PROPOSED CY 2013 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)

On July 6, 2012, the Centers for Medicare & Medicaid Services (CMS) posted the proposed rule for payments in the Medicare physician fee schedule (MPFS) for calendar year (CY) 2013. In addition to payment policy and payment rate updates, the MPFS addresses a number of quality initiatives. The Academy will submit comments to CMS on the MPFS proposed rule by the **September 4, 2012 deadline.**

PROPOSED PAYMENT POLICY CHANGES

1) Medicare Sustainable Growth Rate (SGR)

The overall ***estimated*** potential impact of the CY 2012 MPFS for otolaryngology – head and neck surgery is 0 percent. [Note: This amount does not include the possible 27% reduction to the conversion factor ($34.0376 in 2012 to potentially $24.7124 with the possible cut for CY 2013).] This is partially the result of CMS' proposal to add new G codes to the Medicare system which, due to budget neutrality requirements, causes a reduction to all other services in the fee schedule in order to pay for the existence of the new code's expected utilization. (For more on the G code proposal, see below.)

In the proposed rule, CMS emphasizes its commitment to collaborate with Congress to permanently reform the Sustainable Growth Rate (SGR) methodology for MPFS updates and we applaud CMS for this effort. The Academy will continue campaigning for a permanent repeal and replacement of the SGR formula.

2) Practice Expense (p. 24)

The impact of the relative value unit (RVU) changes on otolaryngology-head and neck surgery are also related to the endof a four year transition of the Physician Practice Expense Information Survey (PPIS) data used to calculate practice expense RVUs for services. ***This policy change has impacted the specialty positively over the last four years because many of the services members perform are heavily weighted in practice expense.***

3) Potentially Misvalued Services Under the Fee Schedule (p. 51-107)

In recent years CMS and the AMA Relative Update Committee (RUC) have taken increasingly significant steps to address potentially misvalued codes. The categories of codes targeted for review include: those with the fastest growth, having significant changes in practice expense, codes for new technologies, codes frequently billed together for one service, codes with low values billed multiple times for a single treatment, and codes that have not been subject to review since the implementation of the resource based relative value system (RBRVS). ***While there were no specific codes related to otolaryngology – head and neck surgery noted in the proposed rule, it is important for members to be aware that many of the codes that go through the CPT and RUC process are codes caught in these screens.***

4) Improving Valuation of the Global Surgical Package (p. 58)

CMS notes in the proposed rule that since 1992 different methodologies have been used in valuing global surgical services through the RUC process and more recently reviewed codes tend to have fewer evaluation and management (E/M) visits in their global periods. In contrast, codes reviewed less recently did not appear to have the full work RVUs of each E/M service in the global surgical package, resulting in inconsistent numbers of E/M visits during the post-operative period across families of procedures. CMS acknowledges that under current policy the surgeon is not required to document in the medical record what level of E/M visit they are providing, making it difficult to determine whether the number and type of visits provided in association with a surgical procedure is appropriate. ***As a result, CMS states they are particularly interested in a "claims-based data collection approach" and are requesting comments on this and other methods of obtaining data. This proposal could add potential administrative burdens to otolaryngology-head and neck surgeons.***

5) Validating RVUs of Services (p. 57)

Under the ACA, the Secretary is directed to validate a sampling of RVUs for services identified by the seven categories listed above. ***In the proposed rule, CMS states they intend to "enter into a contract to assist them in validating RVUs of potentially misvalued codes that will explore a model for the validation of physician work under the PFS, for both new and existing services."*** They state they plan to discuss this model in future rulemaking. This may impact the role of the American Medical Association (AMA)/Specialty Society's Relative Value Update Committee (RUC) in the future.

6) Expanding the Multiple Procedure Payment Reduction Policy (MPPR) (p. 89)

CMS also proposes to expand the MPPR to the Professional Component (PC) of certain advanced diagnostic imaging services (CT, MRI, and Ultrasound) when two or more physicians in the same group practice furnish services to the same patient, in the same session, on the same day." Under the proposed policy, full payment would be made for the PC and technical component (TC) of the highest paid procedure, and payment would be reduced by 25 percent for the PC and TC for each additional procedure furnished to the same patient, in the same session, on the same day, by the same physician or a member of the physician's group practice. ***Upon initial analysis, while this may impact some otolaryngology-head and neck surgeons, the proposal will not be an issue for a majority and will not significantly impact the specialty.***

7) G-Code for Care Coordination (p. 180)

Within the proposed rule, CMS proposes the creation of a HCPCS G-code at 1.28 RVUs to describe the work involved with care management and coordination (including non-face-to-face care management services). Specifically, the transition of a beneficiary from care furnished by a treating physician during a hospital stay (inpatient, outpatient observation services, or outpatient partial hospitalization), and other facilities specified; to care furnished by the beneficiary's primary care physician within 30 calendar days following the date of discharge.

Of note, CMS clarifies that the new G-code IS NOT billable by a physician or non-physician billing for a procedure with a 10 or 90 day global period because they consider such management "included in the post-operative portions of the global period." However, some otolaryngology-head and neck surgeons may be able to use this code, e.g., those who receive patients from a hospital and provide Evaluation and Management (E&M) services through referrals, those treating trauma cases, and those treating cancer patients.

PROPOSED QUALITY INITIATIVE CHANGES

8) Physician Quality Reporting System (PQRS) (p. 559)

CMS proposes many overarching changes to the PQRS system, with highlights of those potentially impacting otolaryngology-head and neck surgery below.

- ***New Reporting Mechanism for 2015 & 2016*****:** In addition to the ability to report via claims, Electronic Health Recodes, a registry, or the web-interface for Group Practice Reporting Option (GPRO), CMS proposes a new administrative claims reporting mechanism for years 2015 and 2016. ***Although CMS is proposing 19 measures for reporting via administrative-claims, otolaryngology-head and neck surgeons would not be able to successfully report using this mechanism to avoid the penalty adjustment because none of the measures apply to otolaryngology-head and neck surgery.***

- ***Changes to Group Reporting:*** Most notable of the changes to this section, CMS proposes to change the definition of a "group practice" from requiring the practice to consist of 25 or more eligible professionals, to defining a group as 2 or more eligible professionals. ***This will allow groups of a***

smaller size to participate in the GPRO option and may result in the opportunity for more otolaryngology-head and neck surgeons to avoid the penalty and possibly meet the requirements for the incentive in 2013 and 2014.

- ***Modification of Reporting Periods:*** Along with the typical calendar year reporting period for 2015 and 2016 for individuals and groups, CMS is also proposing the addition of a 6 month reporting period (July 1 – Dec. 31) for reporting measures groups via registry for the 2015 and 2016 payment penalty. ***This may provide otolaryngology-head and neck surgeons with more opportunities to report. However, CMS intends to end the 6 month reporting period for the 2017 payment year and beyond, by proposing that payment penalties be specified by only a 12-month calendar year reporting period.***

- ***Individual Measure Groups via Claims-Based and Registry Reporting:*** CMS proposes to allow individuals to report at least 1 PQRS measures group AND report each group for at least 20 patients for claims-based and registry reporting (with an option of a 6 month and a 12 month reporting period for registry reporting). Measures groups containing a measure with a zero percent (0%) performance rate will not be counted. ***These proposals may allow otolaryngology-head and neck surgeons to avoid the penalty for 2013 and 2014.***

- ***Satisfactorily reporting for the 2015 and 2016 payment adjustments:*** **The penalty adjustment will be a -1.5% in 2015 and -2% in 2016 and subsequent years.**

- ***Adult Sinusitis Measures:*** ***CMS proposes the addition of 13 new measures for reporting individual quality measures in 2013 and proposes the addition of 45 new measures for reporting individual measures in 2014. However, the newly approved 'Adult Sinusitis' measures are not included in either of these sets of proposed additional new measures for PQRS individual measures for 2013 and 2014. Separate from the proposed rule, CMS issued a call for measures and the Academy submitted a letter of support for inclusion of the sinusitis measures for 2013. The Academy will be including similar comments in the letter to CMS regarding the proposed rule.***

9) Physician Compare Website (p. 277)

CMS is considering allowing measures that have been developed and collected by "approved and vetted specialty societies" to be reported on Physician Compare, "as deemed appropriate, and as they are found to be scientifically sound and statistically valid." CMS also plans to publish additional information to the Physician Compare website (http://www.medicare.gov/find-a-doctor/provider-search.aspx) including whether a professional is accepting new Medicare patients, board certification information, whether or not a professional participates in the electronic health record (EHR) Incentive Program, names of professionals satisfactorily participating in PQRS, as well as foreign language and hospital affiliation data. CMS also suggests posting whether or not a physician received a Maintenance of Certification Program incentive payment beginning as soon as 2014. In addition, CMS proposes adding patient experience survey measures such as Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for groups participating in the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) and Accountable Care Organization (ACO) programs. ***These proposed changes will likely impact otolaryngology-head and neck surgeons as more information about them will be publicly posted.***

10) Electronic Prescribing (eRx) Incentive Program (p. 528)

In addition to the proposal to expand the minimum group practice size for participation in PQRS, CMS also proposes reducing the minimum group practice size for participation in the eRx incentive program from 25 to 2 eligible professionals (EPs) for 2013. Groups of 2-24 would have to report the eRx numerator code during a denominator-eligible encounter at least 225 times from January 1, 2013-December 31, 2013. For 2014, groups would have to report 225 times within a six month period (January 1- June 30th, 2014) to successfully participate. ***This proposal may allow more otolaryngology-head and neck surgeon practices***

the opportunity to participate in the program, but the requirement to report the encounter 225 times would still need to be met.

CMS also proposes adding two new hardship exemptions to the 2013 and 2014 eRx payment penalties, including an exemption from those who meet Meaningful Use and exemption for the intent to participate in the EHR Incentive Program and adopt Certified EHR technology (CEHRT). ***Most otolaryngology-head and neck surgeons are unable to meet Meaningful Use due to the requirements, so the first exemption may not likely impact the specialty. But if otolaryngology-head and neck surgeons intend to meet Meaningful Use, they could apply for the exemption for either 2013 or 2014.***

Finally, CMS proposes extending the PQRS-Medicare EHR Incentive Pilot for 2013. The program includes incentive payments for submitting clinical quality measures electronically using CEHRT. CMS only proposes to extend the program through 2013 because Stage 2 of the EHR incentive program is expected to begin in 2014. ***Again, based upon the fact that most of the clinical quality measures are not related to otolaryngology-head and neck surgeons, this pilot likely will not have a major impact on the specialty.***

For more details on the proposed changes to the PQRS and eRx programs, and the Physician Compare website, see: http://www.ntocc.org/Portals/0/PDF/Attachments/PublicPolicyUpdates/FSQ-MPFS-2013-NPRM-20120706.pdf.

11) Value Based Payment Modifier and Physician Feedback Reporting Program (p. 559)

Beginning January 1, 2015, the Affordable Care Act requires the Secretary to establish a value-based payment modifier (incentive or penalty) to specific physicians and groups of physicians. ***The incentive or penalty is based on measuring quality of care furnished as compared to cost of that care for Medicare beneficiaries with certain chronic conditions not related to otolaryngology-head and neck surgery.*** In order for CMS to implement the ACA requirement, the agency is proposing to begin the phase-in of a three year program that would apply the incentive (up to potential +2%) or penalty (up to potential -1%) in 2015 on 2013 performance for groups of 25 or more providers. CMS proposes that incentives or penalties in 2016 will be based on 2014 performance for groups of 25 or more providers. ***The program is voluntary the first two years, but not later than 2017, the value-based payment modifier will apply to all physicians, regardless of group size.***

As part of this program, the Secretary is required to provide confidential Physician Feedback reports to providers that measure the resources used in providing care to beneficiaries a well as the quality of care provided. To achieve this outcome, CMS has included information reported in the PQRS program in the 2010 Physician Feedback reports that were provided to groups of physicians in 2011 and individual physicians in early 2012, which some otolaryngology-head and neck surgeons received. For more information on the proposed program, requirements for eligible professionals, and proposed penalties, see: http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/8-1-12-VBPM-NPC-Presentation.pdf.

12) Additional Information

- For more details on the proposed requirements for the programs highlighted above, email Academy staff at HealthPolicy@entnet.org.
- The CY 2013 Proposed MPFS rule with comment period on interim policies is published at: http://www.ofr.gov/OFRUpload/OFRData/2012-16814_PI.pdf.