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CMS Releases Final Physician Fee Schedule Rule: Key Payment and Policy Highlights [Ober|Kaler]

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On October 31, 2014, CMS released the final Medicare physician fee schedule (PFS) rule. The new payment policies and rates set forth in the PFS final rule will go into effect on or after January 1, 2015.

Highlights of the final rule include:

- ***Sustainable Growth Rate:*** Current law requires physician fee schedule rates to be reduced by an average of 21.2 percent from the CY 2014 rates. However, the Protecting Access to Medicare Act of 2014 provides for a zero percent PFS update for services furnished between January 1, 2015 and March 31, 2015. Unless Congress acts, Medicare physician payment rates are subject to a 21.2 percent reduction, effective March 1, 2015.
- ***Primary care and chronic care management:*** Effective January 1, 2015, CMS will make payments for chronic care management (CCM) services, at a rate of $40.39, billable once per month per qualified patient. CCM services are described in the CMS fact sheet as "non-face-to-face services [for] Medicare beneficiaries who have multiple, significant, chronic conditions (two or more)." Providers may bill CCM services as "incident to."
- ***Global Surgery – Elimination of 10 and 90 day global codes:*** Surgeons are paid a single global fee, which may include the value of the surgical procedure and post-surgery visits for up to 10 days or 90 days. Effective calendar year (CY) 2017, CMS is transforming all 10 day global surgery codes to 0 day global codes. Likewise, in CY 2018, CMS plans to transition all 90 day global services to 0 day global codes. Pursuant to this payment change, medically reasonable and necessary visits will be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure. The payment change seeks to address two concerns raised by CMS: (1) CMS's global payments for surgical procedures pay for more follow-up care than is, on average, provided to patients and (2) postsurgical visits are valued higher than visits furnished and billed separately by other physicians, such as general internists or family physicians.
- ***Data collection for off-campus provider-based departments:*** Effective January 1, 2016, CMS will require hospitals to report a modifier for services furnished in an off-campus provider-based department of the hospital. Reporting will be voluntary for hospitals in 2015. CMS's stated goal in collecting such information is, at least in part, to better understand differences in practice costs at different sites.
- ***Telehealth services:*** Annual wellness visits, psychoanalysis, psychotherapy, and prolonged evaluation and management services may now be furnished to Medicare beneficiaries under the telehealth benefit.
- ***Increased transparency in how PFS rates are set:*** Historically, CMS has adopted rates in its final PFS rule for new and revised codes for the following calendar year on an interim basis, subject to public comment. To ensure payment policies are subject to public scrutiny prior to implementation – particularly payment reductions – CMS is changing the process for valuing the "vast majority" of such codes. Payment changes will go through notice and comment rulemaking before being adopted. Pursuant to the CMS fact sheet, the new, more transparent process will be fully implemented in CY 2017, with a transition period in CY 2016.

- ***Radiation codes:*** CMS originally proposed to reclassify radiation treatment vaults (protective encasements built around linear accelerators to protect workers from radiation) as indirect, rather than direct, practice expenses. Such code changes would have resulted in significant radiation therapy cuts in 2015. However, in response to public comments, CMS is not adopting the proposed code changes.