AMERICAN ACADEMY OF OTOLARYNGOLOGY– HEAD AND NECK SURGERY

AAO-HNS SUMMARY OF CY 2014 PROPOSED MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)

On July 8, 2013, the Centers for Medicare & Medicaid Services (CMS) posted the proposed rule for payments in the Medicare physician fee schedule (MPFS) for calendar year (CY) 2014. 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 proposed rule by the September 6, 2013 deadline.

PROPOSED PAYMENT POLICY

1) Medicare Sustainable Growth Rate (SGR):

The Medicare law includes the standard statutory formula that will require (absent congressional intervention) a CMS projected reduction of 24.4% to the conversion factor (CF) which would result in a CF of $26.8199 in 2014. As in years prior, it is expected that Congress will take action to avoid the impending cut due to the sustainable growth rate (SGR) before the January 1, 2014 deadline. This CF also assumes that all proposed changes are implemented in the final 2014 MPFS.

2) Estimated Overall Impact on Total Allowed Charges for ENT Services (Table71)

The overall ***estimated*** potential impact of the CY 2014 proposed rule for otolaryngology-head and neck surgery is – 2 percent. **It is important to note that these estimates DO NOT INCLUDE the proposed reduction attributable to the SGR absent a Congressional fix prior to January 1, 2014 and are not necessarily reflective of changes that may occur among families of codes within any given specialty designation. The Academy continues to campaign for a permanent repeal and replacement of the SGR formula.**

3) Practice Expense (PE) (p. 13)

Reduction to Office PE RVUs that Exceed OPPS/ASC Facility Payment Rates: Within the proposed rule, CMS proposes a major change to the methodology for setting practice expense RVUs for services under the PFS. **They propose to limit the office PE RVUs for individual codes so that the total office MPFS payment amount would not exceed the total combined amount Medicare pays for the same code in the facility (hospital or ASC) setting.** Specifically, they propose to use Medicare hospital outpatient prospective payment system (OPPS) and Ambulatory Surgical Center (ASC) payment amounts to "cap" the practice expense (PE) relative value units (RVUs) for certain physicians' services furnished in the physician office setting. They note that for the total Medicare payment for some services provided in the physician offices setting exceed those for the same procedure when performed in a facility (hospital outpatient department (HOPD) or Ambulatory Surgical Center (ASC)). In these instances, CMS would use current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services in the office under the PFS. In setting PFS rates, they would compare the PFS payment rate for a service furnished in an office setting to the total Medicare payment to practitioners and facilities for the same service when furnished in a HOPD setting. For services on the ASC list, they would make the same comparison except they would use the ASC rate as the point of comparison instead of the OPPS rate. (Note that CMS proposes several categories of codes for exemption from this proposed policy.)

CMS rationalizes this policy proposal based on their concern that the current basis for estimating the resource costs (i.e. utilizing invoices or quotes submitted via the RUC process) involved in furnishing a PFS service is significantly encumbered by their inability to obtain accurate information regarding supply and equipment prices, as well as procedure time assumptions. They believe this policy will lessen the negative impact of those difficulties on both the appropriate relativity of PFS services, and overall Medicare spending. Addendum B to the proposed rule reflects the changes to PE RVUs that would occur in 2014 should this policy be finalized. ***Of note, this policy will severely impact several key Otolaryngology services and the Academy plans to submit comments to CMS on this issue.*** ***Click here for a full analysis of impact on ENT services.***

Collecting Data on Services Furnished in Off-Campus Hospital Provider-Based Departments: CMS draws attention to the recent trend, in literature and in practice patterns, across the U.S. of providers moving from the private practice/office based setting to an integrated model where they practice in an off-campus hospital setting that looks very much like a private practice. In these scenarios, the physicians are paid their physician work fee from the PFS and the hospital is paid a separate "facility fee" from the OPPS payment system. As a result, the overall cost for services provided in off-campus departments is typically higher than the cost of services provided in the physician office setting.

CMS expresses concern in the proposed rule that they do not currently require hospitals to seek a CMS determination of provider-based status for a facility that is located off campus, nor is there a formal process for gathering information on the frequency, type and payment for services provided in off-campus provider-based departments of a hospital. As such, CMS is seeking public comment on three proposals for collecting more data in this area, including: Using a claims-based approach; Creating a HCPCS modifier; or Asking hospitals to break out the costs and charges for their provider-based departments into an outpatient service cost center on their Medicare hospital cost report form.

4) Potentially Misvalued Services Under the Fee Schedule (p. 74)

In recent years CMS and the AMA Relative Update Committee (RUC) have taken increasingly significant steps to address potentially misvalued codes. Most recently, the categories examined included potentially misvalued services in seven categories including those with the fastest growth, families that have experience substantial changes in practice expenses, those that are new technology, codes frequently billed together, those with low RVUs billed multiple times for a single treatment, and those that have not been RUC reviewed.

In CY 2013, CMS finalized their proposal from 2012 to allow public nomination of potentially misvalued codes which should be considered for review. Within the 2014 proposed rule no codes were nominated by the public as potentially misvalued / requiring review. CMS noted they are exploring new ways to broaden the process of identifying potentially misvalued codes, and for the CY 2014 proposed rule they solicited feedback from Medicare Contractor Medical Directors (CMDs) in developing a list of potentially misvalued codes. They felt CMDs were able to offer a unique perspective on the Medicare program as they administer the program in their assigned geographic areas, are physicians themselves, and are on the front line of administering the program and serve as the first point of contact for any provider with questions regarding coverage, coding and claims processing. ***While this is an important policy change to note, none of the codes proposed for review impact our specialty.***

5) Improving Valuation of the Global Surgical Package (p. 86)

In the CY 2013 proposed rule, CMS sought comments on methods of obtaining accurate and current data on E/M services furnished as part of a global surgical package. Commenters provided a variety of suggestions including comments from the AMA RUC noting that the hospital and discharge day management services included in the global period for many surgical procedures may have been inadvertently removed from the time file in 2007. CMS said in the CY 2013 final rule with comment period that they would review this file and, if appropriate, propose modifications to the physician time file in the CY 2014 PFS proposed rule. After extensive review, CMS states they believe that the data were deleted from the time file due to an inadvertent error as noted by the AMA RUC. Thus, they propose to replace the missing post-operative hospital E/M visit information and time for the 117 codes that were identified by the AMA-RUC. Nine of the 117 CPT codes noted by the AMA RUC are provided by Otolaryngology, including:

TABLE 13: Proposed Physician Time Changes for CY 2014 Potentially Misvalued Codes

CPT Code	Descriptor	AMA RUC-Recommended Visits				CY 2013 MD Time	AMA RUC-Recommended MD Time
		99231	99232	99238	99291		
20100	Explore wound neck	2		1		218	266
21139	Reduction of forehead	1		1		400	466
21151	Reconstruct midface lefort	2		1	1	567	686
21154	Reconstruct midface lefort	3		1	2	664	853
21155	Reconstruct midface lefort	2		1	2	754	939
21175	Reconstruct orbit/forehead		1	1	2	549	767
21182	Reconstruct cranial bone		1	1	2	619	856
21188	Reconstruction of midface	2		1		397	372
31582	Revision of larynx	8	1			489	654

6) Validating RVUs of Services (p. 79)

Under the ACA, the Secretary is directed to validate a sampling of RVUs for services identified by the seven categories listed above. ***In the CY 2013 proposed rule CMS informed the public of their intent 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, both for new and existing services."*** Both contracts will extend over a 2 year period. More details were released regarding these contracts in the 2014 NPRM. Specifically, the RAND Corporation will use available data to

build a validation model to predict work RVUs and the individual components of work RVUs, time and intensity. Urban Institute will focus on the central role of time in establishing work RVUs and the concerns that have been raised about the current time values. A key focus of the project is collecting data from several practices for services selected by the contractor. The data will be used to develop time estimates. The project team will includegroups of physicians from a range of specialties to review the new time data and their potential implications for work and the ratio of work to time. This may impact the role of the AMA RUC in the future and is being closely monitored by the Academy.

7) Requirements for Billing "Incident To" Services (p. 192)

The Social Security Act establishes the Medicare benefit category for services and supplies furnished as "incident to" the professional services of a physician and 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, there are regulations specific to each type of practitioner (clinical psychologists, PAs, NPs, clinical nurse specialists, and certified nurse-midwives) allowed to bill for "incident to" services. CMS notes in the proposed rule that there have been situations 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 and they acknowledge that current regulations do not specifically make compliance with state law a condition for payment for "incident to" services. ***CMS proposes to revise its regulations to require that the individual performing "incident to" services meets any applicable requirements to provide the services, including licensure, imposed by the state in which the services are being furnished.***

8) Complex Chronic Care Management Services (p. 201)

CMS notes in the proposed rule that in the context of their broader multi-year strategy to appropriately recognize and value primary care and care management services, they are proposing payment under the PFS, beginning in CY 2015, for complex chronic care management services *furnished to patients with multiple (two or more) complex chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at a significant risk of death, acute exacerbation/decompensation, or functional decline; for the initial and subsequent 90 days.* ***CMS does not propose physician work or practice expense relative value units for these services, rather, they request input from the public as to how these services should be valued. They also request input the standards required to submit a claim for these services, (see section II.I.3 of the NPRM).***

PROPOSED QUALITY INITIATIVE CHANGES

9) Physician Compare Website (p. 266)

Under the ACA, CMS was required to develop a Physician Compare Internet website with information physicians enrolled in the Medicare program. Recently, CMS released a redesigned Physician Compare website which can be found here: www.medicare.gov/physiciancompare. Information that is currently reflected on the site includes address, education and American Board of Medical Specialties (ABMS) board certification information, hospital affiliations, and language skills. CMS is required to post the names of eligible professionals (EPs) who satisfactorily report under PQRS as well as those who are successful e-prescribers under the Medicare eRx Incentive Program. CMS states that all information posted on the website is derived from the PECOS system, and is verified by claims.

CMS intends to place a check mark moving forward for any individual who has earned a Maintenance of Certification additional Incentives starting with data reported for CY 2013. CMS also plans to post the following in 2014:

- 2014 Physician Quality Reporting System (PQRS) Group Reporting Option (GPRO) performance data and data from the CG-CAHPS surveys for group practices of 100 or more EPs (EPs) reporting data under the GPRO in 2013, as well as for ACOs participating in the MSSP in 2014.

For future years CMS proposes to post adding performance rates on measures and patient experience survey measures such as Clinicians and Group Consumer Assessment of Health Providers and Systems (CG-CAHPS) for groups participating in the 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) Value Based Payment Modifier (VM) (p. 447)

The VM assesses both quality of care furnished and the cost of care under the MPFS. CMS has begun with a phase-in of the VM in 2015, which will apply to all physicians, regardless of group size by 2017. Implementation of the VM is based on participation in Physician Quality Reporting System (PQRS). For CY 2015, the VBPM applies to groups of physicians

with 100 or more EPs. ***In 2014, CMS proposes to expand this to groups with 10+ EPs.*** For specifics on the proposals in the 2014 NPRM outlined below, access the Academy's website at: http://bit.ly/entVBPM.

Value Modifier Components	2015 Finalized Policies	2016 Proposed Policies
Performance Year	2013	2014
Group Size	100+	**10+**
Available Quality Reporting Mechanisms	GPRO-Web Interface, CMS Qualified Registries, Administrative Claims	GPRO-Web Interface, CMS Qualified Registries, **EHRs**, OR **70% of EPs reporting individually**
Quality / Outcome Measures	• Measures reported through the GPRO PQRS reporting mechanism selected by the group **OR i**ndividual measures reported by at least 70% of the EPs within the group • All Cause Readmission • Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration) • Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease (COPD), heart failure, diabetes)	Same as 2015
Patient Experience of Care Measures	N/A	**PQRS CAHPS: Option for groups of 25+ EPs**
Cost Measures	1) Total per capita costs measure (annual payment standardized and risk-adjusted Part A and Part B costs) 2) Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes	Same as 2015 **and** **Medicare Spending Per Beneficiary measure** (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)
Benchmarks	Group Comparison	**Specialty Adjusted Group Cost**
Quality Tiering	Optional	**Mandatory** Groups of 10-99 EPs receive only the upward adjustment, no downward adjustment
Payment at Risk	-1.0%	**-2.0%**
Physician Feedback Reports (QRURs)	Reports sent to 24,000 providers in Iowa, Kansas, Missouri and Nebraska.	**On September 16, 2013 groups with 25+ EPs will receive Quality Resource Use Reports (QRURs) which reflect their performance on quality and cost reporting measures based on their 2012 PQRS reporting.**

11) Physician Quality Reporting System (PQRS) (p. 282)

PQRS Proposed Changes in 2014

- **CMS proposes inclusion of 4 of the Academy's Sinusitis Measures for inclusion in 2014 and beyond.**
- CMS increased the number of measures required to avoid the 2016 payment penalty for Individuals from 3 in 2013, to 9 in CY 2014.
- CMS is proposing removing 2 measures applicable to Otolaryngologists.
- CMS proposes eliminating the claims-based reporting method for 2 measures applicable to Otolaryngology
- CMS proposes adding a new method of reporting, Qualified Clinical Data Registry.
- CMS proposes increasing the number of measures in a measure group from 4 to at least 6 due to the increase in the number of measures reported for satisfactory participation.
- CMS proposes to reduce the percentage of patients EPs must report on using Registry reporting from the previous 80% to 50% for CY 2014 reporting.
- CMS proposes groups of 25-99 EPs may only use the GPRO Web-Interface if they report CG CAHPS survey data.

PQRS Incentives and Penalties in 2014 and Beyond

CMS proposes aligning the criteria for earning an incentive payment and being penalized based on 2014 reporting. For 2014, CMS sets the incentive payment for satisfactory participation in PQRS at .05% of all Medicare Part B charges. ***For 2014 and beyond, CMS has set the penalty for unsatisfactory participation in PQRS at -2% of all Medicare Part B charges.***

How to Earn an Incentive Payment

1. **Determine whether to report as an individual EP or group** (which CMS defines as 2 or more EPs, as identified by those who have reassigned their Medicare billing rights to the TIN).

2. **Determine which reporting mechanism to use in 2014** (options outlined below).
   a) **Proposed 2014 Options for Individual Reporting**
   Claims, Registry, Qualified Clinical Data Registry, or Electronic Health Record (EHR)
   b) **Proposed 2014 GPRO Reporting Mechanisms**
   Registry, GPRO Web-Interface (available only for groups of 100+ EPs), CG-CAHPS Survey + Measure Reporting (available for groups 25-99 using GPRO web interface), or EHR.

Individual Reporting Requirements:

- ***Claims***- Report at least 9 measures, covering at least 3 separate National Quality Strategy Domains. If less than 9 measures apply, the EP reports 1 to 8 applicable measures AND reports each measure for at least 50% of applicable Medicare Part B beneficiaries seen.
  - ***Exception:*** individuals reporting via claims may report 3 measures to avoid the payment adjustment in CY 2016; however, they will not qualify for the payment incentive unless they report 9 measures, as outlined above.
- ***Registry*** (such as the Academy's PQRS*Wizard*)**,** Report at least 9 measures, covering at least 3 of the National Quality Strategy domains AND report each measure for at least 50% of the EP's Medicare Part B beneficiaries seen during the reporting period to which the measure applies.
- ***Qualified Clinical Data Registry (QCDR)*** - Report at least 9 measures, covering at least 3 of the National Quality Strategy domains AND report each measure for at least 50% of the EP's Medicare Part B beneficiaries seen during the reporting period to which the measure applies.
- ***EHR***- Report 9 Clinical Quality Measures (CQMs), outlined in the Stage 2 EHR final rule, covering at least 3 domains; or if an EP does not have data for at least 9 CQMs covering at least 3 domains the EP reports CQMs for which there is data and reports the remaining CQMs as "zero denominators".
- ***Measure Groups:*** Individuals electing to report via Measure Groups must report ALL measures included in one (1) Measure Group.

Group Practice (GPRO) Reporting Requirements

- ***Registry*** (such as the Academy's PQRS*Wizard*)- Report at least 9 measures covering at least 3 of the National Quality Strategy domains AND report each measure for 50% of Medicare Part B beneficiaries seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
- ***CG CAHPS Survey + Measure Reporting:*** *(available for groups of 25-99 EPs)*- Groups of 25-99 EPs may elect to report on 6 PQRS measures via the GPRO Web-Interface AND report on all CG-CAHPS survey measures, covering 2 National Quality Strategy domains. Groups can utilize Certified Survey Vendor + Qualified Registry, direct EHR product, EHR data submission vendor, or GPRO web interface.
- ***GRPO Web Interface*** *(available for groups of 100+ EPs)* - CMS maintains the web-interface for groups of 100+ EPs. Groups must report on all measures included in the web interface AND populate data fields for the first 411 consecutively ranked, and assigned, beneficiaries in the order in which they appear in the group's sample for each disease module or preventative care measure. If the pool of beneficiaries is less than 411, then groups must report on 100% of beneficiaries.
- ***Note (QCDR)***: CMS has stated since the release of the rule that it was not their intention to limit the use of the new Qualified Clinical Data Registry's (discussed above) to individual reporting only. Thus, they intend to clarify that this option will be available to groups for CY 2014 in future rulemaking.

3. **Report over the CY 2014 reporting period, 12 month span** (Jan. 1- December 31, 2014): CMS has established CY 2014 (Jan. 1, 2014 – Dec. 31, 2014) as the reporting period for the CY 2016 payment adjustment. CMS has finalized **one exception to the 12 month reporting period** which will apply to individuals reporting via registries to report measure groups. In that instance, a 6 month reporting period will be available (July 1-December 31) as finalized in the 2013 final MPFS.

12) Electronic Health Record Incentive Program (EHR) (p. 424)

CMS proposes EPs may use a qualified clinical data registry to report CQMs that meet both EHR Meaningful Use and PQRS quality reporting specifications. EPs would report 9 CQMs in the Stage 2 EHR final rule covering at least 3 domains, or if an EP does not have data for at least 9 CQMs covering at least 3 domains, the EP reports CQMs for which there is data and reports the remaining CQMs as "zero denominators". CMS states EPs that report CQMs through the EHR incentive program must use the most up to date versions of CQMs (June 2013 for 2014 reporting) or use attestation if using older versions.

Additional Information

The CY 2014 Proposed MPFS rule with comment period on interim policies is published at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-16547.pdf. CMS will respond to comments in the CY 2014 MPFS final rule. The electronic submissions of comment can be made at URL: www.Regulations.gov search for CMS and proposed rules.