Final Rule: CY2013 Physician Fee Schedule

Description: This major final rule with comment period addresses changes to the physician fee schedule, payments for Part B drugs, and other Medicare Part B payment policies to ensure that CMS payment systems are updated to reflect changes in medical practice and the relative value of services. It also implements provisions of the Affordable Care Act by establishing a face-to-face encounter as a condition of payment for certain durable medical equipment (DME) items. In addition, it implements statutory changes regarding the termination of non-random prepayment review.

The rule will be published on November 16, 2012. It will take effect January 1, 2013 with a comment period that closes on December 31, 2012.

Major Provisions:

- ***Sustainable Growth Rate:*** The final rule includes the statutorily required **26.5 percent across-the-board reduction to Medicare payment rates** under the Balanced Budget Act of 1997's Sustainable Growth Rate (SGR) methodology. Without Congressional action, this will affect more than 1 million physicians and non-physician practitioners.

- ***Primary Care:*** The changes in care coordination payment and other changes in the rule are expected to increase payment to family practitioners by **seven percent** - and other primary care practitioners — such as internal medicine physicians, pediatricians, and nurse practitioners — between **three and five percent** (emergency room physicians and OB/GYNs have been excluded).
    - Much of the increase in the physician fee schedule reimbursement will come from new added payments for coordinating a patient's care in the 30 days following a hospital or skilled nursing facility stay. Under the rule, providers will for the first time receive a separate payment to help a patient transition back to the community following a discharge.
    - The proposed post-discharge transitional care HHCPCS G code involves the following required elements:
        - Communication (direct contact, telephone, electronic) with the patient or caregiver within two business days of discharge.
        - Medical decision making of moderate or high complexity during the service period.
        - To be eligible to bill the service, physicians or qualified nonphysician practitioners must have had a face-to-face E/M visit with the patient in the 30 days prior to the transition in care or within 14 business days following the transition in care.

- ***Physician Value-Based Modifier:*** The final rule with comment period continues the careful implementation of the physician value-based payment modifier by phasing in application of the

modifier and enabling physicians in larger groups to choose how to participate. The statute allows CMS to phase in the value modifier over three years from 2015 to 2017.

  - The final rule applies the value modifier to groups of physicians with 100 or more eligible professionals, a change from the proposed rule, which would have set the group size at 25 or above.
  - For physicians and groups of physicians who elect to participate in 2015, common sense incentives will improve the care that beneficiaries receive; physicians with higher quality and lower costs will be paid more, and those with lower quality and higher costs will be paid less. The performance period for the application of the value modifier in CY 2015 was previously established as CY 2013 in the CY 2012 MPFS final rule.

- ***Specialists will still see reduced charge rates:*** The proposed rule stated that many specialty physicians will see their Medicare rates decrease, and that carried forward in the final rule as well. Here are some of following specialties that will see the biggest decreases in Medicare total charge rates/payments: independent laboratory providers (**14 percent**), neurologists (**seven percent**), radiation oncologists (**seven percent**), pathologists (**six percent**), interventional radiologists (**three percent**) and cardiologists (**two percent**).

- ***Multiple Procedure Payment Reductions (MPPR):*** The final rule applies a **payment reduction to the technical component (TC) of the second and subsequent imaging services and diagnostic tests furnished in the same session**. Such an approach will define imaging consistent with the existing definition of imaging for purposes of the statutory cap on PFS payment at the OPPS rate including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography.

- The final rule also **expanded Medicare telehealth services** and simplified reporting within the Medicare Electronic Health Records Incentive Pilot Program for physicians.

- **Medicare will now pay certified registered nurse anesthetists** for providing all services that are allowable under state law and within the full extent of their state's scope of practice.