

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2840	Date: December 20, 2013
	Change Request 8533

SUBJECT: Summary of Policies in the CY 2014 Medicare Physician Fee Schedule (MPFS) Final Rule and the Telehealth Originating Site Facility Fee Payment Amount

I. SUMMARY OF CHANGES: This Change Request (CR) provides a summary of the policies in the CY 2014 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. The attached Recurring Update Notification applies to Publication 100-04, Chapter 12, Section 190.6 and Publication 100-02, Chapter 15, Section 270.5.

EFFECTIVE DATE: January 1, 2014

IMPLEMENTATION DATE: January 6, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 2840	Date: December 20, 2013	Change Request: 8533
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SUBJECT: Summary of Policies in the CY 2014 Medicare Physician Fee Schedule (MPFS) Final Rule and the Telehealth Originating Site Facility Fee Payment Amount

EFFECTIVE DATE: January 1, 2014

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request is to provide a summary of the policies in the CY 2014 Medicare Physician Fee Schedule (MPFS). Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 27, 2013 that updates payment policies and Medicare payment rates for services furnished by physicians and nonphysician practitioners (NPPs) that are paid under the MPFS in CY 2014.

The final rule addresses Medicare public comments on payment policies that were described in the proposed rule earlier this year, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014," (displayed July 8, 2013 and published in the Federal Register on July 19, 2013).

The final rule also addresses interim final values established in the CY 2013 MPFS final rule with comment period (displayed November 1, 2012 and published in the Federal Register November 16, 2012). The final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2014 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until January 27, 2014.

B. Policy: *Sustainable Growth Rate (SGR) and MPFS conversion factor for CY 2014:* Without a change in the law, the MPFS conversion factor will be reduced by 20.1 percent for services in 2014. The President's budget calls for averting these cuts and finding a permanent solution to this problem. The CY 2014 conversion factor is \$27.2006, which reflects a smaller reduction in the conversion factor than the 24.4 percent reduction that we projected in March 2013. The smaller reduction is due in part to a 4.72 percent adjustment to the conversion factor to offset the decrease in Medicare physician payments that would otherwise have occurred due to the CY 2014 rescaling of the RVUs so that the proportions of total payments for the work, PE, and malpractice RVUs match the proportions in the final revised Medicare Economic Index (MEI) for CY 2014. This issue is discussed further below. The overall 2014 reduction in physician fee schedule payments required under the SGR methodology is unchanged by this rescaling. We note that the preliminary estimate CY 2014 SGR is lower than projected in March primarily due to lower enrollment.

Medicare Economic Index: CMS finalized the proposed revisions to the calculation of the MEI, which is the price index used to update physician payments for inflation. The changes are in response to recommendations by a Technical Advisory Panel that met during CY 2012. Application of the MEI along with the SGR determines the conversion factor that is used to determine payments made each year under the PFS. The final rule includes changes in the PFS RVUs assigned to the work and practice expense categories so that the weights used in the PFS payment calculation will continue to mirror those in the MEI. As a result, some payment is being redistributed to work from practice expense. In addition, we are updating the GPCI cost share weights consistent with the revised 2006-based MEI cost share weights.

Telehealth Services: We modified our regulations establishing the geographic criteria for eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of urban

areas as determined by the Office of Rural Health Policy. We believe this change will more appropriately allow sites located within HPSAs in MSAs that have rural characteristics to qualify as originating sites and improve access to telehealth services in shortage areas. In this rule we also finalize a policy that determines an originating sites geographic eligibility based on the areas as of December 31st of the preceeding year for the entire calendar year. This change will avoid mid-year changes to geographic designations (sometimes without advance notice to Medicare beneficiaries and providers) that could result in unexpected disruptions to established telehealth originating sites and avoid the need to make mid-year Medicare telehealth payment policy changes. In addition, we are adding transitional care management services (CPT codes 99495 and 99496) to the list of eligible Medicare telehealth services).

Telehealth Originating Site Facility Fee Payment Amount Update. Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2014 is 0.8 percent. Therefore, for CY 2014, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or \$24.63. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

Revisions To The Practice Expense Geographic Adjustment: As required by the Medicare law, CMS adjusts payments under the PFS to reflect the local cost of operating a medical practice as compared to the national average. CMS calculates separate geographic practice cost indices (GPCIs) to adjust the work, practice expenses (PE), and malpractice cost components of each payment. The law requires that we review the GPCIs every three years and adjust them as appropriate with a two-year phase-in of the new GPCIs. We are finalizing new GPCIs using updated data. The updated GPCIs will be phased in over CY 2014 and CY 2015. Additionally, we will apply the statutorily mandated 1.5 work GPCI floor in Alaska and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming). Note that the separate statutory 1.0 work GPCI floor is scheduled to expire under current law on December 31, 2013 and therefore, the finalized GPCIs do not include the 1.0 work GPCI floor.

Misvalued Codes: Consistent with amendments made by the Affordable Care Act, CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and make adjustments where appropriate. We finalized the values for around 200 codes in this final rule. In addition, we assigned interim final values for approximately 200 services, including hip and knee replacements, mental health services, and GI endoscopy services. These interim final rates are open for public comment until January 27, 2014.

CMS is not finalizing its proposal to adjust relative values under the PFS to effectively cap the physician practice expense payment for procedures furnished in a non-facility setting at the total payment rate for the service when furnished in an ambulatory surgical center or hospital outpatient setting. Instead, CMS will take additional time to consider issues raised by the public commenters and plans to address this issue in future rulemaking. In addition, for CY 2014, we are finalizing 18 codes that we identified and proposed as potentially misvalued services in consultation with Contractor Medical Directors.

Application of Therapy Caps to Critical Access Hospitals: The law applies annual limitations or “therapy caps” on per beneficiary incurred expenses for outpatient therapy services —one for physical therapy and speech-language pathology services combined and another for occupational therapy services. We finalized our proposal to apply the therapy caps and related policies to outpatient therapy services furnished by a CAH beginning on January 1, 2014 in order to properly apply the law that established the therapy caps.

Compliance with State Law for Incident To Services: We are requiring as a condition of Medicare payment that “incident to” services be furnished in compliance with applicable state law. This policy strengthens program integrity by allowing Medicare to deny or recoup payments when services are furnished not in compliance with state law. We also eliminated redundant regulations for each type of practitioner by consolidating the “incident to” requirements for all practitioners that are permitted to bill Medicare directly

for their services, reducing the regulatory burden and making it less difficult for practitioners to determine what is required in order to bill Medicare for “incident to” services. This portion of the final rule with comment period is effective on March 3, 2014.

The Outpatient Mental Health Treatment Limitation: Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends Section 1833(c) of the Social Security Act to phase out the outpatient mental health treatment limitation over a 5-year period, from 2010-2014. The limitation had resulted in Medicare paying only 50 percent of the approved amount under the physician fee schedule for outpatient mental health treatment rather than the 80 percent that is paid for most other services. This limitation expires on January 1, 2014. In CY 2014, Medicare will pay the same percentage of the PFS amount for outpatient mental health services as other Part B services (i.e. 80 percent of the PFS amount)..

Primary Care and Chronic Care Management: As part of our ongoing efforts to appropriately value primary care services, Medicare will begin making a separate payment for chronic care management services beginning in 2015. Chronic care management services include the development, revision, and implementation of a plan of care; communication with the patient, caregivers, and other treating health professionals; and medication management. Medicare beneficiaries with multiple chronic conditions who wish to receive these services can choose a physician or other eligible practitioner from a qualified practice to furnish these services over 30-day periods. The rule indicates that CMS intends to establish practice standards necessary to support payment for furnishing care management services through future notice-and-comment rulemaking.

The final rule will appear in the December 10, 2013, Federal Register. For more information, see: www.federalregister.gov/inspection.aspx#special

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E	Shared-System Maintainers				Other
		A	B	H H H		F M V C	I C M W	S S S F		
8533.1	Effective for dates of service January 1, 2014 and after, Medicare contractors shall pay for the Medicare telehealth originating site facility fee as 80 percent of, the lesser of the actual charge or \$24.63, as described by HCPCS code Q3014 “Telehealth facility fee.”	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H		

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
8533.2	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: 2014 Physician Fee Schedule Payment File: MU00.@BF12390.MPFS.CY14.RV1.C00000.V1202

2014 FI Abstract Files:

MU00.@BF12390.MPFS.CY14.SNF.V1202.FI – SNF
 MU00.@BF12390.MPFS.CY14.ABSTR.V1202.FI – Therapy Abstract
 MU00.@BF12390.MPFS.CY14.MAMMO.V1202.FI – Mammography
 MU00.@BF12390.MPFS.CY14.HHH.V1202.FI – HHH
 MU00.@BF12390.MPFS.CY14.PAYIND.V1202 – Payment Indicator

MU00.@BF12390.MPFS.CY14.ANES.V1203 - Anesthesia

V. CONTACTS

Pre-Implementation Contact(s): Kathy Bryant, 410-786-3448 or Kathy.Bryant@cms.hhs.gov , Larry Chan, 410-786-6864 or Larry.Chan@CMS.hhs.gov , Charles Campbell, 410-786-7209 or Charles.Campbell@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.