CMS has issued a final rule regarding revisions to payment policies under the Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2013. The final rule also addresses payments for Part B drugs and other Medicare Part B payment policies to ensure that the payment systems are updated to reflect changes in medical practice and the relative value of services. It also establishes a face-to-face encounter as a condition of payment for certain durable medical equipment (DME) items and includes provisions for implementing the value-based payment modifier (value modifier) required by the Affordable Care Act (ACA), which will affect payment rates to certain groups based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare fee-for-service (FFS) program. In addition to many other provisions, the rule also includes a discussion regarding the Chiropractic Services Demonstration program.

**CY13 PFS Conversion Factor**
The annual update to the physician fee schedule (PFS) conversion factor (CF) is calculated based on a statutory formula that measures actual versus allowed or “target” expenditures, and applies a sustainable growth rate (SGR) calculation intended to control growth in aggregate Medicare expenditures for physicians’ services.

The final rule with comment period announced a reduction to payment rates for physicians’ services in CY13 under the SGR formula. These payment rates were to be reduced by 26.5 percent under the SGR system on January 1, 2013. However, under The American Taxpayer Relief Act of 2012, Medicare physician payment rates will be kept at a 0.0 rate of increase through December 31, 2013. Therefore, 2012 payments will be extended through 2013. This provision does not permanently “fix” the SGR issue. It just postpones it for another year. The Congressional Budget Office has preliminarily scored the cost of this item at $10.6 billion in 2013 and $25.2 billion over 10 years.

The MPFS Addenda, along with other supporting documents and tables referenced in the final rule with comment period, are available on the CMS web site at [www.cms.gov/PhysicianFeeSched](http://www.cms.gov/PhysicianFeeSched). Click on the link on the left side of the screen titled “PFS Federal Regulations Notices” for a chronological list of PFS Federal Register and other related documents. For the CY13 PFS final rule with comment period, refer to item CMS–1590–FC.
Provisions of the Final Rule for the Physician Fee Schedule Practice Expense Methodology

As CMS explained in the CY10 PFS final rule with comment period, because of the magnitude of payment reductions for some specialties resulting from the use of the physician practice information survey (PPIS) data, CMS finalized a 4-year transition (75 percent old/25 percent new for CY10, 50 percent old /50 percent new for CY11, 25 percent old /75 percent new for CY12, and 100 percent new for CY13) from the previous practice expense relative value units (PE RVUs) to the PE RVUs developed using the new PPIS data. Section 3134(a) of the ACA requires the HHS Secretary to periodically identify potentially misvalued services using certain criteria, and to review and make appropriate adjustments to the relative values for those services. Section 3134(a) of the ACA also added a new section 1848(c)(2)(L) to the Social Security Act (the Act) which requires the HHS Secretary to develop a process to validate the RVUs of certain potentially misvalued codes under the PFS, identified using the same criteria used to identify potentially misvalued codes, and to make appropriate adjustments.

Refinements to the RVUs
In the CY12 PFS final rule with comment period, CMS finalized a proposal to consolidate into one annual process reviews of work and PE RVUs under section 1848(c)(2)(B) of the Act and reviews of potentially misvalued codes under section 1848(c)(2)(K) of the Act.

Most Recent Changes to the Fee Schedule
The CY12 PFS final rule with comment period (76 FR 73026) implemented changes to the PFS and other Medicare Part B payment policies. It also finalized many of the CY11 interim RVUs and implemented interim RVUs for new and revised codes for CY12 to ensure that the payment systems are updated to reflect changes in medical practice and the relative values of services.

Malpractice RVUs
For CY13, CMS will continue its current approach for determining malpractice RVUs for new/revised codes. In section II.M.2 of the final rule with comment period, CMS published a list of new/revised codes and the malpractice crosswalk(s) used for determining their malpractice RVUs. These malpractice RVUs for new/revised codes will be implemented for CY13 on an interim final basis and the malpractice crosswalks are subject to public comment. CMS will respond to comments and finalize the malpractice crosswalks for the majority of these codes in the CY14 PFS final rule with comment period.

Identifying, Reviewing, and Validating the RVUs of Potentially Misvalued Services on the PFS
In recent years, CMS and the American Medical Association Relative (Value) Update Committee (AMA RUC) have taken increasingly significant steps to address potentially misvalued codes. CMS has identified and reviewed numerous potentially misvalued codes in all seven of the categories specified in section 1848(c)(2)(K)(ii) of the Act, and plans to continue its work examining potentially misvalued codes in these areas over the upcoming years. In the CY12 final rule with comment period, CMS finalized a policy to consolidate the review of physician work and practice expense (PE) at the same time, and established a process for the annual public nomination of potentially misvalued services to replace the
five-year review process. In September 2012, CMS entered into two contracts to assist in validating RVUs of potentially misvalued codes. The implementation details for these contracts are currently under development. Contractors will explore models for the validation of physician work under the PFS, both for new and existing services. CMS plans to discuss these models further in future rulemaking.

*CY13 Identification and Review of Potentially Misvalued Services*

In the CY12 PFS final rule, CMS finalized a public nomination process for potentially misvalued codes. Under this newly established process, after CMS receives the nominated codes during the 60-day comment period following the release of the annual PFS final rule with comment period, it evaluates the supporting documentation and assesses whether the submitted codes appear to be potentially misvalued codes appropriate for review under the annual process. In the following year’s PFS proposed rule, CMS publishes the list of nominated codes, and proposes which ones will be reviewed as potentially misvalued. CMS encourages the public to submit nominations for potentially misvalued codes in the 60-day comment period following the publication of this final rule with comment period.

In the 60 days following the release of the CY12 PFS final rule with comment period, CMS received nominations and supporting documentation for review of the codes listed in Table 4 of the final rule. A total of 36 CPT codes were nominated. The majority of the nominated codes were codes for which CMS finalized RVUs in the CY12 PFS final rule.

In the CY13 proposed rule, CMS stated that it did not consider the nominated codes that were last reviewed and valued for CY12 to be potentially misvalued because the supporting documentation did not provide sufficient evidence to demonstrate that the codes should be reviewed as potentially misvalued for CY13 or CY14. The supporting documentation for these services generally mirrored the public comments previously submitted, to which CMS has already responded. Having received no new information on the CPT codes listed in Table 4 not previously discussed, CMS finalized its proposal not to review these services as potentially misvalued.

CMS believes it is imperative that it continues to identify new lists of potentially misvalued codes for review to appropriately identify, review, and adjust values for potentially misvalued codes for CY13.
Expanding the Multiple Procedure Payment Reduction (MPPR) Policy

Medicare has long employed multiple procedure payment reduction (MPPR) policies to adjust payment to more appropriately reflect reduced resources involved with furnishing certain sets of services frequently furnished together. Under these policies, CMS reduces payment for the second and subsequent services within the same MPPR category furnished in the same session or same day.

Section 3135(b) of the ACA increased the MPPR reduction percentage on the technical component (TC) of diagnostic imaging from 25 to 50 percent. Sections 3 and 4 of the *Physician Payment and Therapy Relief Act of 2010* decreased the MPPR reduction percentage on the PE of therapy services from 25 to 20 percent for therapy services furnished in office settings, and exempted from budget neutrality, the change in expenditures resulting from the MPPR on therapy services.

Proposed MPPR for the TC of Cardiovascular and Ophthalmology Services

CMS continues to examine whether it would be appropriate to apply MPPR policies to other categories of services that are frequently billed together, including the TC for other diagnostic services, such as the TC for diagnostic services other than advanced imaging services. For CY13, CMS examined other diagnostic services to determine whether there typically are efficiencies in the technical component when multiple diagnostic services are furnished together on the same day. CMS has conducted an analysis of the most frequently furnished code combinations for all diagnostic services using CY11 claims data. Of the several areas of diagnostic tests examined, CMS found that billing patterns and PE inputs indicated that cardiovascular and ophthalmology diagnostic procedures, respectively, are frequently furnished together and that there is some duplication in PE inputs when this occurs.

For CY13, CMS will adopt its proposal to apply an MPPR to the TC of diagnostic cardiovascular and ophthalmology services, with a modification to apply a 20 percent reduction for diagnostic ophthalmology services rather than the 25 percent reduction that it proposed. The reduction percentage for diagnostic cardiovascular services remains at 25 percent, as proposed. CMS continues to believe that efficiencies exist in the TC of multiple diagnostic cardiovascular and ophthalmology services and will continue to monitor code combinations for possible future adjustments to the reduction percentage applied through the MPPR policy.

Specifically, beginning in CY13 CMS will adopt an MPPR that applies a 25 percent reduction to the TC of second and subsequent diagnostic cardiovascular, and a 20 percent reduction to the TC of second and subsequent diagnostic ophthalmology services, furnished by the same physician (or physicians in the same group practice) to the same beneficiary, on the same day. CMS provides examples illustrating the current and CY13 payment amounts in Table 10 of the final rule. No changes have been made to the proposed list for diagnostic ophthalmology services. In Table 11 of the final rule, CMS has revised the proposed list for diagnostic cardiovascular services by removing codes deleted for CY13, add-on codes, and remote monitoring codes, and adding global codes corresponding to technical-only codes already on the list. The complete list of services subject to the MPPR
for the TC of diagnostic cardiovascular and ophthalmology services is shown in Addenda I and J, respectively.

**CY12 Expansion of the MPPR Policy to the Professional Component of Advanced Imaging Services**

In the CY12 final rule, CMS expanded the MPPR to the professional component (PC) of advanced imaging services (CT, MRI, and ultrasound), that is, the same list of codes to which the MPPR on the TC of advanced imaging already applied (see Addendum F of the proposed rule). Thus, this MPPR policy now applies to the PC and the TC of certain diagnostic imaging codes. In response to public comments, in the CY12 PFS final rule with comment period, CMS adopted a 25 percent payment reduction to the PC of the second and subsequent imaging services. Under this policy, full payment is made for the PC of the highest paid procedure, and payment is reduced by 25 percent for the PC for each additional procedure furnished to the same patient in the same session. This policy was based on the expected efficiencies in furnishing multiple services in the same session due to duplication of physician work, primarily in the pre and post-service periods, with smaller efficiencies in the intraservice period.

**Geographic Practice Cost Indices (GPCIs) Revisions for CY12**

In the CY12 PFS final rule with comment period, CMS made several refinements to the GPCIs, including revising the sixth GPCI update to reflect the most recent data, with modifications. CMS finalized its proposal to change the GPCI cost share weights for CY12 to reflect the most recent rebased and revised Medicare economic index.

CY13 is the final year of the sixth GPCI update and, because CMS will propose updates next year, it did not include any proposals related to the GPCIs for the CY13 PFS. In response to public inquiries about exceptions to the calculated GPCIs, CMS provided a brief discussion about the permanent 1.0 PE floor for frontier states, the 1.5 work floor for Alaska, the GPCIs for the Puerto Rico payment locality, and the expiration of the 1.0 GPCI work floor required under section 1848 (e)(1)(E) of the Act. CMS also discussed recommendations from the first Institute of Medicine report that were not addressed during CY12 rulemaking in the CY13 proposed rule.

Although CMS did not propose any changes to the data or methodology used to calculate the work GPCI for CY13, Addenda D and E reflect the expiration of the statutory 1.0 work GPCI floor which is set to expire on December 31, 2012. CMS notes that it does not have authority to extend the 1.0 work GPCI floor beyond December 31, 2012.

**Medicare Telehealth Services for the Physician Fee Schedule**

- **Requests for Adding Services to the List of Medicare Telehealth Services**

  In the December 31, 2002, Federal Register, CMS established a process for adding services to or deleting services from the list of Medicare telehealth services. CMS assigns any requests to make additions to the list of telehealth services to one of two categories. In the November 28, 2011, Federal Register, CMS finalized revisions to criteria used to review requests in the second category, which is services that are not similar to the current list of telehealth services.
Submitted Request and Other Additions to the List of Telehealth Services for CY13

CMS received a request in CY11 to add alcohol and/or substance abuse and brief intervention services as Medicare telehealth services effective for CY13. CMS proposed to add HCPCS code G0396 (Alcohol and/or substance [other than tobacco] abuse structured assessment [for example, AUDIT, DAST] and brief intervention, 15 to 30 minutes) and HCPCS code G0397 (Alcohol and/or substance [other than tobacco] abuse structured assessment [for example, AUDIT, DAST] and intervention greater than 30 minutes) to the list of telehealth services for CY13 on a category 1 basis. CMS also proposed to add HCPCS codes G0442, G0443, G0444, G0445, G0446, and G0447 to the list of telehealth services for CY13 on a category 1 basis. After consideration of the public comments received, CMS finalized its CY13 proposal to add these codes on a category 1 basis. CMS notes that all coverage guidelines specific to the services will continue to apply when these services are furnished via telehealth.

Payment for New Preventive Service HCPCS G-Codes

Under section 1861(ddd) of the Act, as amended by section 4105 of the ACA, CMS is authorized to add coverage of “additional preventive services” if certain statutory criteria are met as determined through the national coverage determination (NCD) process, including that the service meets certain criteria. Medicare now covers the following preventive services: screening and counseling for alcohol misuse, screening for depression in adults, screening for and behavioral counseling to prevent sexually transmitted infections, intensive behavioral therapy for cardiovascular disease, and intensive behavioral therapy for obesity. Table 28 of the final rule lists the HCPCS G-codes created for reporting and payment of these services.

Therapy Services -- Outpatient Therapy Caps for CY13

Section 1833(g) of the Act applies annual, per beneficiary limitations (therapy caps) on expenses considered incurred for outpatient therapy services under Medicare Part B. There is one therapy cap for outpatient occupational therapy services and a separate therapy cap for physical therapy and speech-language pathology services combined. Although therapy services furnished in an outpatient hospital setting have been exempt from the application of the therapy caps, section 3005(b) of the MCTRJCA amended section 1833(g) of the Act to include therapy services furnished in an outpatient hospital setting in the therapy caps. This provision is in effect from October 1, 2012, through December 31, 2012. The annual change in the therapy cap amount for CY13 is computed by multiplying the cap amount for CY12 by the Medicare Economic Index (MEI) for CY13 and rounding to the nearest $10. This amount is added to the CY12 cap, which is currently $1,880, to obtain the CY13 cap amount. The MEI for CY13 is 0.8 percent, resulting in a therapy cap amount of $1,900 for CY13.
Other Provisions of the Final Rule

Primary Care and Care Coordination
CMS has prioritized the development and implementation of a series of initiatives designed to ensure accurate payment for, and encourage long-term investment in, primary care and care management services. In the CY12 PFS proposed rule CMS initiated a public discussion regarding payments for post-discharge care management services, seeking broad public comment on how to further improve care management for a beneficiary’s transition from the hospital to the community setting within the existing statutory structure for physician payment and quality reporting. In the proposed rule, CMS decided to proceed with a proposal to refine PFS payment for post discharge care management services.

As part of its multi-year strategy to recognize and support primary care and care management, CMS proposed to create a HCPCS G code that would describe all non-face-to-face services related to the transitional care management (TCM) furnished by the community physician or qualified nonphysician practitioner within 30 calendar days following the date of discharge from an inpatient acute care hospital, psychiatric hospital, long-term care hospital, skilled nursing facility, and inpatient rehabilitation facility; hospital outpatient for observation services or partial hospitalization services; and a partial hospitalization program at a CMHC to community based care.

While CMS believes that current hospital discharge management and nursing facility discharge services codes adequately capture the care management activities involved with discharging a beneficiary from a hospital or SNF, it does not believe that current evaluation and management (E/M) office or other outpatient visit CPT codes appropriately describe comparable care management work of the community physician or qualified non-physician practitioner coordinating care for the beneficiary post-discharge. CMS considered the proposal to be part of a multiple year strategy exploring the best means to encourage care coordination services.

After considering comments and for a variety of other reasons, CMS is adopting the CPT TCM codes subject with modifications, which include its decision not to restrict the billing of the CPT TCM codes to established patients, its clarification of the post-discharge service period, and its prohibition against billing a discharge day management service on the same day that a required E/M visit is furnished under the CPT TCM codes for the same patient. CMS will provide guidance to contractors and revise the relevant manual provisions in order to implement these policies.

The requirements of the CPT TCM codes as modified for Medicare purposes in the final rule include the following:

- 99495 Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
  - Medical decision making of at least moderate complexity during the service period.
- Face-to-face visit, within 14 calendar days of discharge.
- 99496 Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
  - Medical decision making of high complexity during the service period.
  - Face-to-face visit, within 7 calendar days of discharge.

CPT codes 99495 and 99496 are used to report transitional care management services.

**Ambulance Fee Schedule**
The MCTRCA of 2012 extended ambulance payment add-ons through December 31, 2012. Accordingly, CMS is revising §414.610(c)(1)(ii) to conform the regulations to statutory requirements. CMS notes it is continuing to apply a 22.6 percent rural bonus to ground ambulance services with dates of service on or after January 1, 2012 and before January 1, 2013 where transportation originates in a qualified rural area. These statutory requirements are self-implementing.

**Durable Medical Equipment (DME) Face-to-Face Encounters and Written Orders Prior to Delivery**
CMS proposes to first revise § 410.38(g) to require, as a condition of payment for certain covered items of DME, that a physician must have documented and communicated to the DME supplier that the physician or a physician assistant, a nurse practitioner, or a clinical nurse specialist has had a face-to-face encounter with the beneficiary no more than 90 days before the order is written or within 30 days after the order is written. CMS made this proposal because it believes that a face-to-face encounter that occurs within 90 days prior to the written order for DME should be relevant to the reason for the beneficiary’s need for the DME item, and therefore, should substantiate that the beneficiary’s condition warrants the covered item of DME, and be sufficient to meet the goals of this statutory requirement.

In response to comments, CMS is modifying the encounter timeframe so that the face-to-face encounter must now occur 6 months prior to the written order, as opposed to the 3 months that it had previously proposed. CMS believes this modified timeframe best balances the need to protect the Medicare Trust Funds by limiting waste, fraud, and abuse while limiting burden. CMS believes the new timeframe will make it easier for beneficiaries to access DME than the previously proposed timeframe.

In the CY13 PFS proposed rule, CMS proposed requirements for a written order as a condition of payment. For purposes of this final rule, which is focused on implementing section 1834(a)(11)(B) of the Act and reducing fraud, waste, and abuse, an order without minimum elements would be considered incomplete and would not support a claim for payment. In response to comments, CMS has also removed the requirement that instructions for necessary and proper usage, and the diagnosis be included on the order. CMS, however, is requiring at a minimum that the written order contains: (1) The beneficiary name; (2) the item of DME ordered; (3) the signature of the prescribing practitioner; (4) the prescribing practitioner National Provider Identifier; and (5) the date of
the order. Orders should still comply with standards of practice and therefore may be more detailed.

The final list of specified covered items is in Table 89 of the final rule.

**Physician Compare Web Site**

CMS is developing aspects of the Physician Compare web site using a phased approach. In the first phase, which was completed in 2011, CMS posted the names of those eligible professionals who satisfactorily participated in the 2009 Physician Quality Reporting System (PQRS). The second phase of the plan, which was completed in 2012, included posting the names of eligible professionals who were successful electronic prescribers under the 2009 eRx Incentive Program, as well as eligible professionals who participated in the EHR Incentive Program. The next phase of the plan included posting of performance information with respect to the 2012 PQRS group practice reporting option (GPRO) measures, which is targeted to be completed in 2013. CMS is finalizing proposals to include performance information for the 2013 PQRS GPRO web interface measures data, and targeted posting this data in 2014, in addition to 2013 patient experience data for group practices participating in the 2013 PQRS GPRO. As reporting of physician performance rates and patient experience data on the Physician Compare web site would be performed directly by CMS using the data that it collected under the 2012 PQRS GPRO and other data collection methods, CMS did not anticipate any notable impact on eligible professionals with respect to the posting of information on the Physician Compare web site. Since CMS received no public comments related to Physician Compare it is finalizing this analysis.

**Physician Quality Reporting System**

The PQRS is a quality reporting program that provides incentive payments and payment adjustments to eligible professionals who satisfactorily report data on quality measures for covered professional services furnished during a specified reporting period. CMS notes that, in developing these proposals, its goal was to align program requirements between quality reporting programs, such as the eRx Incentive Program, EHR Incentive Program, Medicare Shared Savings Program, and value-based payment modifier, wherever possible. CMS believes that alignment of these quality reporting programs will lead to greater overall participation in these programs, as well as minimize the reporting burden on eligible professionals. With respect to integration with the value-based payment modifier, CMS notes that it began its efforts to integrate its program requirements with the value based payment modifier in the CY12 Medicare PFS final rule, when CY13 was established as the reporting period for the 2015 PQRS payment adjustment, and the initial performance period for the application of the value modifier. CMS’s intention is move the PQRS and EHR Incentive Program towards greater alignment, benefiting those eligible professionals who wish to participate in both programs. The vision is to report once for multiple programs on a set of measures aligned across programs and with the National Quality Strategy.

There are two ways an eligible professional can participate in the PQRS: (1) as an individual, or (2) as part of a group practice participating in the PQRS GPRO. In the final rule, CMS discusses updates to reporting requirements for the PQRS payment adjustments,
and to the criteria for satisfactory reporting of quality measures data for the 2013 and 2014 payment incentives.

Tables 90 and 91 of the final rule provide a summary of criteria for satisfactory reporting by individual eligible professionals of data on PQRS quality measures for the 2013 and 2014 incentive. Tables 92 and 93 contain the final criteria for satisfactory reporting for group practices selected to participate in the GPRO for the 2013 and 2014. [Please note that the right column is titled “Proposed Reporting Criteria.” This appears to be an error since there are changes from the proposed tables.]

Criteria for Satisfactory Reporting for the 2015 Payment Adjustment for Eligible Professionals and Group Practices Using the Administrative Claims-based Reporting Mechanism

Eligible professionals and group practices have three options for meeting the criteria for satisfactory reporting for the 2015 PQRS payment adjustment:

- Meet the criteria for the 2013 PQRS incentive;
- Report one applicable measure or, for eligible professionals only, measures group; or
- Elect to be analyzed under the administrative claims-based reporting mechanism.

Eligible professionals and group practices have one option for meeting the criteria for satisfactory reporting for the 2016 PQRS payment adjustment:

- Meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment.

PQRS Quality Measures

To align with the proposed measure domains provided in the EHR Incentive Program, CMS classifies all proposed measures against six domains based on the National Quality Strategy’s six priorities:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare
- Clinical Processes/Effectiveness

PQRS Quality Measures Available for Reporting for 2013 and Beyond

In large part, CMS would retain most of the quality measures it finalized for reporting for the 2012 PQRS. However, in 2013 and 2014, CMS would include new measures, as well as remove measures that were available for reporting under the 2012 PQRS (not re-propose certain measures for 2013 and beyond).

- Individual Measures Available for Reporting Under PQRS
With respect to the individual measures CMS proposed to include for reporting in PQRS beginning in 2013 or 2014, since it did not receive public comments on a majority of these measures, based on the reasons previously stated in the CY13 PFS proposed rule, CMS finalizes these measures, as proposed. These measures either meet the requirement that the measures available in the PQRS measure set be NQF endorsed or address an exception to NQF endorsement, such as filling a gap in the PQRS measure set. A list of the measures CMS finalized for PQRS beginning in 2013 or 2014 is contained in Table 95. CMS notes that the titles of the measures may change slightly from CMS program and/or CMS program year based on specifications updates.

The final PQRS quality measures available for group practices using the GPRO web interface beginning in 2013 are listed in Table 96 of the final rule. Also, based on the comments received and for the reasons previously stated, CMS is finalizing the 26 measures groups for inclusion in the PQRS that it proposed previously. These measures are listed, with descriptions, in Tables 97 through 122. CMS notes that some of the proposed measures included within a final PQRS quality measures group may also be available for reporting as an individual measure.

- **Physician Quality Reporting System Measures for Eligible Professionals and Group Practices That Report Using Administrative Claims for the 2015 Payment Adjustment**

  CMS proposed 19 measures, including 15 process and 4 outcome measures, derived from administrative claims for eligible professionals and group practices that report using administrative claims for the 2015 and 2016 payment adjustments. CMS notes that, since it is not finalizing an administrative claims-based reporting option for the 2016 PQRS payment adjustment, the measures will only be available for the purpose of reporting for the 2015 PQRS payment adjustment.

  CMS is finalizing 13 of the proposed 15 process measures and is adding NQF 0022, “Use of High Risk Medicines in the Elderly.” CMS is not finalizing NQF 0021 measure titled “Annual Monitoring for Beneficiaries on Persistent Medications” for the Administrative Claims option, and NQF 0549 Pharmacotherapy Management of COPD Exacerbation.

Based on the comments received, as specified in Tables 123 and 124, CMS finalizes 17 measures, comprised of 14 process and 3 outcome measures (2 of which are PQI composite measures), for inclusion in the PQRS administrative claims-based measure set for reporting for the 2015 PQRS payment adjustment only.

**Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program**

Section 1848(p) of the Act requires that CMS establish a value-based payment modifier and apply it to specific physicians and groups of physicians the Secretary determines appropriate starting January 1, 2015, and to all physicians and groups of physicians by
January 1, 2017. On or after January 1, 2017, section 1848(p)(7) of the Act provides the Secretary discretion to apply the value-based payment modifier to eligible professionals. CMS believes that the value-based payment modifier has the potential to help transform Medicare from a passive payer to an active purchaser of higher quality, more efficient and effective healthcare by providing upward payment adjustments under the PFS to high performing physicians (and groups of physicians) and downward adjustments for low performing physicians.

CMS proposed to apply the value-based payment modifier:
(a) to groups of physicians of 25 or more eligible professionals;
(b) to align quality measurement for purposes of the value-based payment modifier with the reporting requirements for data on quality measures under the PQRS, and
(c) to implement the value-based payment modifier so that it does not affect payment for those groups that satisfactorily report information on quality measures under the PQRS unless the group of physicians expressly elect further assessment using a quality-tiering option.

The statute requires the value-based payment modifier to be budget neutral. CMS is finalizing its overall approach to the value-based payment modifier in which the value-based payment modifier adjustment is based on participation in the PQRS. Although CMS is refining many of the proposed value-based payment modifier policies in response to comments received, the major change from its proposals is that beginning in calendar year 2015, it will apply the value-based payment modifier to groups of physicians of 100 or more eligible professionals rather than to groups of physicians of 25 or more eligible professionals. CMS believes this change in policy is necessary in order for it to gain additional experience with, and to be able to produce data to enhance physician acceptance of, its methodologies and approach.

CMS also is finalizing the following proposed policies related to the definition of a group and group size:

- For purposes of establishing group size only, CMS uses the definition of an eligible professional as specified in section 1848(k)(3)(B) of the Act;
- CMS applies the value-based payment modifier to the Medicare paid amounts for the items and services billed under the PFS at the tax ID number (TIN) level so that beneficiary cost-sharing is not be affected; and
- CMS applies the value-based payment modifier to the items and services billed by physicians under the TIN, not to other eligible professionals that also may bill under the TIN.

CMS identifies the groups of physicians subject to the value-based payment modifier (groups of 100 or more eligible professionals) based on a query of Medicare’s Provider Enrollment, Chain, and Ownership System on October 15, 2013, and will remove any groups from this October 15 list if, based on a claims analysis, the group of physicians did not have 100 or more eligible professionals that submitted claims during the performance period.
Based upon the comments received, CMS is adopting its proposed policy, with one modification: to categorize groups of physicians eligible for the value-based payment modifier into two categories. Specifically, the first category of groups of physicians includes those that (a) have self-nominated for the PQRS as a group and reported at least one measure or (b) have elected the PQRS administrative claims option for CY13. CMS notes that groups in category (a) also include those groups that have self-nominated and have met the satisfactory reporting criteria for the PQRS incentive payment. The value-based payment modifier for the groups of physicians in this first category (both (a) and (b)) will be 0.0 percent, meaning no payment adjustment will be applied to physicians in these groups for CY15.

For those groups of physicians within this first category that have requested that their value-based payment modifier be based on quality-tiering and have either met the satisfactory reporting criteria for the PQRS incentive or have chosen the administrative claims-based option, CMS will use the performance rates on the quality measures reported through these reporting mechanisms (that is, GPRO registries, web-interface, or administrative claims) to calculate their value-based payment modifier. Otherwise, CMS will use the group’s performance on the administrative claims measures for quality-tiering.

The second category includes those groups of physicians with 100 or more eligible professionals that do not fall within either of the two subcategories of category 1. The value-based payment modifier for these groups of physicians will be -1.0 percent in CY15 for poor performance. In the fall of 2013, CMS plans to produce and disseminate Physician Feedback reports at the TIN level to all groups of physicians with 25 or more eligible professionals. These reports will include a “first look” at the methodologies that CMS has adopted in the final rule for the value-based payment modifier. CMS will not apply the value-based payment modifier for 2015 and 2016 to groups of physicians that are participating in the Medicare Shared Savings Program, the testing of the Pioneer ACO model, or other similar Innovation Center or CMS initiatives.

**Quality-Tiering Model**

In making its proposals, CMS developed two models that compare the quality of care furnished to costs: A quality-tiering model and a total performance score model. It proposed the quality-tiering model for the value-based payment modifier, and solicited comments on the total performance score model. The quality-tiering model compares the quality of care composite with the cost composite to determine the value-based payment modifier. CMS proposed to compare quality of care composite classification with the cost composite classification to determine the value-based payment modifier adjustment according to the amounts listed below (found in Table 126 of the final rule).
Value-Based Payment Modifier Amounts for the Quality-Tiering Approach

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+ 2.0x*</td>
<td>+1.0x*</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Average Quality</td>
<td>+ 1.0x*</td>
<td>+0.0%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Low Quality</td>
<td>+ 0.0%</td>
<td>-0.5%</td>
<td>-1.0%</td>
</tr>
</tbody>
</table>

* Groups of physicians eligible for an additional +1.0x if reporting measures and average beneficiary risk score in the top 25 percent of all risk scores.

To make this comparison, CMS proposed to classify the quality of care composite scores into high, average, and low quality of care categories based on whether they are statistically above, not different from, or below the mean quality composite score.

In the final rule, CMS finalized its proposal to adopt the quality-tiering model. CMS believes that this approach is a reasonable way to phase in the value-based payment modifier, especially as more groups of physicians report quality data. CMS also sees it as an opportunity to fine tune its methodology to identify high and low performers. Although CMS recognizes the beneficial aspects of the total performance score model, it believes that model may be inappropriate when groups of physicians have the ability to select the quality measures on which they report, as there would not be a uniform yardstick by which to assess performance improvement.

Medicare Shared Savings Program

Eligible groups of providers and suppliers, including physicians, hospitals, and other healthcare providers, may participate in the Shared Savings Program by forming or participating in an Accountable Care Organization (ACO). The PQRS incentive under the Medicare Shared Savings Program is equal to 0.5 percent of the Secretary’s estimate of the ACO’s eligible professionals’ total Medicare Part B PFS allowed charges for covered professional services furnished during the calendar year reporting period from January 1 through December 31, for years 2012 through 2014. CMS will, as proposed, incorporate requirements for the PQRS payment adjustment that are consistent with requirements for PQRS incentives that were previously adopted in the Shared Savings Program final rule.

Instead of requiring ACOs to report on all of the ACO GPRO quality measures for purposes of satisfactory reporting for the 2015 PQRS payment adjustment under the Shared Savings Program, ACOs must only report one of the ACO GPRO measures that were finalized for the PQRS incentive under the Shared Savings Program.

CMS is finalizing its proposal that the reporting period for the payment adjustment fall two years prior to when the payment adjustment is assessed. For example, under the Shared Savings Program, the reporting period for the 2015 payment adjustment is from January 1, 2013, through December 31, 2013. CMS clarifies that no registration or self-nomination is required for ACO providers/suppliers that are eligible professionals to participate in PQRS under the Shared Savings Program.
Budget Neutrality for the Chiropractic Services Demonstration
Section 651 of MMA requires the HHS Secretary to conduct a demonstration for up to two years to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. Current Medicare coverage for chiropractic services is limited to treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Act provided such treatment is legal in the state or jurisdiction where performed. The demonstration expanded Medicare coverage to include: ‘‘(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and (B) diagnostic and other services that a chiropractor is legally authorized to perform by the state or jurisdiction in which such treatment is provided.’’

In previous years’ PFS final rules (CY06, CY07, and CY08), CMS included a discussion of the strategy that would be used to assess budget neutrality (BN) and the method for adjusting chiropractor fees in the event the demonstration resulted in costs higher than those that would occur in the absence of the demonstration. As explained in the CY10 PFS final rule, because the costs of this demonstration were higher than expected and CMS did not anticipate a reduction to the PFS of greater than two percent per year, it finalized a policy to recoup $50 million in expenditures from this demonstration over a five-year period, from CY10 through CY14. Specifically, CMS is recouping $10 million for each of these years through adjustments to the chiropractic CPT codes. Payment under the PFS for these codes will be reduced by approximately two percent. CMS believes that spreading this adjustment over a longer period of time will minimize its potential negative impact on chiropractic practices.

CMS is continuing the implementation of the required BN adjustment by recouping $10 million in CY13. To recoup $10 million in CY13, the payment amount under the PFS for the chiropractic CPT codes 98940, 98941, and 98942 will be reduced by approximately 2 percent. CMS notes that it is reflecting this reduction only in the payment files used by the Medicare contractors to process Medicare claims rather than through adjusting the RVUs.

The CMS Office of the Actuary estimates chiropractic expenditures in CY13 will be approximately $470 million based on Medicare spending for chiropractic services for the most recent available year and reflecting an approximate 30.9 percent reduction to physician payments scheduled to take effect under current law.

More Information
The provisions of this final rule with comment period are effective on January 1, 2013. Comments on the final rule are due December 31, 2012.

Read the CY13 Medicare physician fee schedule final rule, published in the November 16, 2012, Federal Register.

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