DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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- **"Medicaid Program Integrity: Preventing Provider Medical Identity Theft"** Fact Sheet, ICN 908265, Downloadable

MLN Matters® Number: MM9034 | **Related Change Request (CR) #: CR 9034**

Related CR Release Date: December 24, 2014 | **Effective Date: January 1, 2015**

Related CR Transmittal #: R3157CP | **Implementation Date: January 5, 2015**

Summary of Policies in the Calendar Year (CY) 2015 Medicare Physician Fee Schedule (MPFS) Final Rule and Telehealth Originating Site Facility Fee Payment Amount

Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 9034 which provides a summary of the policies in the CY 2015 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. Make sure that your billing staff are aware of these updates for 2015.

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Background

The Social Security Act (Section 1848(b)(1); (see **http://www.ssa.gov/OP_Home/ssact/title18/1848.htm** on the Internet) requires the Centers for Medicare & Medicaid Services (CMS) to establish a fee schedule of payment amounts for physicians' services for the subsequent year. CMS issued a final rule with comment period on October 13, 2014 (see **https://www.federalregister.gov/articles/2014/11/13** on the Internet), that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in CY 2015.

The final rule also addresses public comments on Medicare payment policies that were described in the proposed rule earlier this year: "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare & Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule" was published in the Federal Register on July 11, 2014. (See **http://www.gpo.gov/fdsys/pkg/FR-2014-07-11/pdf/2014-15948.pdf** on the Internet).

The final rule also addresses interim final values established in the CY 2014 MPFS final rule with comment period. (See **http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf** on the Internet). The final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2015 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until December 30, 2014.

Sustainable Growth Rate (SGR)

The Protecting Access to Medicare Act of 2014 (see **http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf** on the Internet) provides for a zero percent update from the CY 2014 rates for services furnished **between January 1, 2015, and March 31, 2015**. Adjusting by .06 percent to achieve required budget neutrality, the conversion factor for this period is $35.8013.

Under current law, the conversion factor will be adjusted on April 1, 2015. In the final rule CMS announced a conversion factor of $28.2239 for this period, resulting in an average reduction of 21.2 percent from the CY 2014 rates. In most prior years, Congress has taken action to avert large across-the-board reductions in PFS rates before they went into effect. The Administration supports legislation to permanently change SGR to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

Screening and Diagnostic Digital Mammography

To ensure that the higher resources needed for 3D mammography are recognized, Medicare will pay for 3D mammography using add-on codes that will be reported in addition to the 2D mammography codes when 3D mammography is furnished. See **MLN Matters® Article MM8874** for more information.

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Primary Care and Chronic Care Management

Medicare continues to emphasize primary care by making payment for chronic care management (CCM) services -- non-face-to-face services to Medicare beneficiaries who have two or more chronic conditions -- beginning January 1, 2015. CCM services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management. CCM can be billed once per month per qualified beneficiary, provided the minimum level of services is furnished.

CMS is finalizing its proposal to allow greater flexibility in the supervision of clinical staff providing CCM services. The proposed application of the "incident to" supervision rules was widely supported by the commenters.

Payment for CCM is only one part of a multi-faceted CMS initiative to improve Medicare beneficiaries' access to primary care. Models being tested through the Innovation Center will continue to explore other primary care innovations.

Finally, CMS will require that in order to bill CCM, a practitioner must use a certified electronic health record (EHR) that meets the requirements for the EHR Incentive Program as of December 31 of the prior calendar year.

Application of Beneficiary Cost Sharing To Anesthesia Related To Screening Colonoscopies

The Medicare statute waives the Part B deductible and coinsurance applicable to screening colonoscopy. In the CY 2015 final rule, CMS revised the definition of a "screening colonoscopy" to include separately provided anesthesia as part of the screening service so that the coinsurance and deductible do not apply to anesthesia for a screening colonoscopy, reducing beneficiaries' cost-sharing obligations under Part B. For more information, review **MLN Matters® Article MM8874** on the CMS website.

Enhanced Transparency in Setting PFS Rates

Since the beginning of the physician fee schedule in 1992, CMS adopted rates for new and revised codes for the following calendar year in the final rule on an interim basis subject to public comment. This policy was necessary because CMS did not receive the codes in time to include in the PFS proposed rule. Until recently, the only services that were affected by this policy were services with new and revised codes. In recent years, CMS began receiving new and revised codes and revaluing existing services under the misvalued codes initiative. Establishing payment in the final rule for misvalued codes often led to implementation of payment reductions before the public had the opportunity to comment.CMS finalized its proposal to change the process for valuing new, revised and potentially misvalued codes for CY 2016, so that payment for the vast majority of these codes goes through notice and comment rulemaking prior to being adopted. After a transition in CY 2016, the process will be fully implemented in CY 2017.

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Potentially Misvalued Services

Consistent with amendments to the Affordable Care Act (see **http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf** on the Internet), CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and to make adjustments where appropriate.

The following are major misvalued code decisions for 2015:

- **Radiation Therapy and Gastroenterology**: Consistent with the final rule policy and in response to public comments, CMS is not adopting the CPT coding changes for CY 2015 for gastroenterology and radiation therapy services so that CMS can propose and obtain comments on the revised coding prior to using them for payment. As a result, CMS will not recognize some new CPT codes, and created G-codes in place of changed and new CPT codes.
- **Radiation Treatment Vault:** CMS proposed to refine the way it accounts for the infrastructure costs associated with radiation therapy equipment, specifically to remove the radiation treatment vault as a direct expense when valuing radiation therapy services. After considering public comments, CMS did not finalize this proposal.
- **Epidural Pain Injections:** CMS reduced payment for these services in 2014 under the misvalued code initiative. In response to concerns from pain physicians regarding the accuracy of the valuation, CMS proposed to raise the values in 2015 based on their prior resource inputs before adopting further changes after considering RUC recommendations. However, because the inputs for these services included those related to image guidance, CMS also proposed to prohibit separate billing for image guidance for CY 2015. CMS finalized the policy as proposed to avoid duplicate payment for image guidance. CMS has asked the RUC to further review this issue and make recommendations to us on how to value epidural pain injections.
- **Film to Digital Substitution:** CMS finalized its proposal to update the practice expense inputs for X-ray services to reflect that X-rays are currently done digitally rather than with analog film.

Global Surgery

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) has identified a number of surgical procedures that include more visits in the global period than are being furnished. CMS is also concerned that post-surgical visits are valued higher than visits that were furnished and billed separately by other physicians such as general internists or family physicians.

CMS finalized a proposal to transform all 10- day and 90-day globals to 0-day globals, beginning with 10-day global services in CY 2017 and following with the 90-day global services in 2018. As CMS revalues these services as 0-day global periods, CMS will actively assess whether there is a

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better construction of a bundled payment for surgical services that incentivizes care coordination and care redesign across an episode of care.

Access to Telehealth Services

CMS is adding the following services to the 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.

For the list of telehealth services, visit: **http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html** on the CMS website.

Telehealth Origination Site Facility Fee Payment Amount Update

The Social Security Act (Section 1834(m)(2)(B) (see **http://www.ssa.gov/OP_Home/ssact/title18/1834.htm**) establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20.

For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in the Social Security Act (Section 1842(i)(3) (see **http://www.ssa.gov/OP_Home/ssact/title18/1842.htm** on the Internet).

The MEI increase for 2015 is 0.8 percent. Therefore, for CY 2015, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $24.83. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Revisions to Malpractice Relative Value Units (RVUs)

As required by the Medicare law, CMS conducted a five-year review and updated the resource-based malpractice RVUs based on updated professional liability insurance premiums, largely paralleling the methodology used in the CY 2010 update. The final rule indicated that anesthesia RVUs will be updated in CY 2016.

Revisions to Geographic Practice Cost Indices (GPCIs)

As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in the cost of operating a medical practice. For CY 2015, CMS is using territory-level wage data to calculate the work GPCI and employee wage component of the PE GPCI for the Virgin Islands.

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The CY 2015 GPCIs also reflect the application of the statutorily mandated of 1.5 work GPCI floor in Alaska, and 1.0 work GPCI floor for all other physician fee schedule areas, and the 1.0 PE 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, the GPCIs reflect the elimination of the 1.0 work GPCI floor from April 1, 2015, through December 31, 2015.

Services Performed in Off-campus Provider-Based Departments

CMS will collect data on services furnished in off-campus provider-based departments by requiring hospitals to report a modifier for those services furnished in an off-campus provider-based department of the hospital and by requiring physicians and other billing practitioners to report these services using a new place of service code on professional claims.

Data collection will be voluntary for hospitals in 2015 and required beginning on January 1, 2016. The new place of service codes will be used for professional claims as soon as it is available, but not before January 1, 2016.

Additional Information

The official instruction, CR 9034, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3157CP.pdf** on the CMS website.

For more information about the EHR Program, go to **http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html** on the CMS website.

The final rule, published on November 13, 2014, is available at **http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf** on the Internet.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** on the CMS website.

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