Medicare Physician Payment Rule Summary for 2016

New policies now apply to payments under the Medicare Physician Fee Schedule (MPFS) for services delivered on or after Jan. 1.

This is the first Annual Physician Payment Rule released since the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law in April 2015, repealing the sustainable growth rate (SGR), a method to control Medicare spending on physician services.

Here are the major action items in the Final Rule:

**Advance Care Planning Codes Will Now be Reimbursed:**

At the urging of state medical societies and the AMA, the CPT Editorial Panel created two CPT codes (99497 and 99498) for the reporting of advance care planning, including the explanation and discussion of advance directives, such as standard forms by the physician or other qualified health care professional. CMS finalized plans to pay separately for these two codes beginning Jan. 1.

**The CY 2016 Conversion Factor:**

The calendar year (CY) 2016 conversion factor will be $35.83, which reflects the 0.5 percent update adjustment factor specified under MACRA. For a look at the estimated impact of the 2016 Physician Fee Schedule on total allowed charges by medical specialty, turn to Table 62 in the Final Rule. Pathology and laboratories appear to be the biggest gainers in Medicare payouts while gastroenterology and radiation oncology suffer the biggest losses.

**More Telemedicine Codes:**

CMS has added six new telemedicine billing codes to the 2016 Medicare physician fee schedule. Codes 99356 and 99357 cover prolonged service in the inpatient or observation setting, and codes 90963, 90964, 90965 and 90966 relate to end-stage renal disease (ESRD) and home dialysis. Though a patient's home is not an authorized originating site for telehealth, CMS notes that many components of these services could actually be furnished via telehealth connection when a patient is located at a telehealth originating site.

**Chronic Care Management Services Billable by Rural Health Clinics:**

CMS will provide separate payment for non-face-to-face chronic care management (CCM) services to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for chronic care services (CPT code 99490) consistent with the rules established for other practitioners in the CY 2015 Physician Fee Schedule (PFS) Final Rule.

**New Coding Procedures for Rural Health Clinics:**

Beginning with dates of service on or after April 1, CMS will require that all Rural Health Clinics report all services furnished during an encounter using standardized coding systems, such as Level I and Level II of the Healthcare Common Procedure Coding System (HCPCS). This is consistent with the health transactions requirement and would provide useful information on RHC patient characteristics and the types of services being furnished by RHCs. This change will not affect payment rates for RHCs which are paid an All-Inclusive Rate (AIR) per visit for medically necessary face-to-face primary health services and qualified preventive health services furnished by a RHC practitioner to a Medicare beneficiary.
More Clarification on "Incident to" Billing:

"Incident to" billing relates to services or supplies that are furnished as part of a physician’s professional services that are necessary, though "incident to" a physician’s diagnosis or treatment of an injury or illness when services are performed in the physician's office or in the patient’s home. The Final Rule revises statutory language to clarify that the physician or other practitioner directly supervising auxiliary personnel doesn’t have to be the same person treating the patient more broadly. Only the physician or other practitioner who directly supervises auxiliary personnel that provide incident to services may bill Medicare Part B for those services.

Physician Quality Reporting Systems Won't Change – Much:

Overall, Medicare's requirements for satisfactory Physician Quality Reporting Services (PQRS) participation remain largely unchanged. Eligible Professionals (EPs) or groups must report at least nine measures across three domains for at least 50 percent of their Medicare Part B fee-for-service patients. The Final Rule states that at least one of these measures must be from the cross-cutting measure set established by CMS. In addition, CMS made several modifications to PQRS measures that will be available for 2016 reporting. Failure to meet the 2016 reporting requirements will result in a -2 percent payment adjustment in 2018.

Value-Based Modifier Updates:

Policies related to the Value-Based Modifier (VBM) remain similar to those announced for the 2017 payment adjustment period. CMS has said the VBM will apply to all physician and non-physician EPs in 2018 based on reporting in 2016. The Final Rule maintains the maximum -2 percent penalty for physician groups with fewer than 10 EPs, and a maximum -4 percent VBM payment adjustment for groups of ten or more EPs subject to the VBMs that do not meet PQRS reporting requirements. As planned, quality tiering will be mandatory for all groups and physician solo practitioners, with adjustments to be applied in 2018. CMS also plans to waive VBM requirements for physicians who participate in one of the new payment models administered by the Center for Medicare and Medicaid Innovation.

Physician Compare Profile Expands:

All 2016 individual Eligible Professionals (EP) and group practice PQRS measures and Accountable Care Organizations (ACOs) measures will be available for public reporting in late 2017. Physician Compare will also include a visual indicator – a check mark or something similar – on profile pages of EPs who successfully report the PQRS Cardiovascular Prevention measures group for the Million Hearts initiative. CMS will also report measures or item-level benchmarks intended to give patients a point of comparison when looking at quality data available for individual physicians or medical groups.

Appropriate Use Criteria Released for Advanced Diagnostic Imaging:

The Protecting Access to Medicare Act of 2014 (PAMA) includes a provision that will require physicians to consult Appropriate Use Criteria (AUC) prior to ordering advanced diagnostic imaging services. CMS is required to establish a program to promote the use of AUC for these services, which they will do through the rulemaking process. The Final Rule defines which entities are eligible to develop or endorse AUC, the process CMS will use for qualifying those entities and the evidence-based requirements for AUC development. Eligible entities must be “provider-led,” defined as a national professional medical specialty society or another organization comprised primarily of professionals who, either within the organization or outside of the organization, predominantly provide direct patient care. The timeline for implementation depends on the program CMS develops to involve physicians in reviewing the criteria.
Self-Referral Regulations Widen to Facilitate Compensation of Non-Physician Practitioners:

The Final Rule updates physician self-referral regulations to permit payment by a hospital, FQHC or RHC to a physician to enable compensation of a Non-Physician Practitioner (NPP) under certain circumstances. Among other requirements, the NPP must have a contractual relationship directly with the physician and be required to furnish substantially all primary care or mental health services to patients of that physician’s practice. The acceptable payment from the hospital, FQHC, or RHC to the physician is limited to 50 percent of the actual aggregate compensation, signing bonus, and benefits paid to the NPP, and generally may be made no more than once every three years.

Moving to Zero-Day Global Surgery Services:

CMS is on track to transition and revalue all 10-day and 90-day global surgery services to zero-day global periods. MACRA required that CMS develop a process to gather information from a representative sample of physicians on the value of surgical services no later than Jan. 1, 2017. The CY 2016 Proposed Rule solicited feedback on the types of data necessary to increase the accuracy of these values, the best way to collect the data and ways to value the individual components of the surgical package. CMS indicated in the Final Rule that it had received useful comments for consideration as the agency develops proposals for inclusion in next year’s PFS Proposed Rule.

Improving Payment Fee Schedule Accuracy for Primary Care and Care Management Services:

CMS used the CY 2016 Proposed Rule to seek comment on several issues regarding payment for primary care and care coordination under the PFS. These included improving payment for the professional work of care management services, establishing separate payment for collaborative care, reducing administrative burden for CCM and transitional care management services and determining payment for CCM services. CMS indicated in the Final Rule that they received many useful comments that they anticipate using to inform proposals in the CY 2017 PFS Proposed Rule.

MACRA Implementation:

CMS used the CY 2016 Proposed Rule to seek comment on certain provisions in MACRA, specifically consolidating current quality and Electronic Health Record (EHR) performance programs into the new Merit-based Incentive Payment System (MIPS), implementation of MIPS, and promoting alternative payment models. CMS indicated in the Final Rule that they received over 90 comments that will be considered in future rulemaking.

Resources and Additional Information

CMS fact sheet for the Final Rule
Final Rule published in the Federal Register