cost Index (GPCI)
- Multiplied by the Conversion Factor (CF)

\[
\text{Payment} = \left( \text{Work RVU} \times \text{Work GPCI} \right) + \left( \text{PE RVU} \times \text{PE GPCI} \right) + \left( \text{MP RVU} \times \text{MP GPCI} \right) \times \text{CF}
\]
Key Provisions

- Sustainable Growth Rate (SGR)
- Primary care and chronic care management
- Misvalued services
- Global surgery
- Telehealth services
- Malpractice RVUs
- Geographic Practice Cost Index (GPCI)
- Off-campus services
- Open Payments
- Mammography
Sustainable Growth Rate

- Enacted in 1997
- Control growth of spending
- Fatally flawed
- “Patched” 17 times
Sustainable Growth Rate

21.2%

Average rate reduction
April 1, 2015
Primary Care and Chronic Care Management

- Payment for CCM services in 2015
- Payment rate of $42
- Billed once per month per qualified patient
- Patient responsibility 20%
- Patients must agree in writing
- Services provided by doctors and clinical staff

$42
Payment Rate

20%
Patient Responsibility
CCM Requirements

- 24/7 patient access
- Systematic assessments of patients
- Patient-centered care plan
- Enhanced beneficiary/caregiver communication
Misvalued Services

- Hip and knee replacements
- Radiation therapy and gastroenterology
- Radiation therapy (infrastructure)
- Epidural pain injections
- Film to digital distribution
Global Surgery

- Transform 10- and 90-day to 0-day global codes
- Beginning in CY 2017
Telehealth Services

- Annual wellness visits
- Psychoanalysis
- Psychotherapy
- Prolonged evaluation and management services
Malpractice RVUs

- Comprehensive review and update of RVUs
- Proposed new RVUs for all services
- Adopting new resource-based RVUs based on updated professional liability insurance premiums
- Paralleling the methodology used in the CY 2010 update
Revisions to GPCI

• Reflects local differences in operating costs
• Mandated 1.5 work floor in Alaska
• 1.0 work floor for all other areas
• 1.0 PE floor for frontier states
• Statutory 1.0 work floor expires March 31, 2015
• Reflect elimination GPCI floor from April 1- Dec. 31, 2015
Off-Campus Services

- New place of service code on professional claims
- Voluntary for hospitals in 2015, mandatory in 2016
Open Payments

- Deleting duplicative definition “covered device”
- Deleting Continuing Education Exclusion
- Requires reporting of the marketed name and therapeutic area or product category of the related covered drugs, devices, biologicals, or medical supplies
- Requires manufacturers to report stocks, stock options or any other ownership interest as distinct categories
Mammography

- Add-on code for 3D
- Recognizes higher costs for 3D
- Revisit payment 2D & 3D in 2016
## Impact by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Impact</th>
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<tbody>
<tr>
<td>Allergy/Immunology</td>
<td>0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>1%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0%</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>(-2%)</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>0%</td>
</tr>
<tr>
<td>ENT</td>
<td>0%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>0%</td>
</tr>
<tr>
<td>General Practice</td>
<td>0%</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>1%</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>1%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>2%</td>
</tr>
<tr>
<td>Interventional Pain Mgt</td>
<td>1%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0%</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>(-2%)</td>
</tr>
<tr>
<td>Podiatry</td>
<td>0%</td>
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<tr>
<td>Pulmonary Disease</td>
<td>0%</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>(-4%)</td>
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<tr>
<td>Radiation Therapy Centers</td>
<td>(-8%)</td>
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<tr>
<td>Rheumatology</td>
<td>0%</td>
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<tr>
<td>Urology</td>
<td>0%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>1%</td>
</tr>
</tbody>
</table>
PQRS Measures 2015

- New measure high – #402
- 20 new measures
- 53 retired measures
- 14 changed from claims-based to registry only
- 175 total measure available
- 71 available claims-based measures
- Introduction of cross-cut measures
Additional PQRS Requirements

- No bonus incentive in 2016
- Payment reductions in 2016 by -2.0% for non-participation
- Changes in # of patients under the GPRO method
- EPs reporting QCDR required to report 3 outcome measures
- Require to make public QCDR measure data
Value-Based Modifier

Quality & Efficiency > Cost
Value-Based Modifier

Groups of Physicians with 100 or more Eligible Professionals

- **PQRS Participation**
  (Self-nominate/Admin claims)
  - Elect Quality-Tiering Calculation
    - Upward, downward, no
      (Adjustment based on quality-tiering)
  - No Election
    - 0.0%
      (No adjustment)

- **Non-PQRS Participation**
  (Do not self-nominate, do not report minimum of one measure)
  - -1.0%
    (Downward adjustment)
Medicare Wellness Visits

• Welcome to Medicare Preventive Visit G0402
  • Payable once within 12 months of patient joining

• Initial AWV G0438
  • Payable once per lifetime
  • Average reimbursement $172

• Subsequent AWV G0439
  • Payable every 12 months
  • Average reimbursement $111
MWV Requirements

- Performed by Doctor or qualified practitioner
- Document medical/family history
- Self-reported information
- Take no more than 20 minutes
CMS Changes for the -59 Modifier

- Changes implemented January 1st
- 4 new modifiers for more accurate coding options
- Specify the circumstances that call for separate reimbursement
- CMS will continue to recognize the -59 modifier
- More descriptive modifiers should be used
• **XE**-Separate Encounter, a service that is distinct because it occurred during a separate encounter

• **XS**-Separate Structure, a service that is distinct because it was performed on a separate organ/structure

• **XP**-Separate Practitioner, a service that is distinct because it was performed by a different practitioner

• **XU**-Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service
The patient receives an outpatient infusion of antibiotics (CPT code 96365) at 8:00 AM, leaves the facility and returns at 8:00 PM for another infusion of the antibiotics. CPT code 96365 would require the -XE modifier to indicate that it is performed in separate encounter.
A skin lesion of the arm was destroyed via laser surgery and reported with CPT code 17000. Another lesion is biopsied on the leg and reported with CPT code 11100. CPT code 11100 would require the modifier - XS to indicate that it is performed on separate anatomical site.
A laparoscopic hernia repair (CPT code 49650) was performed in the morning by surgeon A; later in the day the patient developed acute abdominal pain and a laparoscopic appendectomy (CPT code 44970) was performed by surgeon B. CPT 44970 would require the modifier -XP to indicate that it is performed by different practitioner.
Two separate lesions are present that are within the same code set, and are excised separately - i.e. a 4 cm. lipoma is excised on the upper thigh (CPT code 27337 - excision tumor soft tissue thigh/knee subcutaneous greater than 3 cm) and a separate lipoma excised on the lower leg (CPT code 27327 - excision tumor soft tissue thigh/knee subcutaneous less than 3 cm). CPT 27327 would require -XU modifier to indicate that it is not an overlapping service.
• Understand how changes will impact your practice
• Maximize the revenue potential of every encounter
• Don’t go it alone - partner for success
• Stay informed, stay educated
Resources

- Medicare Physician Fee Schedule Final Ruling
- Physician Fee Schedule Look-Up Tool
- Open Payments
- PQRS
- PQRS Measures 2015
- Changes for Calendar Year 2015 Physician Quality Programs
- Proposed changes for the Physician Value-based Payment Modifier
- Medicare Manual of 42 CFR 410.16
- -59 Modifier Changes
Contact MDeverywhere

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