From: Regulation, Accreditation, and Payment Practice Group Leadership, and Payment Practice Group Leadership <PracticeGroups@healthlawyers.org>
To: fredhyde <fredhyde@aol.com>
Subject: 2013 Final Physician Fee Schedule Issued
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AMERICAN HEALTH LAWYERS ASSOCIATION

PRACTICE GROUP *email alert*

To: Regulation, Accreditation, and Payment Practice Group Members

From: Regulation, Accreditation, and Payment Practice Group Leadership
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Date: November 14, 2012

2013 Final Physician Fee Schedule Issued

By Neda Ryan*

On November 1, the Centers for Medicare & Medicaid Services (CMS) issued its 2013 Final Physician Fee Schedule (Final Rule). Among other changes, the Final Rule includes the following:

- *Sustainable Growth Rate (SGR) Update*. With the intent of controlling Medicare spending on physician services, Congress established the SGR in 1997, which is utilized to account for fluctuations in healthcare spending. The controversy surrounding the SGR is not uncommon to healthcare industry stakeholders. This year, should Congress not implement either a temporary or permanent solution, providers could experience a 26.5% cut in payment for services.

- *Increased Payments to Primary Care Physicians (PCPs)*. Where there are payment cuts to one area, there are payment increases to another: primary care. Under the Final Rule, PCPs will experience a payment increase for managing beneficiaries' care when the beneficiary is discharged from an inpatient hospital, a skilled nursing facility, an outpatient hospital observation, partial hospitalization services, or a community mental health center.

- *Expansion of Multiple Procedure Payment Reduction (MPPR) Policy*. In the Final Rule, effective January 1, 2013, CMS finalized the MPPR for the following procedures:

i. *Nuclear Medicine Procedures*: For Current Procedural Terminology codes 78306 and 78320, CMS will pay the highest paid procedure and will reduce, by 50%, the second procedure furnished to the same beneficiary on the same day.
ii. *Advanced Imaging Procedures*: CMS will apply the MPPR to both the technical component (TC) and the professional component of advanced imaging procedures (e.g., computed tomography, computed tomography angiography, magnetic resonance imaging, magnetic resonance angiogram, and ultrasound) to multiple physicians in the same group practice (i.e., same group national provider identifier) that furnish services to the same beneficiary, in the same session, on the same day. CMS did not define what it means to furnish services in the same "session."
iii. *Cardiovascular and Ophthalmology Services*: CMS will apply the MPPR to the TC of diagnostic cardiovascular and ophthalmology services. Ophthalmology services will experience a 20% reduction while diagnostic cardiovascular services will experience a 25% reduction.

- *Durable Medical Equipment (DME) Face-to-Face Requirement*. The Final Rule establishes a face-to-face encounter requirement as a condition of payment for Specified Covered Items. "Specified Covered Items" include Healthcare Common Procedure Coding System codes for the following type of DME items: (1) transcutaneous electrical nerve stimulation unit; (2) rollabout chair; (3) oxygen and respiratory equipment; (4) hospital beds and accessories; (5) traction-cervical; and (6) any item of DME that appears on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule with a price ceiling at or greater than $1,000. As a condition of payment for a Specific Covered Item, the following must occur:
  i. A face-to-face encounter with the beneficiary must be documented on the date of the written order up to six months before the date of the written order;
  ii. A needs assessment, evaluation, and/or treatment of the beneficiary for the medical condition that supports the need for each item of DME ordered must be conducted during the face-to-face encounter; and
  iii. The face-to-face encounter must be documented in the medical record, signed, or cosigned by the physician.
  iv. The face-to-face encounter may be performed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist.

- *Revisions to Value-Based Payment Modifier*. The Final Rule restated CMS' intent to implement a Value-Based Payment Modifier utilizing a system based on quality and cost-tiering to groups of more than 100 eligible professionals beginning in 2015. Payment adjustments will be based upon successful reporting of the Physician Quality Reporting System at the group level. This modifier will be applied to all providers beginning 2017.

**We would like to thank Neda M. Ryan, Esquire (Clark Hill PLC, Birmingham, MI), for providing this email alert.*

Member benefit educational opportunity:
Participate in Part I of the post-election webinar series: falling off the fiscal cliff? Consequences of sequestration for providers and the Medicare Program (November 16).