Part B Insider (Multispecialty) Coding Alert

Part B Payment: Final 2014 Fee Schedule Confirms 20.1 Percent Conversion Factor Cut

Services hit hardest include ECGs, lesion destruction.

If you're looking for a silver lining to the Final 2014 Medicare Physician Fee Schedule, it's that although the conversion factor will be steeply slashed by 20.1 percent, it could have been worse, since the proposed fee schedule had predicted a bigger cut. That's the word from the Final Rule, which will be published in the Federal Register on Dec. 10.

Make Congressional Intervention Your New Year's Wish

CMS notes in the Final Rule that the confirmed conversion factor is $27.2006, which is a 20.1 percent cut from the current rate of $34.0230. Although this is better news than the $26.7109 that CMS had predicted for 2014 in the proposed rule, it's still quite dismal, and most practices would not be able to stay in business if they lost 20 percent of their Medicare income. Therefore, as in prior years, practices will have to keep their fingers crossed that Congress votes to increase the conversion factor before Jan. 1 so that physicians don't face such severe cuts.

Physician advocacy organizations are understandably tired of the annual waiting game for Congress to fix the conversion factor. The American Medical Association urged Congress to repeal the current sustainable growth rate formula as soon as possible so this problem can be rectified.

"The AMA has heard the nation's physicians and we're pulling out the stops to get Congress to act and take a fiscally responsible course that will stop the annual cycle of draconian Medicare cuts and short-term patches," said AMA President Ardis Dee Hoven, MD at the AMA's Nov. 18 meeting. "Now is the time to move past the annual SGR crisis and toward a Medicare program that ensures access to high-quality and efficient health care for patients and a stable practice environment for physicians."

Other Specialties Could Face Steeper Cuts

The 20.1 percent cut in the conversion factor will unfortunately not be the only pay cut that the finalized Fee Schedule holds for medical practices.

The hardest hit based on Medicare's proposal will be diagnostic testing facilities, which face a startling 11 percent cut. CMS points out that this is "estimated prior to the application of the negative 2014 on version factor update." In other words, these facilities will face the 20.1 percent overall cut in addition to a 11 percent reduction in pay.

Also impacted negatively will be pathologists, who face a six percent cut, as well as allergists, who will see pay slashed by three percent, and interventional pain management specialists, who face a four percent cut.

As for specific procedures that will take big hits in 2014, you'll see a 34 percent pay cut when performing destruction of premalignant lesions (17000), a 27 percent pay cut performing post-cataract laser surgery (66821), and a 33 percent cut for complete electrograms (93000). You can find the full list of slashed payments starting on page 1,289 of the CMS Final Rule.

Look Ahead to 2015 for Chronic Care Bonuses

As outlined in the proposed rule, the final rule confirms you could see bonuses in 2015 if you care for patients with

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multiple chronic conditions. These bonuses will reflect payments outside of the E/M services for face-to-face visits that you already collect for these patients.

"Health care is changing, and part of delivery system reform is recognizing this and making sure payment systems account for these changes," said CMS Principal Deputy Administrator Jonathan Blum in a Nov. 27 statement. "We believe that successful efforts to improve chronic care management for these patients could improve the quality of care while simultaneously decreasing costs, through reductions in hospitalizations, use of post-acute care services, and emergency department visits."

CMS will be establishing two "G" codes for the new chronic care services, and although the specific code numbers have not been identified, the descriptors were described as follows:

- Gxxx1: Complex chronic care management services furnished to patients with multiple (two or more) complex chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; Initial services; one or more hours; initial 90 days
- Gxxx2: ...Subsequent services; one or more hours; subsequent 90 days.

The second code (Gxxx2) will be limited to the 90-day periods when the patient's medical needs require "substantial revision of the care plan," CMS says in the Final Rule.

CCI plans: And if you're planning to "double dip" for your chronic care services, CMS is already preparing to nip that in the bud, proposing that chronic care management services include transitional care management (99495, 99496), home health care supervision (G0181) and hospice care supervision (G0182). "If furnished, to avoid duplicate payment, we proposed that these services may not be billed separately during the 90 days for which either Gxxx1 or Gxxx2 are billed," CMS says in the Final Rule.

To read CMS's final 2014 Physician Fee Schedule rule, visit www.ofr.gov/(X(1)S(p1ydjssklek03usvybyvckft))/OFRUpload/OFRData/2013-28696_PI.pdf.

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