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Provider eNews - Special Edition

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Announcements

CMS Finalizes Physician Payment Rates for 2014

Final Rule Focuses on Improved Care Coordination

On November 27, CMS finalized payment rates and policies for 2014, including a major proposal to support care management outside the routine office interaction as well as other policies to promote high quality care and efficiency in Medicare. CMS' care coordination policy is a milestone, and demonstrates Medicare's recognition of the importance of care that occurs outside of a face-to-face visit for a wide range of beneficiaries beginning in 2015. The final rule sets payment rates for physicians and non-physician practitioners paid under the Medicare Physician Fee Schedule for 2014 and addresses the policies included in the proposed rule issued in July. CMS projects that total payments under the fee schedule in 2014 will be approximately \$87 billion.

As part of CMS' continuing effort to recognize the critical role primary care plays in providing care to beneficiaries with multiple chronic conditions, beginning in 2015, the agency is establishing separate payments for managing a patient's care outside of a face-to-face visit for practices equipped to provide these services.

The 2014 payment rates increase payments for many medical specialties with some of the greatest increases going to providers of mental health services including psychiatry, clinical psychologists and clinical social workers.

CMS is finalizing a process to adjust payment rates for test codes on the Clinical Laboratory Fee Schedule (CLFS) based on technological changes. Currently, the payment rates for test codes on the CLFS do not change once they have been set (except for changes due to inflation and other statutory adjustments). This review process will enable CMS to pay more accurately for laboratory tests on the CLFS.

The final rule also includes several provisions regarding physician quality programs and the Physician Value-Based Payment Modifier (Value Modifier). As CMS continues to phase-in the Physician Value-Based Payment Modifier, for 2016 CMS is finalizing its proposals to apply the Physician Value Modifier to groups of physicians with 10 or more eligible

professionals, and to apply upward and downward payment adjustments based on performance to groups of physicians with 100 or more eligible professionals. However, only upward adjustments based on performance (not downward adjustments) will be applied to groups of physicians with between 10 and 99 eligible professionals.

CMS also is finalizing several related proposals to the Physician Quality Reporting System (PQRS) for 2014, including a new option for individual eligible professionals to report quality measures through qualified clinical data registries. In 2014, quality measures will be aligned across quality reporting programs so that physicians and other eligible professionals may report a measure once to receive credit in all quality reporting programs in which that measure is used. Additionally, CMS is better aligning PQRS measures with the National Quality Strategy and meaningful use requirements, and transitioning away from process measures in favor of performance and outcome measures. Finally, certain data collected in 2012 for groups reporting certain PQRS measures under the Group Practice Reporting Option (GPRO) will be publicly reported on the CMS Physician Compare website in 2014.

“Aligning measures across quality programs focuses providers on the most important measures and makes it easier to participate in programs like PQRS, which are designed to emphasize quality for Medicare beneficiaries,” said Dr. Patrick Conway, CMS Deputy Administrator for Innovation and Quality and CMS Chief Medical Officer.

Full text of this excerpted [CMS press release](#) (issued November 27).

- [Final Rule](#)
- [Fact Sheet](#): Final Policy and Payment Changes to the Medicare Physician Fee Schedule for CY 2014
- [Fact Sheet](#): Changes for CY 2014 Physician Quality Programs and the Value-Based Payment Modifier
- [Physician Fee Schedule](#)
- [Physician Value-Based Payment Modifier](#)
- [PQRS](#)

CMS Makes Outpatient Facility Policy and Payment Changes

Rule would give hospitals and ASCs flexibility to lower per-case costs

On November 27, CMS released a final CY 2014 hospital outpatient and ambulatory surgical center (ASC) payment rule [CMS-1601-FC] that will give hospitals and ASCs new flexibility to lower outpatient facility costs and strengthen the long-term financial stability of Medicare. In addition, CMS will replace the current five levels of hospital clinic visit codes for both new and established patients with a single code describing all outpatient clinic visits. A single code and payment for clinic visits is more administratively simple for hospitals and better reflects hospital resources involved in supporting an outpatient visit. The current five levels of outpatient visit codes are designed to distinguish differences in physician work.

Provisions in the final Hospital Outpatient Prospective Payment System (OPPS) rule encourage more efficient delivery of outpatient facility services by packaging the payment for multiple supporting items and services into a single payment for a primary service similar to the way Medicare pays for hospital inpatient care. Supporting items and services that will be included in a single payment for a primary service to the hospital and not paid separately include drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure; drugs and biologicals that function as supplies when used in a surgical procedure, including skin substitutes; certain clinical diagnostic laboratory services; certain procedures that are never done without a primary procedure (add-ons); and device removal procedures.

The CY 2014 final rule with comment period increases overall payments for hospital outpatient departments by an estimated 1.7 percent. The increase is based on the projected hospital market basket—an inflation rate for goods and services used by hospitals—of 2.5 percent, minus both a 0.5 percent adjustment for economy-wide productivity and a 0.3 percentage point adjustment required by statute. The rule also updates partial hospitalization payment rates for hospitals and community mental health centers.

As part of this broader proposal to consolidate payment for larger groups of services, the final rule with comment period also establishes an encounter-based or “comprehensive” payment for certain device-related procedures like cardiac stents and defibrillators, but in a change from the proposed rule, delays its effective date to 2015.

Full text of this excerpted [CMS press release](#) (issued November 27).

- [Final Rule](#)
- [Fact Sheet](#)

CMS Extends 2014 Annual Participation Enrollment Period through January 31

The 2014 Annual Participation Enrollment Program allows eligible physicians, practitioners, and suppliers an opportunity to change their participation status by December 31, 2013. Due to the later than usual release of the Medicare Physician Fee Schedule Final Rule, CMS is extending the 2014 annual participation enrollment period through January 31, 2014. Therefore, participation elections and withdrawals must be post-marked on or before January 31, 2014. The effective date for any participation status changes elected by providers during the extension remains January 1, 2014

Updated Information about Incarcerated Beneficiary Claim Denial Corrections

CMS has a new [web page](#) focused on the 2013 claims denials associated with a beneficiary’s incarceration status.



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