



Final 2013 Medicare Physician Fee Schedule

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Executive Summary

On November 1, the Centers for Medicare & Medicaid Services (CMS) released the [final 2013 Medicare Physician Fee Schedule](#). This regulation addresses changes to the physician fee schedule and other Medicare Part B payment policies and implements certain provisions of the *Affordable Care Act* (ACA). It also discusses the 2013 Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, potentially misvalued codes, additions to the Medicare Telehealth Services, updates to the Physician Compare website, and further implements the Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program.

Particularly notable to family physicians, CMS finalized new Medicare coverage for two transitional care management (TCM) codes. These codes are designed to pay a patient’s physician or practitioner to coordinate the patient’s care in the 30 days following a hospital or nursing facility stay. According to the related CMS [press release](#), “the changes in care coordination payment and other changes in the rule are expected to increase payment to family practitioners by seven percent and other primary care practitioners between three and five percent, if Congress averts the statutorily required reduction in Medicare’s physician fee schedule.”

When regulatory policy changes to the relative value units (RVUs) cause expenditures to change by more than \$20 million, CMS must apply an adjustment to the conversion factor to preserve budget neutrality. The agency then states that “Several changes affect the specialty distribution of Medicare expenditures. This final rule with comment period reflects the Administration’s priority to improve payment for primary care services.” And then later, “In the absence of a change in the conversion factor, payments to primary care specialties will increase and payments to select other specialties will decrease due to several changes in how we calculate payments for CY 2013.”

The AAFP recognizes that CMS made an effort to help rectify the worsening gap between payment to primary care physicians and subspecialists. Of this estimated 7 percent, 2 percent stems from the phased-in use of the Physician Practice Information Survey (PPIS) data, discussed further in the Changes to Relative Value Units section, and the remaining 5 percent is the CMS estimated impact on family physicians using an assumption that 5.7 million of the new TCM codes will be billed in 2013. The TCM codes are further discussed in the Primary Care and Care Coordination section.

In a [statement](#) after the final rule became available, the AAFP highlighted that the regulation “confirmed that - short of immediate Congressional action - Medicare payment for needed medical care services will be slashed by 26.5 percent. The 2013 schedule once again focuses a bright light on the dysfunctional sustainable growth rate formula on which Medicare payment is based. It re-emphasizes the imperative that Congress needs to permanently change the basis for calculating Medicare physician payment.” The AAFP calls on Congress to act immediately to prevent this cut from going into effect on January 1 and to permanently reform Medicare physician payment. Access the AAFP’s grassroots website (www.aafp.org/grassroots) today and tell your Congressional legislators how this cut will impact your practice and Medicare patients.

Earlier this year, CMS released the [proposed 2013 Medicare Physician Fee Schedule](#) on May 11 and the AAFP responded to this proposal in an August 22 [letter](#) to CMS.

Conversion Factor for 2013

On December 23, 2011, the *Temporary Payroll Tax Cut Continuation Act* was signed into law resulting in a two-month zero-percent update for physician fee schedule claims submitted from January 1, 2012 through February 29, 2012. On February 22, 2012, the President signed the *Middle Class Tax Relief and Job Creation Act*, which extended the zero-percent update for the remainder of 2012. As a result of these two laws, the 2012 physician fee schedule conversion factor is \$34.0376.

In the initial proposal, CMS estimated that the statutory formula used to determine Medicare physician payments would result in a decrease of 27 percent, but in this final rule, CMS updated that estimate to 26.5 percent. Thus, unless Congress intervenes, Medicare payments for physician services will be slashed by 26.5 percent for dates of service on or after January 1, 2013, resulting in a 2013 conversion factor of \$25.0008 as further illustrated by Table 87 from the final rule:

TABLE 87: CALCULATION OF THE CY 2013 PFS CF

Conversion Factor in effect in CY 2012		\$34.0376
CY 2012 Conversion Factor had statutory increases not applied		\$24.6712
CY 2013 Medicare Economic Index	0.8 percent (1.008)	
CY 2013 Update Adjustment Factor	0.6 percent (1.006)	
CY 2013 RVU Budget Neutrality Adjustment	-0.1 percent (0.99932)	
CY 2013 Conversion Factor		\$25.0008
Percent Change from Conversion Factor in effect in CY 2012 to CY 2013 Conversion Factor		-26.5%

Note: On January 3, President Obama signed into law the American Taxpayer Relief Act. This law prevents the 26.5 percent reduction to Medicare physician payments by continuing the current rate through December 31, 2013. Therefore, the 2013 Medicare conversion factor is \$34.0230.

Changes to the Relative Value Units

Background

Since 1992, Medicare pays for physician services based on relative value units (RVUs) for physician work, practice expenses (such as office rent and personnel wages), and malpractice expenses. CMS establishes physician work RVUs for new and revised codes based in part on recommendations received from the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC). In the past, CMS used Clinical Practice Expert Panels and the AMA’s Socioeconomic Monitoring System (SMS) data to develop practice expense RVUs, but beginning in 2010, CMS began utilizing the AMA’s Physician Practice Information Survey (PPIS). In 2010, CMS implemented the second review and update of malpractice RVUs.

To calculate the payment for a physician's service, the components of the fee schedule (physician work, practice expense, and malpractice RVUs) are adjusted by geographic practice cost indices (GPCIs). The GPCIs reflect the relative costs of physician work, practice expense, and malpractice in an area compared to

the national average costs for each component. RVUs are converted to dollar amounts through the application of a conversion factor.

The formula for calculating the Medicare fee schedule payment allowance for a given service and fee schedule area can be expressed as:

$$\text{Payment Allowance} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU practice expense} \times \text{GPCI practice expense}) + (\text{RVU Malpractice} \times \text{GPCI Malpractice})] \times \text{conversion factor}.$$

Proposed changes

In 2010, CMS initiated a four-year transition to the use of PPIS data for practice expense RVUs, and 2013 is the final year of the transition. The final year of the PPIS transition results in family physicians receiving an estimated 2-percent increase due to the changes in the RVU distribution. CMS proposed to continue the current method for determining malpractice RVUs by cross-walking codes to the malpractice RVUs of a similar source code and adjusting for differences in work between the source code and the new or revised code.

AAFP recommendations

In previous fee schedule comment letters, the AAFP actively supported the decision to use the revised data sources.

Final policy

CMS finalized many policies as proposed. In 2013, CMS will begin to incorporate two additional specialties' utilization data into the practice expense rate setting. CMS will use proxy practice expense per hour (PE/HR) values by cross-walking values from other specialties that furnish similar services. Sports Medicine will be cross-walked from Family Medicine and Cardiac Electrophysiology will be cross-walked from Cardiology.

For the interest rate utilized in computing equipment costs as part of its practice expense methodology, CMS also finalized the proposal to use a "sliding scale" approach based on the current Small Business Administration (SBA) maximum interest rates for different categories of loan size (price of the equipment) and maturity (useful life of the equipment). CMS will update the interest rate assumption through future rulemaking to account for fluctuations in the prime rate and changes to the SBA's formula to determine maximum allowed interest rates. CMS clarified that the agency generally intends to update the interest rate calculation through future rulemaking only in years when the agency broadly updates one or more of the other direct practice expense inputs; thus, updating the interest rate calculation will likely be less frequently than annually.

Potentially Misvalued Codes under the Physician Fee Schedule

Background

In lieu of the traditional 5-year review of RVUs, CMS and the RUC now identify and review potentially misvalued codes on an annual basis. The *Affordable Care Act* requires CMS to periodically identify, review, and adjust values for potentially misvalued codes with an emphasis on codes that:

- Have grown the most,
- Have experienced substantial changes in practice expenses,
- Are recently established for new technologies or services,
- Are multiple ones frequently billed together in conjunction with furnishing a single service,
- Have low relative values, particularly those that are often billed multiple times for a single treatment,
- Are so-called 'Harvard valued codes,' which have not been reviewed since the implementation of the Resource-Based Relative Value Scale (RBRVS), or
- Are determined inappropriate by CMS.

In the final 2012 Medicare physician fee schedule, CMS consolidated the formal 5-year review of work and practice expense RVUs with the annual review of potentially misvalued codes and established a process for CMS to accept public nominations of potentially misvalued codes for review coinciding with the release of the annual Medicare physician fee schedule. CMS still plans to review malpractice RVUs at 5-year intervals.

Proposed changes

CMS discussed that over 1,000 potentially misvalued codes have been identified and that they “intend to enter into a contract to assist ... in validating RVUs of potentially misvalued codes that will explore a model for the validation of physician work under the physician fee schedule, for both new and existing services.” Of these identified codes, over 650 are surgical services. Of these 650 codes, CMS completed a review of 450 of them. CMS further discussed that 36 codes were nominated by the public as potentially misvalued. CMS proposed to reduce the procedure time assumptions used in developing RVUs for intensity modulated radiation treatment (IMRT) delivery and stereotactic body radiation therapy (SBRT) delivery. These services have been identified as potentially misvalued by CMS and the Medicare Payment Advisory Commission (MedPAC). In addition, CMS requested that the RUC and public review these codes and provide valid and reliable alternative data sources to develop appropriate RVU amounts.

AAFP recommendations

The AAFP supported CMS’s intent to investigate potentially misvalued codes and to do so outside current processes. The AAFP remains fully committed to assisting CMS and the agency’s contractors in efforts to properly validate relative value units (RVUs) for the identified and potentially misvalued codes.

Final policy

CMS’s decisions regarding each of the potentially misvalued codes are available for separate [download](#) on CMS’s physician fee schedule website.

CMS continues to employ a multiple procedure payment reduction (MPPR) policy to adjust payment to reflect more appropriately the reduced resources involved with furnishing services that are frequently furnished together. For 2013, CMS proposed to apply the MPPR policy to the technical component (TC) of certain cardiovascular and ophthalmology diagnostic tests. Tables 11 – 16 in the final rule illustrate the impacted codes.

As indicated in the proposed rule, CMS will continue the current approach for determining malpractice RVUs for new or revised codes. The final rule also publishes a list of new or revised codes and the malpractice crosswalk(s) used for determining the related malpractice RVUs. These malpractice RVUs for new or revised codes are implemented for use in 2013 on an interim final basis and the malpractice crosswalks are subject to further public comment.

Geographic Practice Cost Indices

Background

CMS is required to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three components (physician work, practice expense, and malpractice) of the fee schedule. The agency must review and adjust as necessary the GPCIs at least every 3 years. Since 2009, a permanent 1.5 work GPCI floor for services furnished in Alaska has existed. Separately and since 2011, Congress set a permanent 1.0 practice expense GPCI floor for services furnished in “frontier states” (defined as at least 50 percent of the state’s counties have a population density of less than 6 persons per square mile). CMS identified five frontier states -- Montana, Wyoming, North Dakota, Nevada and South Dakota. For all other states, the current 1.0 physician work floor will expire at the end of 2012 unless Congress intervenes. CMS last updated the physician work GPCI in 2011 based on 2006-2008 Bureau of Labor Statistics (BLS) Occupational Employment Statistics data

Proposed changes

CMS discussed that 2013 is the final year of the sixth GPCI update and therefore the agency will propose changes for 2014. CMS did not propose GPCI changes in this regulation, though the regulation discussed the permanent 1.5 work GPCI floor for services furnished in Alaska, the 1.0 practice expense GPCI floor for the five frontier states, and the agency’s anticipation of the Institute of Medicine’s Phase II report on geographic adjustment in Medicare payment.

AAFP recommendations

The AAFP urged CMS to refocus efforts on ensuring a properly distributed healthcare workforce that is meeting the demands of a growing beneficiary population. It is AAFP policy to support the elimination of all geographic adjustment factors from the Medicare fee schedule, except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). The Institute of Medicine's recommendations would increase, rather than decrease, the number of payment localities and are thus inconsistent with AAFP policy; therefore, the AAFP urged CMS not to implement the recommendations.

Final policy

CMS indicates that the agency will respond to the report of the Institute of Medicine (IOM) in subsequent rulemaking. CMS notes that [Addenda D and E](#) reflect the expiration of the statutory 1.0 work GPCI floor, which is set to expire at the end of 2012 unless Congress intervenes. *Note: On January 3, President Obama signed into law the American Taxpayer Relief Act. This law prevents the 26.5 percent reduction to Medicare physician payments and extends the Medicare physician work geographical adjustment floor through December 31, 2013.* Without making any changes for 2013, CMS discussed various potential implications to the 10 different recommendations.

Medicare Telehealth Services for the Physician Fee Schedule

Background

In 2001, CMS defined Medicare telehealth services to include consultations, office visits, office psychiatry services, and any additional service specified by CMS when delivered via an interactive telecommunications system. CMS defines an interactive telecommunications system as, "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way real time interactive communication between the patient and the practitioner at the distant site." CMS notes that telephones, fax machines, and email systems do not meet this definition.

In 2002, CMS established a process for adding or removing services from the list of Medicare telehealth services. Since establishing this process and with certain coding requirements, CMS added individual and group health and behavior assessment and intervention services, psychiatric diagnostic interview examination, end-stage renal disease related services with 2 to 3 visits per month and 4 or more visits per month, individual and group medical nutrition therapy, neurobehavioral status exam, initial and follow-up inpatient telehealth consultations for beneficiaries in hospitals and skilled nursing facilities, subsequent hospital care, subsequent nursing facility care, individual and group kidney disease education, and individual and group diabetes self-management training services, and smoking cessation services.

Provided that the health care professional is licensed under state law to deliver the service being furnished via a telecommunications system, eligible providers at the distant site include physicians, physician assistants, nurse practitioners, clinical nurse specialist, nurse-midwives, clinical psychologists, clinical social workers, or registered dietitian or nutrition professionals.

Proposed changes

CMS proposed to add the following Healthcare Common Procedure Coding System (HCPCS) codes to the list of telehealth services for 2013:

- G0396: Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention, 15 to 30 minutes
- G0397: Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention greater than 30 minutes
- G0442: Annual alcohol misuse screening, 15 minutes
- G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- G0444: Annual Depression Screening for adults, 15 minutes
- G0445: High-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semiannually, 30 minutes
- G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

- G0447: Face-to-face behavioral counseling for obesity, 15 minutes

AAFP recommendations

The AAFP supports the proposals to add recently covered "additional preventive services" to the list of Medicare telehealth services for 2013 and intends to partner with CMS to help educate physicians about these preventive telehealth services newly available in 2013.

Final policy

CMS finalized the proposals to add HCPCS codes G0396, G0397, G0442, G0443, G0444, G0445, G0446, and G0447 to the list of telehealth services for CY 2013. CMS notes that all coverage guidelines specific to the services will continue to apply when these services are furnished via telehealth. For example, when the national coverage determination requires that the service be furnished to beneficiaries in a primary care setting, the telehealth originating site must also qualify as a primary care setting under the terms of the national coverage determination. Similarly, when the national coverage determination requires that the service be furnished by a primary care practitioner, the distant site practitioner who furnishes the telehealth service must also qualify as a primary care practitioner under the terms of the national coverage determination.

CMS also reminded the public that requests to add services to the list of Medicare telehealth services must be received by the end of the year for consideration in the next rulemaking cycle. For example, requests submitted before the end of 2012 will be considered in the proposed rule for the 2014 fee schedule.

Primary Care and Care Coordination

Background

CMS states that, "In recent years, we have recognized primary care and care coordination as critical components in achieving better care for individuals, better health for individuals, and reduced expenditure growth." CMS then lists a "series of initiatives designed to ensure accurate payment for, and encourage long-term investment in, primary care and care management services." These include the:

- Medicare Shared Savings Program, including the Pioneer Accountable Care Organization (ACO) model and the Advance Payment ACO model;
- Primary Care Incentive Payment program;
- Multi-payer Advanced Primary Care Practice;
- Federally Qualified Health Center Advanced Primary Care Practice demonstration; and
- Comprehensive Primary Care initiative.

CMS discussed that they "continue to explore other potential refinements to the physician fee schedule that would appropriately value primary care and care coordination within Medicare's statutory structure for fee-for-service physician payment and quality reporting." The agency noted that they continue, "...to hear concerns from the physician community that the care coordination included in many of the evaluation and management (E/M) services, such as office visits, does not adequately describe the non-face-to-face care management work involved in primary care."

Proposed changes

Noting that "the current E/M office/outpatient visit CPT codes were designed to support all office visits and reflect an overall orientation toward episodic treatment," CMS agreed that E/M codes may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries such as those who are returning to a community setting following discharge from a hospital or skilled nursing facility (SNF) stay.

CMS therefore proposed to create a single G-code that specifically described "post-discharge transitional care management services". The code would describe "all non-face-to-face services related to the transitional care management furnished by the community physician or qualified nonphysician practitioner within 30 calendar days following the date of discharge from an inpatient acute care hospital, psychiatric hospital, long-term care hospital, skilled nursing facility, and inpatient rehabilitation facility; hospital outpatient for observation services or partial hospitalization services; and a partial hospitalization program at a community mental health center to community-based care." In this discussion, CMS referred to the "community-based physician managing and

coordinating a beneficiary's care in the post-discharge period. We anticipate that most community physicians will be primary care physicians and practitioners.”

CMS had proposed reimbursement for the proposed new G-code by utilizing:

- The work RVU of CPT code 99238 (Hospital discharge day management; 30 minutes or less). This results in a proposed work RVU of 1.28.
- The clinical labor practice expense inputs for CPT 99214 (Level 4 established patient office or other outpatient visit). This results in a proposed practice expense RVU of 1.41.
- The malpractice expense RVUs for CPT 99214, which results in a proposed malpractice expense RVU of 0.09.

Based off the proposed RVU amounts and assuming that Congress interceded before 2013 to prevent the projected 26.5 percent reduction to the conversion factor, the AAFP estimated that payment for the proposed G-code would be approximately \$94.62.

CMS proposed that the post-discharge transitional care code would be payable only once in the 30 days following a discharge, per patient per discharge, to a single community physician or qualified nonphysician practitioner (or group practice) who assumes responsibility for the patient's post-discharge transitional care management. The post-discharge transitional care management service would be distinct from services furnished by the discharging physician or qualified nonphysician practitioner reporting CPT codes 99238, 99239, 99217, and 99234 - 99236. The post-discharge transitional care management code, like all other services paid under the physician fee schedule, would be subject to a 20-percent beneficiary coinsurance and the Part B deductible.

The agency concluded this section by discussing future proposals to support primary care under the Medicare physician fee schedule. Without making any specific proposal, CMS discussed methods to identify and pay "advanced primary care practices" that have implemented the patient centered medical home. CMS stated that, "Should any of these discrete proposals, like this one, become final policy, they may be short-term payment strategies that would be modified and/or revised to be consistent with broader primary care and care management and coordination services if the agency decides to pursue payment for a broader set of management and coordination services in future rulemaking."

AAFP recommendations

The AAFP supported CMS's proposal to create a post-discharge, transitional care management code as a short term payment strategy; however, the AAFP urged CMS to restrict use of this code to the patient's primary care physician.

Final policy

CMS discusses that, after publication of the proposed rule, the AMA's Chronic Care Coordination Workgroup (C3W) completed development of two new transitional care management (TCM) codes that are similar to the transitional care management G-code that CMS proposed to create.

CMS discussed receiving widespread public support for the effort to recognize and pay for TCM services. CMS accepted the recommendation to adopt the AMA's CPT TCM codes in place of the earlier proposal to create a TCM G-code. Mainly, CMS agreed with the AMA's CPT construction that uses two separate codes to distinguish between moderate and high complexity services in place of the single proposed G-code, which allowed for reporting services of either moderate or high complexity.

In 2013, CMS will pay for new CPT TCM codes 99495 and 99496 with some small modifications to the code descriptions developed by the AMA's C3W. CMS created [Table 26](#) to describe the key differences between its proposed G-code and the CPT TCM codes, 99495 and 99496.

In summary, these modifications are CMS's decision not to restrict the billing of the CPT TCM codes to established patients, clarification of the post-discharge service period, and the prohibition against billing a

discharge day management service on the same day that a required E/M visit is furnished under the CPT TCM codes for the same patient.

Below are the requirements of the CPT TCM codes as modified.

- 99495 Transitional Care Management Services with the following required elements:
 - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
 - Medical decision making of at least *moderate* complexity during the service period.
 - Face-to-face visit, within 14 calendar days of discharge.
- 99496 Transitional Care Management Services with the following required elements:
 - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
 - Medical decision making of *high* complexity during the service period.
 - Face-to-face visit, within 7 calendar days of discharge.

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- Communication (direct contact, telephone, electronic) with the patient or caregiver within 2 business days of discharge.
- Communication with home health agencies and other community services utilized by the patient.
- Patient and family/caretaker education to support self-management, independent living, and activities of daily living.
- Assessment and support for treatment regimen adherence and medication management.
- Identification of available community and health resources.
- Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- Obtaining and reviewing the discharge information (for example, discharge summary, as available, or continuity of care documents).
- Reviewing need for or follow-up on pending diagnostic tests and treatments.
- Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems.
- Education of patient, family, guardian, and/or caregiver.
- Establishment or reestablishment of referrals and arranging for needed community resources.
- Assistance in scheduling any required follow-up with community providers and services.

CMS finalized reimbursement for the two new CPT TCM codes as follows:

- 99495 (moderate complexity):
 - Work RVU of 2.11 with intra-service time of 40 minutes.
 - Malpractice RVU will be 0.14.
 - Practice expense RVU of 2.57 for non-facility and 1.71 for facility
- 99496 (high complexity):
 - Work RVU of 3.05 with intra-service time of 50 minutes.
 - Malpractice RVU will be 0.20.
 - Practice expense RVU of 3.54 for non-facility and 2.56 for facility

The proposed G-code, if it was finalized, would have reimbursed physicians an estimated \$94.62. Based on the RVU amounts CMS finalized and assuming that Congress averts the pending 26.5-percent reduction, code 99495 performed in a facility reimburses approximately \$135; in a non-facility setting, 99495 reimburses approximately \$164. Code 99496 performed in a non-facility reimburses approximately \$231.12 and, when performed in a facility setting, it would reimburse approximately \$197.76.

CMS estimates that physicians or qualified nonphysician practitioners would provide the post-discharge transitional care management service for 5.7 million discharges in 2013, though the AMA RUC estimated only 2 million codes would be billed per year.

In a section discussing the ability of non-primary care specialties and non-physician practitioners to bill these TCM codes, CMS says that while they “expect the TCM codes to be billed most frequently by primary care physicians, specialists who furnish the requisite services in the code descriptions may also bill the new TCM codes. As for nonphysician qualified health care professionals, we believe only NPs, PAs, CNSs, and certified nurse midwives (CNMs) can furnish the full range of E/M services and complete medical management of a patient under their Medicare benefit to the limit of their state scope of practice.”

Payment for New Preventive Service G-Codes

Background

The *Affordable Care Act* authorizes CMS to add coverage of “additional preventive services” as determined through the national coverage determination (NCD) process and if the service is:

- Reasonable and necessary for the prevention or early detection of illness or disability;
- Recommended with a grade of A or B by the United States Preventive Services Task Force, and
- Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

As a result of this authority, Medicare now covers:

TABLE 28: New Preventive Service HCPCS G-Codes

HCPCS Code	HCPCS Code Long Descriptor	CMS National Coverage Determination (NCD)	CMS Change Request (CR)
G0442	Annual alcohol misuse screening, 15 minutes	Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (NCD 210.8)	CR7633
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	Screening Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (NCD 210.8)	CR7633
G0444	Annual Depression Screening, 15 minutes	Screening for Depression in Adults (NCD 210.9)	CR7637
G0445	High-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	Screening for Sexually Transmitted infections(STIs) and High- Intensity Behavioral Counseling (HIBC) to prevent STIs (NCD 210.10)	CR7610
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	Intensive Behavioral Therapy for Cardiovascular Disease (NCD 210.11)	CR7636
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	Intensive Behavioral Therapy for Obesity (NCD 210.12)	CR7641

Proposed changes

While the NCD process already established coverage for these five services, that process was not completed in time for the final 2012 Medicare physician fee schedule; thus, in this regulation, interim RVUs and CMS’ proposed justification for each of these preventive services were discussed.

AAFP recommendations

The AAFP agreed with the proposal to add coverage of “additional preventive services;” however, the AAFP questioned several of the proposed payment amounts.

Final policy

CMS finalized their proposed RVUs for the six codes. These RVUs are available for separate [download](#) on CMS's Physician fee schedule website.

Durable Medical Equipment (DME) Face-to-Face Encounters and Written Orders Prior to Delivery

Background

The *Affordable Care Act* requires a face-to-face encounter with a patient before physicians may certify eligibility for home health services or DME. Specific to DME, this section requires that an order be written pursuant to the physician documenting that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by CMS.

Proposed changes

Referencing a need to combat fraud and reduce improper payments in DME items, CMS proposed policy to implement the face-to-face requirement as a condition of payment for certain high-cost DME covered items. The list included many items that have historically been targets of Medicare fraud as identified by various program integrity experts. As a condition of payment for certain covered items of DME, a physician must have documented and communicated to the DME supplier that the physician or a PA, an NP, or a CNS has had a face-to-face encounter with the beneficiary no more than 90 days before the order is written or within 30 days after the order is written.

CMS proposed that, when the face-to-face encounter is performed by a physician, the submission of the pertinent portion(s) of the beneficiary's medical record, containing sufficient information to document that the face-to-face encounter meets CMS requirements, would be considered sufficient and valid documentation of the face-to-face encounter when submitted to the supplier and made available to CMS or its agents upon request. CMS stated that they "strive to find the option that strikes a balance between minimizing the effect on physicians, while still meeting the statutory objective to limit fraud, waste, and abuse."

Recognizing this provision imposes a new burden on physicians, CMS proposed to create a G-code, estimated at \$15, to compensate a physician who documented that a physician assistant, a nurse practitioner, or a clinical nurse specialist practitioner has performed a face-to-face encounter for an item from the list of specified covered items. Only a physician who does not bill an E/M code for the beneficiary in question would be eligible for this G-code.

AAFP recommendations

The AAFP considered the proposal to require that a physician has a face-to-face encounter with a beneficiary within 90 days before or 30 days after a written order for certain Medicare covered durable medical equipment as reasonable.

Final policy

CMS modified their initial proposals and made additional clarifications "to limit burden and still protect the Medicare Trust Funds." The face-to-face encounter requirement will begin only for new orders written after the effective date, and to allow sufficient time for implementation, the effective date for this provision is now July 1, 2013, instead of January 1. Significantly, CMS modified the encounter timeframe so that the face-to-face encounter must now occur 6 months prior to the written order, as opposed to the 90 days CMS previously proposed. CMS also removed the proposed option that the face-to-face encounter could occur 30 days after the written order. Instead, CMS believes it is "critical that the face-to-face be conducted before the item is delivered to the beneficiary's home."

Regarding documentation requirements, CMS agreed with comments that it is duplicative to have the physician document that the face-to-face occurred when the physician conducted the face-to-face encounter. Therefore, CMS is not mandating additional documentation requirements for the physician in addition to what he or she is required to document during the actual face-to-face encounter. Thus, the submission of the pertinent portion of the medical record documented by the physician is sufficient to document that the face-to-face encounter has occurred, when the physician conducts the face-to-face encounter. Documentation of the face-to-face

encounter must include an evaluation of the beneficiary, needs assessment for the beneficiary, or treatment of the beneficiary for the medical condition that supports the need for each covered item of DME. A written order is still required for these covered items of DME.

The list of 167 applicable DME items is outlined in Table 89 in the final rule, and CMS notes that the list does not include power mobility devices (PMDs), which are subject to already existing face-to-face requirements.

CMS recognizes there is a burden associated with the requirement placed on the physician to document that a face-to-face encounter has occurred between a PA, an NP or a CNS, and the beneficiary. Thus, CMS will pay G0454 "MD document visit by NPP" at approximately \$8.85. CMS believes any necessary coordination with a physician following a face-to-face encounter with a beneficiary is covered appropriately under the corresponding E/M code that would be billed by the PA, NP, or CNS for documenting the occurrence.

Physician Quality Reporting System

Background

The Physician Quality Reporting System (PQRS) provides incentive payments or penalties to identified eligible professionals or group practices who satisfactorily report (via Medicare Part B claims, qualified PQRS registry, or qualified PQRS electronic health record) data on quality measures for covered professional services furnished during a specified reporting period (full and half-year options).

In 2011, the incentive payment for successful PQRS participation was 1 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. For 2011 through 2014, an additional 0.5 percent is available if the individual professional participates via a "continuous assessment program" such as a qualified American Board of Medical Specialties Maintenance of Certification (MOC) program or an equivalent program as determined by CMS. In 2012 through 2014, the incentive payment is lowered to 0.5 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. Under current law, CMS will impose a 1.5 percent penalty on practices in 2015 that did not successfully participate in the 2013 PQRS. For those that did not successfully participate in 2014, the payment penalty would be 2 percent in 2016 and beyond.

Proposed changes

CMS proposed to include a total of 264 individual measures from which eligible professionals can choose for the 2013 and 2014 PQRS. This regulation included several proposals to align PQRS measures available for the electronic health record (EHR) based reporting option with measures available for reporting under the EHR Incentive Program. CMS also proposed the inclusion of 26 measure groups for reporting. CMS also proposed to align measures for reporting via the Group Practice Reporting Option (GPRO) web-interface with the measures required under the Medicare Shared Savings Program.

AAFP recommendations

The AAFP appreciated that CMS proposed to establish a PQRS informal review process and that the agency proposed to continue most of the program uninterrupted. The AAFP strongly supported CMS's proposal to streamline the implementation of the PQRS incentive and reporting programs within the context of the Medicare Shared Saving Program.

Final policy

CMS continued most of the PQRS program uninterrupted, though the final rule contains several efforts by CMS to better align quality reporting requirements across programs to reduce burden and complexity. Table 90 summarizes criteria for satisfactory reporting by individual eligible professionals in 2013, and in a similar format, Table 91 summarizes the criteria for 2014. Table 95 lists the individual quality measures for the PQRS available for reporting via claims, registry, EHR or GPRO web interface beginning in 2013 and 2014. Tables 97-122 list the PQRS measures groups, of which Table 99 lists the 9 individual measures that comprise the Preventive Care Measures Group.

Electronic Prescribing Incentive Program

Background

From 2009 through 2013, CMS is authorized to provide eligible professionals who are successful electronic prescribers an incentive payment equal to a percentage of the eligible professional's total estimated Medicare Part B physician fee schedule allowed charges for all covered professional services furnished by the eligible professional during the respective reporting period. However, CMS is also conducting the Medicare EHR Incentive Program. Successful participation in the Medicare EHR Incentive Program supersedes eRx incentive payments for an eligible professional, though successful participation in the Medicare EHR program does not satisfy eRx reporting requirements needed to avoid the payment penalty.

For years 2012 through 2014, CMS will apply a payment penalty to eligible professionals who are not successfully electronic prescribing. The applicable eRx percent for payment incentives and penalties under the eRx Incentive Program are as follows:

- 2011: 1.0 percent incentive for successful electronic prescribers.
- 2012: 1.0 percent incentive for successful electronic prescribers or 1.0 percent penalty for non-successful electronic prescribers.
- 2013: 0.5 percent incentive for successful electronic prescribers or 1.5 percent penalty for non-successful electronic prescribers.
- 2014: 2.0 percent penalty for non-successful electronic prescribers.

The requirements for the 2013 eRx incentive and 2013 and 2014 eRx payment adjustment (i.e., penalty) were established in the 2012 MPFS final rule with comment period. Also in the 2012 final rule, CMS finalized four circumstances under which an eligible professional or group practice can request consideration for a significant hardship exemption for the 2013 and 2014 eRx payment adjustments, these are:

- The eligible professional or group practice is in a rural area with limited high speed internet access.
- The eligible professional or group practice is in an area with limited available pharmacies for electronic prescribing.
- The eligible professional or group practice is unable to electronically prescribe due to local, state, or Federal law or regulation.
- The eligible professional or group practice has limited prescribing activity, as defined by an eligible professional generating fewer than 100 prescriptions during a 6-month reporting period.

Proposed changes

In the 2013 proposed rule, CMS proposed new criteria for being a successful electronic prescriber for groups of 2-24 eligible professionals using the eRx GPRO. CMS proposed to establish an informal review process. CMS also proposed two additional significant hardship exemptions to the 2013 and 2014 payment adjustments related to participation in the EHR Incentive Program.

AAFP recommendations

The AAFP supported the proposal to create new criteria for being a successful electronic prescriber for groups of 2-24 eligible professionals using the eRx GPRO. The AAFP also supported the proposal to establish an informal review process.

Final policy

In addition to the four electronic-prescribing exemptions already available in 2012, CMS finalized two additional exemption reasons. These are:

- Eligible professionals or group practices who achieve meaningful use during certain eRx payment adjustment reporting periods.
- Eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology.

Specific to these two new exemptions, eligible professionals must become eligible for the exemptions by January 31, 2013. Table 125 summarizes all hardship exemption categories for the 2013 electronic prescribing payment adjustment. CMS also finalized the proposal to establish an informal review process.

Physician Value-Based Payment Modifier and the Physician Feedback Program

Background

The *Affordable Care Act* call for CMS to establish a value modifier that provides for differential payment to a physician or group of physicians under the Medicare physician fee schedule based upon the quality of care furnished to Medicare beneficiaries compared to the cost of that care during a performance period. Further, the statute requires CMS to begin applying the value modifier in 2015, with respect to items and services furnished by specific physicians and groups of physicians and to apply it to all physicians and groups of physicians beginning not later than January 1, 2017. The statute also requires that the value modifier be implemented in a budget neutral manner, meaning that upward payment adjustments for high performance will balance the downward payment adjustments applied for poor performance.

In 2012, CMS established 2013 as the performance period for the determination of the value modifier to be applied in 2015 and proposed to use 2014 as the performance period for the value modifier to be applied in 2016. The law requires CMS to measure quality of care furnished as compared to cost using composites of appropriate quality and cost measures. Also in 2012, CMS adopted both a total per capita cost measure for all beneficiaries, as well as four total per capita cost measures for beneficiaries with certain chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes) to be used under the value modifier.

Proposed changes

In this first phase of implementation, CMS proposed to apply the value modifier to groups of physicians with 25 or more eligible professionals. In this regulation, CMS discussed a goal of providing physicians choices as to how their quality of care will be measured and how their payments will be adjusted. CMS highlighted that physician groups could avoid all negative adjustments through PQRS participation. Physician groups seeking to be paid a bonus according to their measured cost and quality may elect to do so for 2015.

CMS proposed to apply the value modifier at the Tax Identification Number (TIN) level to items and services paid under the Medicare physician fee schedule to physicians under that TIN. Thus, if a physician moves from one group to another between the performance period (2013) and the payment adjustment period (2015), the physician's payment will be adjusted based on the value modifier earned by the TIN where the physician is practicing in 2015.

To obtain the quality data, CMS proposed that groups of physicians with 25 or more eligible professionals satisfactorily submit data using one of the proposed PQRS quality reporting mechanisms for groups of physicians. Reported data would include:

- A common set of quality measures based on clinical data and that focus on preventive care and care for prevalent and costly chronic conditions in the Medicare population;
- Quality measures of their own selection that they report through claims, registries, or EHRs; or
- A common set of quality measures that focus on preventive care and care for chronic conditions that CMS would calculate from administrative claims data that require no action for the physician group beyond notifying CMS that the group elects this option.

AAFP recommendations

The AAFP mostly supported the CMS proposal to begin applying the value-based payment modifier only to groups of 25 or more eligible providers in 2015, so the agency can begin learning how to properly fulfill the statutory requirements. However, the AAFP noted our concern with CMS's inability to specify the exact amount of the upward payment adjustment because of budget neutrality considerations.

Final policy

The final rule applies in 2015 the value modifier to groups of physicians with 100 or more eligible professionals, a change from the proposed rule, which would have set the group size at 25 or above. As CMS succinctly states, "Therefore, smaller groups of 2-99 eligible professionals will remain unaffected by the final policies we are finalizing under the value-based payment modifier in 2013."

This change was adopted to gain experience with the methodology and approach before expanding to smaller groups. The final rule provides an option for these groups of physicians to choose how the value modifier is calculated, based on whether they participate in the PQRS. The statute allows CMS to phase in the value modifier over three years from 2015 to 2017.

In this section, CMS also urges, “solo practitioners and physicians in smaller groups to participate in the PQRS now, because when we propose in future rulemaking to apply the value-based payment modifier to smaller groups and solo practitioners, we anticipate basing the quality composite on PQRS quality data reported by such physicians. We also anticipate that we would propose to increase the amount of payment at risk under the value-based payment modifier as we gain additional experience with the methodologies used to assess the quality of care furnished, and the cost of care, by physicians and groups of physicians.”

Medicare Coverage of Hepatitis B Vaccine

Background

Medicare Part B coverage of hepatitis B vaccine and its administration is currently covered if furnished to an individual who is at high or intermediate risk of contracting hepatitis B. In late 2011, the Centers for Disease Control and Prevention (CDC) published a *Morbidity and Mortality Weekly Report* that included an article entitled “Use of Hepatitis B Vaccination for Adults with Diabetes Mellitus: Recommendations of the Advisory Committee on Immunization Practices (ACIP).” As a result of this report and other findings, ACIP recommended that:

- Hepatitis B vaccination should be administered to unvaccinated adults with diabetes mellitus who are aged 19 through 59 years.
- Hepatitis B vaccination may be administered at the discretion of the treating clinician to unvaccinated adults with diabetes mellitus who are aged 60 years and older.

Proposed changes

Based on the ACIP recommendations, CMS proposed to expand coverage for hepatitis B vaccine and its administration to all individuals diagnosed with diabetes mellitus, not just those individuals with diabetes who are receiving glucose monitoring in facilities.

AAFP recommendations

The AAFP fully supported the agency’s proposal to begin Medicare Part B coverage of the hepatitis B vaccine for high risk groups, specifically persons with diabetes.

Final policy

CMS finalized their proposal and in 2012 will begin covering hepatitis B vaccine and its administration to all individuals diagnosed with diabetes mellitus.

TABLE 26: Key Differences between Proposed Transitional Care Management (TCM) G-code and the CPT codes

	CMS Proposed TCM G-code	CPT TCM Codes
Code(s)	GXXX1—Post-discharge transitional care management (medical decision making of moderate to high complexity)	99490X—Transitional care management services (medical decision making of moderate complexity), and 99491X—Transitional care management services (decision making of high complexity)
Face-to-face visit	Separately billed face-to-face E/M visit within 30 days prior to the hospital discharge or within the first 14 days of the 30-day period of TCM services	Face-to-face visit within 14 calendar days of discharge (99490X), or within 7 calendar days (99491X). The first face-to-face visit is part of the TCM service and not reported separately. E/M services after the first face-to-face visit may be reported separately.
Relationship with patient	The patient may be new to the physician's practice (provided the face-to-face visit requirements above are met).	The reporting physician or NPP must have an established relationship with the patient. Established patient means a visit in the past 3 years.
Discharge management	The physician or NPP who bills for discharge management services during the time period covered by TCM services may not also bill for GXXX1.	A physician or NPP may report both the discharge code and appropriate TCM code.
Global services	The physician who reports a service with a global period of 010 or 090 days may not also report the TCM service.	The physician who reports a service with a global period of 010 or 090 days may not also report the TCM service. However, the AMA recommends that specialties work on a CPT proposal for a new code to describe extensive post-discharge TCM services.

TABLE 135: CY 2013 PFS Final Rule with Comment Period Estimated Impact on Total Allowed Charges by Specialty by Selected Policy**

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of End of PFS Transition	(D) New and Revised Codes, MPPR, New Utilization and Other Factors	(E) Updated Equipment Interest Rate Assumption	(F) Transitional Care Management	(G) Input Changes for Certain Radiation Therapy Procedures	(H) Total (Cumulative Impact)
TOTAL	\$ 86,588	0%	0%	0%	0%	0%	0%
01-ALLERGY/IMMUNOLOGY	\$ 200	0%	1%	2%	0%	0%	3%
02-ANESTHESIOLOGY **	\$ 1,923	1%	-1%	0%	0%	0%	1%
03-CARDIAC SURGERY	\$ 369	-1%	0%	0%	0%	0%	-1%
04-CARDIOLOGY	\$ 6,733	-2%	0%	0%	-1%	0%	-2%
05-COLON AND RECTAL SURGERY	\$ 153	1%	0%	0%	0%	0%	2%
06-CRITICAL CARE	\$ 263	0%	0%	0%	0%	0%	1%
07-DERMATOLOGY	\$ 3,024	0%	0%	1%	-1%	0%	0%
08-EMERGENCY MEDICINE	\$ 2,839	0%	0%	0%	0%	0%	0%
09-ENDOCRINOLOGY	\$ 437	1%	1%	0%	-1%	0%	1%
10-FAMILY PRACTICE	\$ 5,943	1%	1%	0%	4%	0%	7%
11-GASTROENTEROLOGY	\$ 1,896	0%	0%	0%	0%	0%	0%
12-GENERAL PRACTICE	\$ 587	1%	0%	0%	-1%	0%	1%
13-GENERAL SURGERY	\$ 2,283	1%	0%	0%	0%	0%	0%
14-GERIATRICS	\$ 220	1%	1%	0%	2%	0%	5%
15-HAND SURGERY	\$ 135	1%	0%	0%	-1%	0%	1%
16-HEMATOLOGY/ONCOLOGY	\$ 1,909	-1%	3%	1%	-1%	0%	2%
17-INFECTIOUS DISEASE	\$ 629	1%	1%	0%	0%	0%	1%
18-INTERNAL MEDICINE	\$ 11,163	1%	1%	0%	3%	0%	4%
19-INTERVENTIONAL PAIN MGMT	\$ 539	1%	0%	0%	-1%	0%	1%
20-INTERVENTIONAL RADIOLOGY	\$ 204	-2%	0%	0%	0%	0%	-3%
21-MULTISPECIALTY CLINIC/OTHER PHY	\$ 81	0%	0%	0%	-1%	0%	-1%
22-NEPHROLOGY	\$ 2,080	0%	0%	0%	0%	0%	0%
23-NEUROLOGY	\$ 1,604	1%	-8%	0%	0%	0%	-7%
24-NEUROSURGERY	\$ 687	0%	0%	0%	0%	0%	0%
25-NUCLEAR MEDICINE	\$ 49	-2%	0%	-1%	0%	0%	-3%
27-OBSTETRICS/GYNECOLOGY	\$ 704	0%	0%	0%	-1%	0%	0%
28-OPHTHALMOLOGY	\$ 5,645	2%	-4%	0%	0%	0%	-3%
29-ORTHOPEDIC SURGERY	\$ 3,643	1%	0%	0%	0%	0%	0%
30-OTOLARNGOLOGY	\$ 1,076	1%	1%	1%	-1%	0%	2%
31-PATHOLOGY	\$ 1,210	-1%	-5%	0%	0%	0%	-6%
32-PEDIATRICS	\$ 65	1%	0%	0%	3%	0%	3%
33-PHYSICAL MEDICINE	\$ 999	1%	-5%	0%	-1%	0%	-4%
34-PLASTIC SURGERY	\$ 356	1%	0%	0%	0%	0%	1%
35-PSYCHIATRY	\$ 1,170	0%	2%	0%	-1%	0%	2%
36-PULMONARY DISEASE	\$ 1,703	0%	1%	0%	-1%	0%	1%
37-RADIATION ONCOLOGY	\$ 1,988	-4%	2%	-3%	-1%	-1%	-7%
38-RADIOLOGY	\$ 4,818	-2%	0%	-1%	0%	0%	-3%
39-RHEUMATOLOGY	\$ 548	0%	1%	0%	-1%	0%	0%
40-THORACIC SURGERY	\$ 343	-1%	0%	0%	0%	0%	-1%
41-UROLOGY	\$ 1,918	-2%	1%	0%	-1%	0%	-1%
42-VASCULAR SURGERY	\$ 888	-1%	-1%	0%	0%	0%	-2%
43-AUDIOLOGIST	\$ 57	-3%	0%	0%	0%	0%	-4%
44-CHIROPRACTOR	\$ 746	1%	0%	0%	0%	0%	1%
45-CLINICAL PSYCHOLOGIST	\$ 575	-2%	1%	0%	0%	0%	-2%
46-CLINICAL SOCIAL WORKER	\$ 406	-2%	0%	0%	0%	0%	-2%
47-DIAGNOSTIC TESTING FACILITY	\$ 888	-5%	0%	-2%	-1%	0%	-7%
48-INDEPENDENT LABORATORY	\$ 1,073	-2%	-12%	1%	-1%	0%	-14%
49-NURSE ANES / ANES ASST **	\$ 1,104	2%	-1%	0%	0%	0%	1%
50-NURSE PRACTITIONER	\$ 1,623	1%	1%	0%	2%	0%	4%
51-OPTOMETRY	\$ 1,061	2%	-1%	0%	0%	0%	1%
52-ORAL MAXILLOFACIAL SURGERY	\$ 45	1%	0%	1%	-1%	0%	1%
53-PHYSICAL/OCCUPATIONAL THERAPY	\$ 2,636	2%	2%	0%	0%	0%	4%
54-PHYSICIAN ASSISTANT	\$ 1,229	1%	0%	0%	2%	0%	3%
55-PODIATRY	\$ 1,925	2%	0%	1%	-1%	0%	2%
56-POR X-RAY SUPPLIER	\$ 106	1%	4%	1%	-1%	0%	5%
57-RADIATION THERAPY CENTERS	\$ 72	-5%	4%	-5%	-1%	-1%	-9%
98-OTHER	\$ 19	1%	0%	0%	0%	0%	1%

*Table 135 shows only the proposed payment policy impact on PFS services. We note that these impacts do not include the effects of the negative January 2013 conversion factor change under current law.

** These figures have been revised to correct errors in the calculations presented in the CY 2013 PFS proposed rule.