Final Rule with Comment Period – 2014 Physician Fee Schedule

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Description: This major final rule with comment period addresses changes to the physician fee schedule, clinical laboratory fee schedule, and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This final rule with comment period also includes a discussion in the Supplementary Information regarding various programs.

Major Provisions

Sustainable Growth Rate

- The proposed rule calls for 20.1 percent reduction in Medicare payments to physicians.
- Pathway for SGR Reform Act of 2013 delayed this cut for three months (through March 31, 2014) and replaces the cuts with a 0.5 percent increase to physicians.

Requirements for Billing "Incident To" Services

- CMS finalized its proposal to require as a condition of payment that an individual who provides services and supplies "incident to" a physician's professional services must meet any applicable state requirements, including licensure, and that services and supplies must be provided in accordance with state law.

Using OPPS and ASC Rates in Developing PE RVUs

- CMS is not finalizing its proposal to adjust relative values under the PFS to effectively cap the physician practice expense payment for procedures furnished in a non-facility setting at the total payment rate for the service when furnished in an ambulatory surgical center or hospital outpatient setting.

Chronic Care Management

- Beginning in 2015, Medicare will pay for monthly chronic care management services.
- CMS defines chronic conditions as conditions that are expected to last at least 12 months or until the death of the patient and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Revisions to the Medicare Economic Index (MEI)

- CMS has finalized its proposed revisions to the MEI, which are based on the recommendations of a technical advisory panel convened in 2012. These revisions include:

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- Moving payroll for non-physician personnel who can bill independently from the practice expense portion to the physician compensation (work) portion of the index;
- Changing the price proxy for physician compensation to wages of professionals instead of all private non-farm workers;
- Creating new categories for clinical labor costs and for other professional services like billing; and
- Changing the price proxy for fixed capital to business office space costs instead of residential costs.

- CMS estimates that the revised MEI for CY 2014 will yield an increase to PFS payment rates of 0.7 percent.

Physician Compare

- CMS has finalized its proposal to publicly report in 2015 all measures collected through the Group Practice Reporting Option (GPRO) web interface for groups of all sizes participating in the 2014 PQRS GPRO, and for ACOs participating in the Medicare Shared Savings Program (MSSP).
  - CMS will provide a 30-day preview period prior to publication of quality data on Physician Compare so that group practices and ACOs can view their data as it will appear on Physician Compare before it is publicly reported.
- CMS also finalized its proposal to publicly report, in 2014, certain measures that groups report via registries and electronic health records under the PQRS GPRO.
  - CMS will report Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) data for group practices of 100 or more eligible professionals that report data in 2013 under the GPRO, and for ACOs participating in the MSSP. CMS anticipates posting the data on Physician Compare as early as 2014.

Physician Quality Reporting System

- CMS finalized its proposal to lower the percentage of applicable patients a physician must report on from 80 percent to 50 percent in order to be considered a satisfactory reporter. In addition, the agency will eliminate the six-month reporting period for 2014.
  - For individual participation, CMS finalized its plan to increase the number of measures that must be reported from three to nine measures for incentive purposes. The measures must cover at least three of the National Quality Strategy (NQS) domains.
  - For group practices reporting through the GPRO, CMS did not finalize its proposal to eliminate the GPRO web interface option for practices comprised of 25-99 eligible professionals (EPs). Practices comprised of 25-99 EPs may satisfy PQRS reporting in 2014 through the GPRO web-interface.
- 2014 is the last year a physician can qualify for an incentive payment of 0.5 percent under PQRS.
- 2014 will also serve as the performance year for the 2016 penalty adjustment of two percent.
- PQRS Qualified Clinical Data Registries
  - CMS finalized its proposal to add a new clinical data registry option permitting physicians and other PQRS-eligible professionals to report quality measures within a clinical data registry instead of those on the PQRS measures list.
- PQRS Measures and Measure Groups
  - For 2014, CMS is adding 57 new individual measures and two measures groups to fill existing measure gaps and plans to retire a number of claims-based measures to encourage reporting via registry and EHR-based reporting mechanisms.

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Electronic Health Records (EHR) Incentive Program

- CMS is establishing an option for EPs to submit clinical quality measure (CQM) information using qualified clinical data registries (as defined for PQRS) for purposes of meeting the CQM reporting component of meaningful use (MU) for the Medicare EHR Incentive Program beginning in 2014.

Value-Based Payment Modifier (VBM)

- CMS has finalized its proposals to more than double the number of physicians who are subject to the VBM and to increase penalties under the program from a maximum of one percent to a maximum of two percent.
- CMS is basing adjustments in any given year on a "performance year" two years earlier, which means that the 2016 VBM policies included in the rule are governed by what the covered physicians do in 2014.

Telehealth Services

- Currently, Medicare coverage for telehealth services is limited to counties outside of a Metropolitan Statistical Area (MSA), designated rural health professional shortage areas (HPSA), and sites participating in a federal telemedicine demonstration project.
- The final rule adds "rural census tracts," as defined by the Office of Rural Health Policy.
- In addition, CMS will establish and maintain geographic eligibility for an originating telehealth site on an annual basis. Specifically, eligibility will be based on the status of the area as of Dec. 31 of the prior calendar year.
- CMS finalized its proposal to add transitional care management services (CPT codes 99495 and 99496) to its list of approved Medicare telehealth services.

Ambulance Fee Schedule

- The rule implements the ATRA's extensions to the existing add-on payments for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas – through Dec. 31, 2013.
- It also extends through Dec. 31 the "super rural" ambulance add-on.
- These provisions are retroactive to Jan. 1, 2013.

Clinical Laboratory Fee Schedule

- In the final rule, CMS finalizes a detailed plan for reviewing all 1,250 existing codes on the CLFS over at least a five-year period. In this review, a key consideration will be technological changes, which CMS defines as changes to the tools, machines, supplies, labor, instruments, skills, techniques and devices by which laboratory tests are produced and used.

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