American Academy of Sleep Medicine

AASM Summary: 2014 Medicare Physician Fee Schedule Proposed Rule

On July 8, 2013 the Centers for Medicare & Medicaid Services (CMS) published the display copy of the 2014 Medicare Physician Fee Schedule (MPFS) proposed rule. The rule describes proposed payment policy and rates for 2014. Policy and rates described in the proposed rule are subject to public comments and may be finalized in the final rule, which will be published on or around November 1, 2013. Below is a summary of the key policies impacting sleep as well as projected payment rates for sleep services. The AASM is developing comments to submit to CMS regarding the first two items: proposed payment and the physician quality reporting system.

1. 2014 Proposed Payment & Conversion Factor

Payment: Members can download a CMS Sleep Services Payment Comparison detailing proposed national payment for sleep services in 2014. All sleep services are projected to see a drop in global payment. Payment for the technical component (modifier TC) of all sleep services is also projected to decrease in 2014. Payment for the professional component (modifier 26) is projected to increase slightly because of a proposed increase to the 2014 conversion factor.

Local Payment: Medicare payment for services can vary significantly based on location. Location-specific payment information is calculated using a factor known as the Geographic Practice Cost Indicator (GPCI). GPCI's are assigned to the physician work, practice expense (PE) and malpractice insurance (MP) component of each service. In the proposed rule, Medicare has proposed some changes to GPCIs which may impact certain members. Members can download a CMS GPCI Comparison showing GPCI values from 2013 and proposed GPCI values for 2014.

Conversion Factor: The current (2013) conversion factor is set at $34.023. The proposed rule lists a proposed conversion factor cut of -24.4% based on the sustainable growth rate (SGR) formula. However, in past years, this "SGR cut" has been averted by legislative action. If the SGR cut is averted again in 2014, a minimal increase to the conversion factor is proposed. This increase is due to a proposed recalculation of the Medicare Economic Index – a factor similar to the SGR which impacts the calculation of the conversion factor. The proposed rule describes a $1.6423 increase in the conversion factor for 2014, which results in an estimated proposed conversion factor of $35.6653. This increase is balanced by a proposed cut to practice expense relative value units (RVUs) for many services including sleep services. More conclusive information describing the conversion factor calculation will be included in the final rule, which will be published in November.

2. Physician Quality Reporting System

Currently, CMS includes a sleep apnea measures group in its Physician Quality Reporting System (PQRS) incentive program. The measures group includes the four sleep apnea measures that were developed by the AASM in conjunction with the AMA PCPI and other specialty societies. In the 2014 MPFS proposed rule, CMS proposes to change the minimum required number of measures in each measures group from four to six. If this proposed change is implemented, the sleep apnea measures group will not meet the minimum required number of measures. CMS has proposed to resolve this issue by recommending the addition of three existing measures to the sleep apnea measures group:

- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- Documentation of Current Medications in the Medical Record
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

All three proposed new measures are National Quality Forum (NQF) approved. The Preventive Care and Screening measures are already a part of the Preventive Care and Screening measures group. CMS has proposed similar changes to twenty other existing measures groups.

3. Telemedicine

In the rule, CMS proposes a number of changes to existing CMS coverage of telemedicine services for 2014. The rule proposes to expand the definition of a rural health professional shortage area (HPSA). CMS suggests that using data collected by the Office of Rural Health Policy will allow a greater number of rural areas to be appropriately identified as rural HPSAs. The rule also proposes to add coverage for a number of new telemedicine services. The transitional care management codes, which were added in 2013, are recommended for approval as telemedicine services for 2014. CMS also proposes to cover counseling for obesity and screening for depression in adults when conducted via telemedicine.

Providers submitting claims for telemedicine services to CMS will continue to be able to do so by submitting the HCPCS code traditionally used for a face-to-face service accompanied by one of two telemedicine modifiers:

- Modifier GT indicates that the service was provided via interactive audio and video telecommunications system (live interaction)
- Modifier GQ indicates that the service was provided via asynchronous telecommunications system (store and forward technology)

4. "Incident-to" Billing

In the rule, CMS proposes to amend the "incident-to" regulations for 2014 to clarify that auxiliary personnel performing "incident-to" services must meet applicable requirements to provide the services, including licensure, imposed by the State in which the services are being furnished. This proposed change reflects CMS concerns that non-qualified auxiliary staff are performing services while not meeting state licensure or training requirements. Amending the "incident-to" regulations as described will allow CMS to recover funds in cases where the regulations are not met.

5. Complex Chronic Care Management

In the rule, CMS has proposed to begin paying for complex chronic care management in 2015 as a mechanism for compensating primary care physicians for the work they perform outside of face-to-face visits. CMS proposes to establish strict requirements for the situations in which complex chronic care management can be billed including:

- The patient must have at least two chronic conditions that are expected to last at least 12 months or until death.
- The chronic conditions must put the patient at risk of death, acute exacerbation/decompensation, or functional decline.
- The patient must have received an Annual Wellness Visit within the past 12 months.
- The practitioner that provides the Annual Wellness Visit must provide the complex chronic care management.

The proposals are subject to comment and further exploration. Unlike many proposals in the rule, this proposal is not intended to be implemented in 2014; CMS plans to finalize this proposal in 2015.

6. Physician Compare Website

CMS is continuing to expand and refine the information available on the Physician Compare website (www.medicare.gov/physiciancompare). The site currently displays basic location and specialty information about physicians as well as whether or not each physician successfully participates in CMS quality incentive programs. The proposed rule outlines next steps for 2014 including adding to the website the performance rates of certain quality metrics (including PQRS data) for physicians who participate using the group reporting option. The rule also proposes to make Accountable Care Organization (ACO) quality data public via the website. The rule proposes to post individual physician performance data on the website in 2015.

7. Medicare Shared Savings Program

The Medicare Shared Savings Program was established to facilitate care coordination and reduce the rate of growth in healthcare costs. Providers participate in the program by joining or establishing an ACO, and participating ACOs are required to report on 33 quality performance measures. CMS is proposing to align ACO quality reporting with the group reporting requirements under PQRS. CMS is also proposing to establish benchmarks for ACO quality performance.

8. Value Based Modifier

The Value Based Modifier is a quality initiative created under the Affordable Care Act. The Act requires implementation of the modifier for group practices by 2015 and for individual physicians by 2017. The modifier results in a positive payment adjustment for high quality providers and a negative payment adjustment for low quality providers. The 2014 proposed rule recommends detailed methodology for implementing the value based modifier. Proposed cuts and incentives begin at a rate of 1% (-1% for low quality providers and +1% for high quality providers) and are recommended to increase.