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CMS PUBLISHES 2014 PHYSICIAN FEE SCHEDULE FINAL RULE

On November 27, 2013, the Centers for Medicare & Medicaid Services ("CMS") issued the Physician Fee Schedule ("PFS") Final Rule for calendar year ("CY") 2014. The Final Rule calls for a 20.1% reduction in payments to physicians for services rendered in CY 2014, although Congress may act to avoid this reduction. Additionally, the Final Rule implements a separate payment for non-face-to-face chronic care management services beginning in CY 2015. A summary of these and other program changes is discussed below.

It is possible that Congress may make legislative changes to several of the items discussed in this article, including sustainable growth rate and therapy caps. Providers should watch for legislative updates in coming weeks.

SUSTAINABLE GROWTH RATE

Without a change in the current law, physicians and non-physician practitioners will face a steep 20.1% reduction in payment rates for professional services rendered in 2014. The President's budget calls for averting these cuts and finding a permanent solution to this problem. As time runs out, it is becoming more likely that lawmakers will seek another temporary reimbursement patch.

CARE MANAGEMENT

CMS will implement a new policy in 2015 to pay separately under the PFS for non-face-to-face chronic care management services furnished to patients with multiple chronic conditions. Care management will include 24-hour-a-day access to address chronic care needs, continuity of care with a designated practitioner and management of care transitions to other clinicians as well as other services. CMS intends to develop standards for furnishing chronic care management services in 2014 and implement this policy in 2015.

TELEHEALTH

CMS is modifying regulations regarding telehealth originating sites to define rural Health Professional Shortage Areas ("HPSAs") as those areas located in rural census tracts as determined by the Office of Human Research Protections ("OHRP"). CMS believes this will allow for the inclusion of additional HPSAs as areas for telehealth originating sites and will expand access to health care services for Medicare beneficiaries located in rural areas. Additionally, CMS is changing telehealth policy so geographic eligibility for an originating site will be established and maintained on an annual basis. CMS believes this change will reduce the likelihood that mid-year changes to geographic designations would result in sudden disruptions to access to services and unexpected changes in eligibility for established originating sites.

MISVALUED CPT CODES

The Affordable Care Act requires CMS to make appropriate adjustments to services and CPT codes that are periodically determined to be misvalued. As part of this ongoing effort, CMS will address nearly 200 CPT codes that are believed to be misvalued. These adjustments are open for comment until January 27, 2014.

UPDATES TO CLINICAL LABORATORY FEE SCHEDULE

In order to accommodate the increase in the number of codes in the Clinical Laboratory Fee Schedule ("CLFS"), CMS is exploring a process to re-examine payments amounts on the CLFS to take into account changes driven by technology advances. CMS states this review will involve examining test codes in several different ways, such as those that have been on the CLFS the longest, high volume test codes, high dollar payment codes and those that have experienced rapid spending growth among other considerations. For those codes where CMS determines that payment adjustments should be made, the code adjustment will be identified, discussed and available for comment beginning with the CY 2015 PFS Proposed Rule.

COMPLIANCE WITH STATE LAW FOR "INCIDENT TO" SERVICES

CMS is requiring as a condition of Medicare payment that "incident to" services be furnished in accordance with state laws. CMS intends to avoid situations where Medicare is paying for "incident to" services that were provided by auxiliary personnel who did not meet the state standards for those services in the state in which the services were provided.

APPLICATION OF THERAPY CAPS TO CAHS

CMS finalized a policy that will apply the therapy caps to outpatient therapy services provided at critical access hospitals ("CAHs") beginning

on January 1, 2014. The therapy caps, which are legislatively prescribed, are applied on a per-beneficiary basis for incurred expenses for outpatient therapy services: one for physical therapy and speech-language pathology services combined and another for occupational therapy services. The therapy caps are increased to $1,920 for CY 2014.

Historically, CMS has not applied the therapy caps to services at CAHs. However, after reviewing the statutory language, CMS concluded that the therapy caps should be applied to outpatient therapy services furnished by CAHs. This change will take effect even though outpatient therapy services provided by PPS hospital outpatient departments will not count toward the therapy caps beginning January 1, 2014, unless Congress enacts legislation otherwise. In addition, both the automatic exception process and the manual review exception process to the therapy caps are set to expire on December 31, 2013, absent Congressional action.

UPDATE TO GPCI

Every three years, CMS is required to review and adjust payments under the PFS to reflect local costs of operating a medical practice as compared to the national average. For 2014, CMS finalized new Geographic Practice Cost Indices ("GPCI") to use updated data. The updated GPCIs will be phased in over CY 2014 and CY 2015.

MEDICARE ECONOMIC INDEX

CMS is finalizing proposed revisions to the calculation of the Medicare Economic Index ("MEI"), which is the price index used to update physician payments for inflation. These revisions come in response to recommendations by a Technical Advisory Panel ("TAP") that had several meetings in 2012. CMS chose to implement ten of TAP's thirteen recommendations, and the remaining three will continue to be evaluated for future changes. The Final Rule includes changes to the PFS Relative Value Units and GPCI weights assigned to the work and practice expense categories so that the weights used in the PFS payment calculation will continue to mirror those in the MEI. CMS did not propose to rebase the MEI for 2014 since the TAP concluded that there is not a newer, reliable or ongoing source of data to maintain the MEI.

PHYSICIAN QUALITY REPORTING SYSTEM

Starting in 2015, a downward payment adjustment will apply to eligible professionals who fail to satisfactorily report data on quality measures for covered professional services. CMS is amending the Physician Quality Reporting System ("PQRS") in 2014 to allow eligible professionals the option to satisfactorily report quality measures through qualified clinical data registries.

CMS also revised and adopted new criteria for satisfactory reporting under the Group Practice Reporting Option ("GPRO"). Beginning in 2014, group practices must register to participate in the GPRO by September 30th of the year in which the reporting period occurs. Furthermore, group practices comprised of 25 or more eligible professionals that wish to report the Clinician and Group Consumer Assessment of Healthcare Providers and Systems survey measures can now elect to do so through certified survey vendors on the same website used by the group practice to register to participate in the PQRS GPRO.

MEDICARE EHR INCENTIVE PROGRAM

For the purpose of meeting the clinical quality reporting ("CQR") component of meaningful use for the Medicare EHR Incentive Program, CMS established that eligible professionals may submit information using qualified clinical data registries, as defined for PQRS. Eligible professionals are required to use certified EHR technology and also submit CQR data in accordance with the Medicare EHR Incentive Program Stage 2 final rule. Furthermore, CMS added a group reporting option to the Medicare EHR Incentive Program beginning in 2014 for eligible professionals who are part of a Comprehensive Primary Care Initiative practice site.

PHYSICIAN VALUE-BASED PAYMENT MODIFIER

CMS finalized policy changes to the value-based payment modifier, which will be applied in CY 2016. The group size threshold will be lowered to groups of physicians with 10 or more eligible professionals, thereby impacting a significantly greater number of physicians to potential payment adjustments. Additionally, the maximum downward payment adjustment in CY 2016 will be increased from 1.0% to 2.0%. The performance on quality and cost measures in CY 2014 will form the basis for the value-based payment modifier applied to items and services paid under the PFS in CY 2016.

This Final Rule was delayed because of the government shutdown in October. A display copy of the rule is available here. Most provisions of this Rule will go into effect on January 1, 2014. However, certain sections of the Rule, which are listed in the Supplementary Information Section, are still open for comment until January 27, 2014. If you have any questions or would like additional information about this topic, please contact:

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