CMS Releases CY2015 Physician Fee Schedule Proposed Rule

From NASL

Late on July 3, 2014, the Centers for Medicare & Medicaid Services (CMS) issued the *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, the Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare & Medicaid Innovation Models, & Other Revisions to Part B for CY 2015 (PFS) Proposed Rule* effective for services on and after January 1, 2015. The proposed rule will be published in the *Federal Register* on July 11, 2014. CMS will accept comments on the proposed rule until September 2, 2014. To view the proposed rule, please visit the *Federal Register* Public Inspection Desk at https://www.federalregister.gov/public-inspection. CMS' Fact Sheet can be viewed here.

The Proposed Rule includes changes to the misvalued CPT code review process as well as several of the reporting initiatives that are associated with PFS payments the Physician Quality Reporting System (PQRS), Medicare Shared Savings Program and Medicare Electronic Health Record (EHR) Incentive Program, as well as changes to the Physician Compare tool on Medicare.gov. The proposed rule also continues the phased-in implementation of the physician value-based payment modifier. The modifier provides differential payments to physicians based on comparison of the quality of care furnished to beneficiaries and the cost of care.

The following is an overview of the proposed policy and payment changes to the Medicare Physician Fee Schedule for Calendar Year 2015 of interest to NASL members.

Sustainable Growth Rate (SGR)
Although Medicare physician and Part B provider pay rates are due to be cut by at least 20 percent under the SGR, the proposed rule does not include proposals or announcements on the PFS update or SGR as these calculations are determined under a prescribed statutory formula that cannot be changed by CMS. The final figures are announced in the final rule in November. The *Protecting Access to Medicare Act (PAMA) of 2014* provides for a zero percent PFS update for services furnished through March 31, 2015.

Potentially Misvalued Services Under the PFS
CMS has been engaged in a multi-year effort to identify and review potentially misvalued codes and to make adjustments where appropriate. In this year's proposed rule, CMS is proposing to add about 80 codes to its list of potentially misvalued codes, 65 of which account for the majority of spending under the Physician Fee Schedule. CMS identified codes by reviewing high-expenditure services by specialty that have not been recently reviewed. Codes under review include those used in therapy such as 97032 Electrical stimulation, 97035 Ultrasound therapy, 97110 Therapeutic exercises, 97112 Neuromuscular reeducation, 97113 Aquatic therapy/exercises, 97116 Gait training therapy, 97140 Manual therapy 1/> regions, 97530 Therapeutic activities and G0283 Elec stim other than wound.

Geographic Practice Cost Indices (GPCIs)
CMS is required to review and revise the GPCIs at least every 3 years and phase in the adjustment over 2 years (if there has not been an adjustment in the past year). For CY 2015, CMS is not proposing any revisions related to the data or the methodologies used to calculate the GPCIs except in regard to the Virgin Islands. The CY 2015 GPCI reflects the application of the statutorily mandated 1.5 work GPCI in Alaska, and 1.0 work GPCI floor for all other Physician Fee Schedule areas and the 1.0 Practice Expense GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota and Wyoming). However, given that the statutory 1.0 work GPCI floor is scheduled to expire under current law on March 31, 2015, CMS has included two sets of GPCIs and geographic adjustment factors (GAFs) for CY 2015 – one set for January 1, 2015 through March 31, 2015, and another set for April 1, 2015 through December 31, 2015. The April 1, 2015 through December 31, 2015 GPCIs and GAFs reflect the statutory expiration of the 1.0 work GPCI floor.

Telehealth Services
CMS is proposing to add the following to its list of services that can be furnished to Medicare beneficiaries under the telehealth benefit: annual wellness visits, psychoanalysis, psychotherapy and prolonged evaluation and management services.

Valuing New, Revised and Potentially Misvalued Codes
Created through a process in the CY 2012 PFS, CMS establishes a final list of potentially misvalued codes in the final rule for that year. CMS is proposing to revise the current process such that it would propose work and malpractice RVUs and direct PE inputs for all new, revised and potentially misvalued codes in a proposed rule. Under the proposed approach, for those codes for which it has complete RUC recommendations by January 15th of the preceding year, CMS would evaluate the RUC recommendations for all new, revised and potentially misvalued codes and include proposed work and malpractice RVUs and direct PE inputs in the first available PFS proposed rule for the next calendar year, and it would establish final values in the final rule. Thus, for the CY 2016 rulemaking process, which is the first rulemaking to which this proposed process would apply, it would include codes for which it has complete RUC recommendations by January 15, 2015, and, if finalized the values would take effect on January 1, 2016. CMS is seeking comments on its proposed approach.

Chronic Care Management (CCM)
CMS continues to emphasize primary care management services by beginning to make separate payment for chronic care management (CCM) services beginning in 2015, for beneficiaries who have multiple, significant chronic conditions (two or more). CMS proposes: a payment rate of $41.92 for the code that can be filled no more frequently than once per month per qualified patient; to allow greater flexibility in the supervision of clinical staff providing CCM services; and one additional requirement – standards for electronic health records – and seek comment on whether additional standards are needed. CMS is not proposing to establish separate standards that practitioners and practices furnishing this service would have to meet, as indicated last year.

Conditions Regarding Permissible Practice Types for Therapists in Private Practice
Based on CMS' recent review of regulations for services furnished by therapists in private practice, including basic qualifications necessary to qualify as a supplier of occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP), CMS is concerned that the language is not as clear as it could be, especially with regard to the relevance of whether a practice is incorporated. The regulations appear to make distinctions between unincorporated and incorporated practices, and some practice types are listed twice.

CMS is proposing changes to the regulatory language to remove unnecessary distinctions and redundancies within the regulations for OT, PT and SLP. To consistently specify the permissible practice types (a solo practice, partnership, or group practice; or as an employee of one of these) for suppliers of outpatient therapy services in private practice (for occupational therapists, physical therapists and speech-language pathologists), CMS proposes to replace the regulatory text at §410.59(c)(1)(ii)(A) through (E), §410.60(c)(1)(ii)(A) though (E), and §410.62(c)(1)(ii)(A) through (E).

Clinical Laboratory Fee Schedule

CMS notes, in the CY 2014 PFS final rule with comment period, they finalized a process under which they would reexamine the payment amounts for test codes on the Clinical Laboratory Fee Schedule (CLFS) for possible payment revision based on technological changes beginning with the CY 2015 proposed rule. Now that Congress enacted the *Protecting Access to Medicare Act (PAMA) of 2014 (Public Law 113-93),* this new law requires CMS to implement a new Medicare payment system for clinical diagnostic laboratory tests based on private payor rates and Section 216 of the *PAMA* rescinds CMS' statutory authority for adjustments based on technological changes. Instead, CMS will establish through rulemaking the parameters for the collection of private payor rate information and other requirements to implement section 216 of the *PAMA*. This rulemaking will begin in the early fall.

Physician Quality Reporting System (PQRS)

The Physician Quality Reporting System (PQRS) is a pay-for-reporting program that uses a combination of incentive payments and downward payment adjustments to promote reporting of quality information by eligible professionals (EPs). The program provides an incentive payment through 2014 to EPs and group practices who, during the applicable reporting period, satisfactorily report data on quality measures for covered professional services furnished to Medicare Part B fee-for-service beneficiaries or satisfactorily participate in a qualified clinical data registry (QCDR). Beginning in 2015, a downward payment adjustment will apply to EPs who do not satisfactorily report data on quality measures for covered professional services or satisfactorily participate in a QCDR. In the CY 2015 PFS proposed rule, CMS is proposing updates to the PQRS primarily related to the 2017 PQRS payment adjustment.

Electronic Health Record (EHR) Incentive Program

The *HITECH Act* authorizes incentive payments under Medicare and Medicaid for the adoption and meaningful use of certified EHR technology (CEHRT). Section 1848(o)(2)(B)(iii) of the *Act* requires that in selecting clinical quality measures (CQMs) for eligible professionals (EPs) to report under the EHR Incentive Program, and in establishing the form and manner of reporting, the Secretary shall seek to avoid redundant or duplicative reporting otherwise required. This section of the rule discusses steps CMS has taken to establish alignments among various quality reporting and payment programs that include the submission of CQMs. While we are still requiring EPs report on the most recent version of electronically specified clinical quality measures (eCQMs), CMS is proposing that EPs would not be required to ensure that their Certified EHR Technology (CEHRT) products are recertified to the most recent version of the electronic specifications for the CQMs.

For further information, please visit NASL.org.

HHI 7/7/2014