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Pain Management Coding Alert

2016 Changes: Don't Miss How RVU Reductions Might Hit Your Reimbursement

Plus incident-to coding could also see updates.

You might not mind moving into 2016 coding because you won't be dealing with the devastating conversion factor cuts of the past. But some other changes announced by CMS in its Proposed Medicare Physician Fee Schedule for 2016 could be just as painful to your bottom line, thanks to a revamp of RVU (relative value unit) valuations.

Get the Scoop on the RVU Reduction Plan

The Protecting Access to Medicare Act (PAMA) required Medicare to phase in reductions of 20 percent or more RVUs over a period of two years. Rather than dividing those reductions into two equal parts, CMS has proposed a different methodology.

According to the proposed 2016 Medicare Physician Fee Schedule, CMS wants to base the payment reduction on how much the RVU value drops. If the value of the RVU drops by 20 percent or more, CMS proposes a 19 percent reduction for physician payment in the first year and the remainder of the cut the second year. The proposed 19 percent limit means the bulk of cuts for most services would happen the first year, followed by a moderate cut. The exception would be for services that have a 40 percent (or greater) RVU reduction. In those cases, the larger cut would come during the second year.

Keep these points in mind when reading up on the proposed RVU reduction:

- The two-year reduction only applies to procedures with no changes to their codes. A code would be excluded from the phased-in reduction if its descriptor is revised or if the code describes different services because of a descriptor change within the code family.
- When new or revised codes are being valued, CMS will interpret PAMA to mean that the 20 percent threshold does not apply.
- Changes in values because of the place of service or technical/professional components could impact how the reductions are implemented. For example, the technical component of a service might be reduced in the first year and the professional component reduced the second.

PM focus: Each year, CMS identifies (and asks for help identifying) codes that are potentially misvalued. The current list being evaluated includes a procedure of importance to pain management specialists: 96372 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular).

You might report 96372 when your provider administers therapeutic injections of substances such as Kenalog or Toradol for pain relief. One reason CMS includes 96372 on its "watch list" is because it's a high-volume code. Keep a close eye on every detail when you file 96372 to ensure you're reporting it correctly.

Prepare for Potential Incident-to Changes

Another proposed change by CMS affects every specialty that files incident-to claims. The suggested changes which

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allows a non-physician practitioner (NPP) to bill under the physician's ID number and collect a full fee rather than filing under the NPP's number and collecting 15 percent less.

Proposed 2016 way: In the proposed fee schedule, CMS suggests only paying for incident to services if the doctor who provides the direct supervision for the NPP and thus is the physician under which the NPP's service is billed is the physician that developed the patient's plan of care. That's a big change from the current policy of allowing direct supervision and reporting any physician in the office on the claim as the person providing direct supervision for the NPP who performs the service.

"To be certain that the incident to services furnished to a beneficiary are in fact an integral, although incidental, part of the physician's or other practitioner's personal professional service that is billed to Medicare, we believe that the physician or other practitioner who bills for the incident to service must also be the physician or other practitioner who directly supervises the service," CMS says in the proposed rule.

In addition, CMS is proposing that the person providing the incident to service does so in accordance with state law and is licensed to do it. The incident to provider also cannot have been excluded from any federal health care program or have had their enrollment revoked for any reason. In other words, just because the service is billed under a supervising doctor's number doesn't mean the performing NPP can be excluded from Medicare.

CMS released the proposed rule on July 8. Physicians can submit comments to CMS regarding the proposal until Sept. 8, 2015 (it was published in the July 15, 2015, Federal Register). CMS will release the final rule by Nov. 1.

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