Physician & Freestanding Center Regulatory Update

Since 1992 Medicare has paid for the services of physicians, nonphysician practitioners, and certain other suppliers under the Medicare Physician Fee Schedule (PFS). For reimbursement purposes, relative values are assigned to each of more than 7,000 services to reflect the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice expenses typically involved in furnishing that specific service. After applying a geographic practice cost indicator, the resulting relative value units (RVUs) are summed for each service and multiplied by a fixed-dollar conversion factor to establish the payment amount for each visit or procedure.

The Sustainable Growth Rate (SGR) is a formula adopted by the Balanced Budget Act of 1997 to determine the conversion factor that may result in steep across-the-board reductions in fee schedule reimbursement. The President's budget calls for averting these cuts and finding a permanent solution to this annual problem, and the legislation preventing the SGR-related cut was signed into law Dec. 26, 2013. As a result, the 2014 PFS conversion factor is $35.8228, a slight increase over 2013. Table 5 (page 23) shows the Estimated Impact Table that projects payment increases or decreases by specialty.

Non-Facility Payment Cap Update

CMS is not finalizing its proposal to adjust relative values under the PFS to effectively cap the physician practice expense payment for procedures furnished in a non-facility setting at the total payment rate for the service when furnished in an ambulatory surgical center or hospital outpatient setting. Instead, CMS will take additional time to consider issues raised by the public commenters and plans to address this issue in future rulemaking. The 2014 PFS final rule states:

As we stated in the proposed rule, when services are furnished in the facility setting, such as an HOPD [hospital outpatient department] or ASC [ambulatory surgical center], the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We continue to believe that this payment difference generally reflects the greater costs that facilities incur compared to those incurred by practitioners furnishing services in offices and other nonfacility settings. We also continue to believe that if the total Medicare payment when a service is furnished in the physician office exceeds the total Medicare payment when a service is furnished in an HOPD or ASC, this is generally not the result of appropriate payment differentials between the services furnished in different settings.

Off-Campus Provider-Based Departments

In recent years, research literature and popular press have documented the increased trend toward hospital acquisition of physician practices, integration of those practices as a department of the hospital and the resultant increase in the delivery of physicians' services in a hospital setting. As more physician practices become hospital-based, news articles have highlighted beneficiary liability, such as higher co-pays, that is incurred when services are furnished in a hospital-based practice. In addition, when a service is furnished in a freestanding clinic or physician office, only one payment is made under the PFS; however, when a service is furnished in a hospital-based clinic, Medicare pays the hospital a facility fee and a separate payment for the physician professional portion of the service. CMS received a number of comments recommending various methodologies to collect information to analyze the frequency, type, and payment of these services, and will take this information into consideration as it continues to consider approaches to collecting data on services furnished in off-campus provider-based departments.

Potentially Misvalued Codes

Consistent with amendments made by the Affordable Care Act (ACA), CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes and make adjustments where appropriate. CMS proposed to address nearly 200 procedure codes that appear to have misvalued resource inputs, including radiation oncology code **77301** (intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications). These are codes for which the total PFS payment when furnished in an office or other nonfacility setting would exceed the total Medicare payment when the service is furnished in a facility. In addition, for CY

Table 5. Estimated Impact Table

Specialty	Allowed Charges (mil)	Impact of Work & MP RVU Changes	Impact of PE RVU Changes	Impact of Adjusting the RVUs to Match the Revised MEI Weights	Combined Impact
Hematology/Oncology	$1,896	0%	0%	-2%	**-2%**
Radiation Oncology	$1,788	0%	3%	-2%	**+1%**
Radiation Therapy Centers	$ 63	0%	5%	-6%	**-1%**

Specialty: The Medicare specialty code as reflected in the physician/supplier enrollment files.

Allowed Charges: The aggregate estimated PFS allowed charges for the specialty based on CY 2012 utilization and CY 2013 rates.
Impact of Work & Malpractice RVU Changes: This column shows the estimated CY 2014 impact on total allowed charges of the changes in the work and malpractice RVUs, including the impact of changes due to new, revised, and misvalued codes.
Impact of Practice Expense RVU Changes: This column shows the estimated CY 2014 impact on total allowed charges of the changes in PE RVUs, including the impact due to new, revised, and misvalued codes and miscellaneous minor provisions.
Impact of Adjusting the RVUs to Match the Revised MEI Weights: This column shows the estimated CY 2014 combined impact on total allowed charges of the changes in the RVUs and conversion factor adjustment resulting from adjusting the RVUs to match the revised Medical Economic Index (MEI) weights.

Combined Impact: This column shows the estimated CY 2014 combined impact on total allowed charges of all the changes in the previous columns.

2014 CMS, in consultation with Contractor Medical Directors, is finalizing 18 codes to be reviewed as potentially misvalued services, including the following ultrasound codes that are performed with fiducial marker placement and other radiation services:

- **76942:** Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation.
- **76950:** Ultrasonic guidance for placement of radiation therapy fields.
- **76965:** Ultrasonic guidance for interstitial radioelement application.

Chronic Care Management Services

As part of the ongoing effort to appropriately value primary care services, CMS will make a separate payment for chronic care management services beginning in calendar year 2015. In last year's PFS final rule, CMS established separate payment for transitional care management services for a beneficiary making the transition from a facility to the community setting. In the 2014 PFS final rule, CMS establishes policies to facilitate separate payment for non-face-to-face chronic care management services for Medicare beneficiaries who have multiple (two or more) significant chronic conditions. Chronic care management includes the development, revision, and implementation of a plan of care; communication with the patient, caregivers and other treating health professionals; and medication management. While any specialty can report these codes when the work effort is performed and documented, it is unlikely that oncologists will perform these services.

Telehealth Update

CMS is also modifying regulations describing the geographic criteria for eligible telehealth originating sites to include health professional shortage areas located in rural census tracts of urban areas as determined by the Office of Rural Health Policy. In addition, there will be a policy to determine geographic eligibility for an originating site on an annual basis, consistent with other telehealth policies. Last, CMS will update the list of eligible Medicare telehealth services to include transitional care management services.

Scope of Practice

Section 1861 of the Social Security Act establishes the benefit category for services and supplies furnished as incident-to the professional services of a physician. The statute specifies that "incident-to" services and supplies are "of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in physicians' bills." In addition to the requirements of the statute, CMS regulations establish specific requirements that must be met in order for physicians or qualified practitioners to bill Medicare for incident-to services. According to the 2014 PFS final rule:

As the services commonly furnished in physicians' offices and other nonfacility settings have expanded to include more complicated services, the types of services that can

be furnished "incident to" physicians' services have also expanded. States have increasingly adopted standards regarding the delivery of health care services in all settings, including physicians' offices, in order to protect the health and safety of their citizens. These state standards often include qualifications for the individuals who are permitted to furnish specific services or requirements about the circumstances under which services may actually be furnished.

Over the past years, several situations have come to our attention where Medicare was billed for "incident to" services that were provided by auxiliary personnel who did not meet the state standards for those services in the state in which the services were furnished. The physician or practitioner billing for the services would have been permitted under state law to personally furnish the services, but the services were provided by auxiliary personnel who were not in compliance with state law in providing the particular service (or aspect of the service).

The changes being adopted in this final rule with comment period are consistent with the traditional approach of relying primarily on the states to regulate the health and safety of their residents in the delivery of healthcare services. Throughout the Medicare program the qualifications required for the delivery of healthcare services are generally determined with reference to state law.

As a result, CMS is requiring as a condition of Medicare payment that "incident-to" services be furnished in compliance with applicable state law. This policy eliminates redundant regulations for each type of practitioner, reduces regulatory burden, makes it easier for compliance, and strengthens program integrity by allowing Medicare to deny or recoup payments when services furnished as not in compliance with state law.

Radiosurgery Code Updates

Since CY 2001, CMS has used HCPCS G-codes in addition to the CPT codes for SRS to distinguish robotic and non-robotic methods of treatment delivery. Based on a review of current SRS technology, CMS believes that most services currently furnished with linac-based SRS technology incorporate some type of robotic features. Therefore, CMS believes that it is no longer necessary to continue to distinguish robotic versus non-robotic linac-based SRS through the HCPCS G-codes. For purposes of the OPPS, CMS will replace current codes **G0173**, **G0251**, **G0339**, and **G0340** with the existing CPT codes **77371**, **77372**, and **77373**. However, two of the four current G-codes are paid in the non-facility setting through the Medicare PFS. These codes are **G0339** (image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment) and **G0340** (image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment), both of which describe robotic SRS treatment delivery, and are contractor priced.

CMS did not propose to replace the robotic G-codes with CPT codes for purposes of non-facility billing and codes **G0339** and **G0340** remain active in the PFS. Comments were received regarding the continued retention of these codes and CMS states that it will consider this information during future rulemaking. OI

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Resources

The two resources listed below were used to compile these coding and regulatory updates:

1. OPPS Final Rule 2014. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1601-FC-.html. Last accessed Jan. 13, 1014.

2. MPFS Final Rule 2014. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html. Last accessed Jan. 13, 1014.