

## Medicare Physician Fee Schedule (PFS) 2015 Final Rule: Changes to Coding and Payment Policies

### *Highlights*

#### Background

On November 13, 2014, the Centers for Medicare & Medicaid Services (CMS) published the 2015 Medicare PFS Final Rule (Final Rule) in the Federal Register. The Final Rule presents payment policies and rates for Medicare Part B physician services effective for calendar year (CY) 2015.<sup>1</sup> This document summarizes the relevant highlights from the 2015 Final Rule related to Medicare Part B coding and payment policy changes under the PFS. An accompanying “Questions and Answers” document that provides further details regarding these topics is attached as Appendix 1.

#### Summary of the Key Coding and Payment Provisions from the 2015 Final Rule

- **No changes to payment methodology for Part B drugs and biologicals**  
The Final Rule does not make any changes to the Average Sales Price (ASP)-based payment methodology for Part B drugs and biologicals – ASP plus 6%. *Note that the 2% payment reduction due to sequestration will continue to apply to Medicare’s share of payment for Part B drugs and other Part B services paid under the PFS in 2015, absent Congressional intervention.*<sup>2</sup>
- **Sustainable Growth Rate (SGR) payment cuts are scheduled to go into effect on April 1, 2015 absent further action from Congress**  
SGR is a statutory formula that ties Medicare reimbursement for physician services to the growth rate of the national economy. Over the past decade, application of the SGR formula has required drastic payment cuts to the PFS and Congress has intervened repeatedly to prevent these cuts from going into effect. Congress earlier this year enacted the Protecting Access to Medicare Act of 2014, providing for a zero percent update to the PFS for services furnished between January 1, 2015 and March 31, 2015.<sup>3</sup> *Absent further action from*

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*Congress, Medicare payment for physician services will be reduced by 21.2% according to the SGR formula beginning on April 1, 2015.<sup>4</sup>*

- Enhanced transparency in PFS rate setting to be implemented by 2017, giving stakeholders a greater opportunity to provide input on new and revised codes**

The Final Rule changes CMS's process for valuing new, revised, and potentially misvalued codes.<sup>5</sup> The new process will give stakeholders an opportunity to provide comments on new and revised codes in the PFS Proposed Rule before they are adopted. At the request of various physician groups, however, CMS is delaying the full implementation of this process until 2017, with a transition in 2016.<sup>6</sup> This delay allows certain new and modified codes to take effect in 2016, consistent with the expectations of those who requested those coding changes.
- Payment to physicians for chronic care management services with new Current Procedural Terminology (CPT) code 99490 begins on January 1, 2015**

The Final Rule assigns a 2015 PFS payment rate of \$42.60 for the newly created code for chronic care management services.<sup>7</sup> Last year, CMS finalized a policy to provide separate payment to physicians for chronic care management services furnished to Medicare beneficiaries with multiple (two or more) chronic conditions beginning in 2015. In the Final Rule, CMS decided to adopt newly created CPT code 99490 in lieu of creating a G-code, as the agency had originally proposed to do.<sup>8</sup> At least 20 minutes of chronic care management services must be provided during the calendar month in order to use this code, and providers must meet various other billing rules.<sup>9</sup> In addition, CMS finalized an additional requirement that, in order to be eligible for Medicare payment, certain of the chronic care management services must be furnished using an EHR system that meets certification standards.<sup>10</sup> Physicians will also be required to collect and share information related to a patient's plan of care electronically.<sup>11</sup>
- CMS's review of "potentially misvalued" codes will not include drug administration codes at this time**

The Final Rule continues CMS's recent efforts to identify and review potentially misvalued codes under the PFS as required by law. Several drug administration codes were included among the potentially misvalued codes identified in the 2015 PFS Proposed Rule as being associated with high Medicare expenditures. In the Final Rule, however, CMS decided not to move forward with reviewing this "high expenditure" code category at this time, but it could be part of a future review.<sup>12</sup> In general, CMS does not make any specific policy changes to drug administration codes in the Final Rule. However, broader PFS changes

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(e.g., the SGR formula) affect these codes as well. A crosswalk of final 2015 drug administration rates for relevant services is attached as Appendix 2.

- **Expansion of eligible Medicare telehealth services**

The Final Rule expands the list of eligible Medicare telehealth services to include annual wellness visits, psychoanalysis, psychotherapy, and prolonged evaluation and management services.<sup>13</sup>

- **Changes to “Open Payments” reporting requirements for drug and device manufacturers**

CMS is making several changes to the Open Payments program (also known as the “Physician Payments Sunshine Act” program), which requires drug and device manufacturers to publicly report certain payments made to physicians and teaching hospitals. Most significantly, CMS is removing the current reporting exemption that applies to payments made to physician speakers at continuing medical education events.<sup>14</sup>

- **New reporting requirements for hospitals and physicians providing care at off-campus provider-based departments of hospitals**

CMS finalized a proposal to collect data on services furnished in off-campus provider-based departments of hospitals that will affect both physicians and hospitals.<sup>15</sup> Physicians will be required to report a new place-of-service (POS) code on their professional claim form that identifies the specific hospital outpatient location where the service was performed. CMS does not expect that the new POS codes will be available before July 1, 2015 and plans to issue additional guidance on the use of these codes at a later date.

<sup>1</sup> CMS, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models, and Other Revisions to Part B for CY 2015, Final Rule, 79 Fed. Reg. 67,548 (Nov. 13, 2014).

<sup>2</sup> CMS, Medicare Learning Network, CMS Medicare FFS Provider e-News (Mar. 8, 2013), <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-08-standalone.pdf> (last visited Nov. 14, 2014); Letter from Marilyn Tavenner, Ctrs. for Medicare & Medicaid Services, to Rep. Pete Sessions, U.S. House of Representatives (June 3, 2013).

<sup>3</sup> Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 101, 128 Stat. 1040 (Apr. 1, 2014).

<sup>4</sup> 79 Fed. Reg. at 67,742.

<sup>5</sup> 79 Fed. Reg. at 67,607-08.

<sup>6</sup> 79 Fed. Reg. at 67,607-08.

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<sup>7</sup> CMS, Addendum B, Relative Value Units and Related Information Used in Determining Final Medicare Payments CY 2015, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html?DLPage=1&DLSort=2&DLSortDir=descending>. Note that this is the national average PFS rate that would apply from January 1, 2015 through March 31, 2015

<sup>8</sup> 79 Fed. Reg. at 67,651.

<sup>9</sup> 79 Fed. Reg. at 67,716.

<sup>10</sup> 79 Fed. Reg. at 67,727.

<sup>11</sup> 79 Fed. Reg. at 67,727-28.

<sup>12</sup> 79 Fed. Reg. at 67,578.

<sup>13</sup> 79 Fed. Reg. at 67,602.

<sup>14</sup> 79 Fed. Reg. at 68,000 (codified at 42 C.F.R. § 403.904).

<sup>15</sup> 79 Fed. Reg. at 67,572.

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**Appendix 1:**  
**Medicare Physician Fee Schedule (PFS)**  
**2015 Final Rule:**  
**Changes to Coding and Payment Policies**

*Questions and Answers*

**Background**

On November 13, 2014, the Centers for Medicare & Medicaid Services (CMS) published the 2015 Medicare PFS Final Rule (Final Rule) in the Federal Register. The Final Rule presents payment policies and rates for Medicare Part B physician services effective for calendar year (CY) 2015.<sup>1</sup> This Questions and Answers (Q&A) document addresses updates and revisions to Medicare PFS coding and payment policies contained in the Final Rule. A separate Q&A focuses on the provisions of the Final Rule related to Medicare physician quality initiatives, including the Physician Quality Reporting System, Value-Based Payment Modifier, and Shared Savings Program.

***Q. What are some of the key issues related to coding and payment policies addressed in the Final Rule?***

**A.** The Final Rule addresses the following key areas:

- payment policies for chronic care management and telehealth services;
- reporting requirements under CMS's Open Payments program;
- payment policies impacting all Medicare Part B physician services, including implementation of the Sustainable Growth Rate (SGR) payment formula; and
- Medicare Part B payment for drugs and drug administration services.

<sup>1</sup>CMS, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models, and Other Revisions to Part B for CY 2015, Final Rule, 79 Fed. Reg. 67,548 (Nov. 13, 2014).

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## I. Payment Policies for Chronic Care Management and Telehealth

The Final Rule includes several provisions that are designed to enhance Medicare payment for primary care services, which include: 1) implementing separate payment for the furnishing of certain “chronic care management” services to Medicare beneficiaries with multiple chronic conditions beginning in 2015; and 2) expanding the list of eligible Medicare telehealth services.

### ***Q. What is Medicare’s payment policy for chronic care management services?***

**A.** In the 2014 Medicare PFS Final Rule, CMS established a policy to provide separate payments to physicians (and qualified non-physician practitioners) for furnishing certain non-face-to-face chronic care management services to Medicare beneficiaries with multiple (two or more) chronic conditions beginning in CY 2015.<sup>2</sup> The 2015 Final Rule makes further refinements to this payment policy, which goes into effect on January 1, 2015.

### ***Q. What types of services will be included within the scope of chronic care management? Does the Final Rule make any changes to the scope of services?***

**A.** In the 2014 Final Rule, CMS described various services that the agency considers to be within the scope of chronic care management, including:

- the provision of 24-hour-a-day, 7-day-a-week access to providers;
- continuity of care with a designated practitioner or member of the care team;
- various interventions furnished under a patient-centered plan of care, including preventive care and medication management;
- management of care transitions;
- coordination with home and community-based clinical service providers; and
- enhanced opportunities for patient-provider communications via telephone, secure messaging, the Internet, or other non-face-to-face consultation methods.<sup>3</sup>

The 2015 Final Rule adds requirements for chronic care management services relating to electronic care planning capabilities and the use of electronic health records (EHR) systems. Specifically, CMS will require that physician practices furnish certain chronic care management

<sup>2</sup> Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014, 78 Fed. Reg. 74,230, 74,416 (Dec. 10, 2013).

<sup>3</sup> 78 Fed. Reg. at 74,416-18.

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services with the use of, at a minimum, EHR technology that meets certification criteria acceptable under the Medicare EHR Incentive Program.<sup>4</sup> Practices will also be required to collect the patient's plan of care information electronically and make the plan of care information available to all members of the care team and, as appropriate, other providers furnishing care to the beneficiary.<sup>5</sup>

**Q. How can physicians bill and be paid for chronic care management services in 2015?**

**A.** CMS will recognize Current Procedural Terminology (CPT) code 99490 to describe chronic care management services in 2015, which has the following description:

*Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.*<sup>6</sup>

The Final Rule assigns a payment amount of \$42.60 to CPT code 99490 in 2015.<sup>7</sup> CMS determined this payment amount by comparing chronic care management to other services payable under the PFS that involve care management. In particular, CMS looked to the non-face-to-face portion of the work relative value units (RVUs) assigned to CPT code 99495, which describes transitional care management services furnished by physicians to patients who are discharged from institutional settings of care (e.g., hospitals or skilled nursing facilities).

At least 20 minutes of chronic care management services must be provided during the calendar month in order for physicians to be eligible to bill using this code. Physicians must also adhere to certain billing and documentation requirements, which were finalized under the 2014 Final

<sup>4</sup> 79 Fed. Reg. at 67,727.

<sup>5</sup> 79 Fed. Reg. at 67,727-28.

<sup>6</sup> 79 Fed. Reg. at 67,651.

<sup>7</sup> CMS, Addendum B, Relative Value Units and Related Information Used in Determining Final Medicare Payments CY 2015, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html?DLPage=1&DLSort=2&DLSortDir=descending>. Note that this is the national average PFS rate that would apply from January 1, 2015 through March 31, 2015 (see discussion of SGR formula below).

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Rule. Among these requirements, physicians must inform beneficiaries of the availability of chronic care management services and offer beneficiaries the opportunity to opt into and out of receiving them.<sup>8</sup>

**Q. What does CMS consider to be a “chronic condition” for purposes of Medicare payment for chronic care management services?**

**A.** CMS does not specify particular diseases or conditions that it will use to identify Medicare beneficiaries eligible to receive separately payable chronic care management services. Physicians must ensure that patients meet the criteria outlined in the description of the Medicare chronic care management CPT code. In previously discussing the rationale for the chronic care management policy, CMS previously referred to a claims analysis of Medicare beneficiaries with 15 common chronic conditions drawn from the CMS Chronic Condition Warehouse.<sup>9</sup> These selected chronic conditions include the following:

- 1) Alzheimer’s/dementia;
- 2) arthritis (including rheumatoid arthritis and osteoarthritis);
- 3) asthma;
- 4) atrial fibrillation;
- 5) cancer (breast, colorectal, lung, and prostate);
- 6) chronic kidney disease;
- 7) chronic obstructive pulmonary disease;
- 8) depression;
- 9) diabetes (excluding diabetic conditions related to pregnancy);
- 10) heart failure;
- 11) hyperlipidemia;
- 12) hypertension;
- 13) ischemic heart disease;
- 14) osteoporosis; and
- 15) stroke/transient ischemic attack.<sup>10</sup>

<sup>8</sup> 79 Fed. Reg. at 40,368.

<sup>9</sup> 78 Fed. Reg. at 74,415.

<sup>10</sup> CMS, Chronic Conditions among Medicare Beneficiaries: Chartbook, 2012 Edition, at 29 (2012), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>.

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However, CMS has made it clear that it does not intend to limit the eligible chronic conditions to those included in this claims analysis.<sup>11</sup>

***Q. Are specialists eligible to bill using CPT code 99490 or is payment only available for primary care physicians?***

**A.** Specialists are eligible to bill Medicare for chronic care management services, provided that they satisfy all applicable billing requirements for the CPT code.<sup>12</sup> It should be noted, however, that only one physician (or qualified non-physician practitioner) is permitted to receive Medicare payment for chronic care management services furnished to a particular patient during a given month.<sup>13</sup>

***Q. Does the Final Rule make any changes to the physician supervision requirements for chronic care management services performed “incident to” the services of a physician by the practice’s clinical staff?***

**A.** Yes. CMS previously relaxed Medicare’s physician supervision requirements that apply when a physician practice’s clinical staff performs chronic care management services. Ordinarily under Medicare rules, in order to bill for a service performed by clinical staff “incident to” a physician’s professional service, the supervising physician must provide “direct supervision” – i.e., he/she must be present in the office suite (but not necessarily in the same room as the patient) and immediately available to provide assistance and direction throughout the service.<sup>14</sup> Because one of the required elements of chronic care management services is the availability of 24-hours-a-day, 7-days-a-week access to a provider, CMS recognized that it would be impractical for supervising physicians to provide direct supervision of their clinical staff outside of the practice’s normal business hours. As such, CMS created an exception to the direct supervision requirement in the case of chronic care management services. This exception permitted chronic care management services to be furnished by the practice’s clinical staff under “general supervision” when performed outside of the practice’s normal business

<sup>11</sup> 78 Fed. Reg. at 74,416.

<sup>12</sup> 78 Fed. Reg. at 74,423.

<sup>13</sup> 78 Fed. Reg. at 74,425.

<sup>14</sup> 42 C.F.R. §§ 410.26(b)(5), 410.32(b)(3)(ii).

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hours, meaning that the supervising physician need only provide overall direction and assistance as needed, but did not need to be present in the office suite.<sup>15</sup>

Under the 2015 Final Rule, CMS further amended the Medicare supervision requirements to grant even greater flexibility to physician practices billing chronic care management services. Most notably, the time spent by clinical staff providing aspects of chronic care management will be eligible to be counted toward CPT code 99490 requirements *at any time* (even outside normal business hours), as long as the clinical staff is under the general supervision of a physician and all other “incident to” requirements are met.<sup>16</sup>

**Q. Can physicians who participate in CMS delivery system reform models and demonstrations bill Medicare for chronic care management services?**

**A.** It depends. Physicians participating in the Multi-Payer Advanced Primary Care Practice Demonstration and the Comprehensive Primary Care Initiative will not be permitted to bill Medicare for chronic care management services furnished to any beneficiary attributed to their practice for purposes of these CMS initiatives.<sup>17</sup> According to CMS, these programs already include payments for care management services that closely overlap with the scope of services for the new CPT code, making separate payment for chronic care management duplicative. However, such physicians can bill Medicare for chronic care management services for beneficiaries who are not attributed to their practices for purposes of these initiatives. Physicians participating in other delivery system reform models and demonstrations are eligible to bill for chronic care management services, but CMS notes that it will monitor these other initiatives and may implement payment policies to address any “overlaps” in the future.

**Q. How would the Final Rule affect Medicare coverage for telehealth services?**

**A.** The Final Rule expands the list of eligible telehealth services to include the following:

- psychotherapy services (CPT codes 90845, 90846, and 90847);
- prolonged service in the office (CPT codes 99354 and 99355); and
- annual wellness visits (G0438 and G0439).<sup>18</sup>

<sup>15</sup> 42 C.F.R. § 410.32(b)(3)(i); 79 Fed. Reg. at 40,366.

<sup>16</sup> 79 Fed. Reg. at 67,720.

<sup>17</sup> 79 Fed. Reg. at 67,729.

<sup>18</sup> 79 Fed. Reg. at 67,602.

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## II. Reporting Requirements Under CMS's Open Payments Program

### ***Q. What is the Open Payments program?***

**A.** The Open Payments program (also known as the "Physician Payments Sunshine Act" program) was established under the Affordable Care Act (ACA) with the goal of increasing transparency and public awareness of financial relationships between pharmaceutical and medical device manufacturers and healthcare providers.<sup>19</sup> It requires manufacturers to annually report to CMS certain payments and other transfers of value made to physicians and teaching hospitals. The program also requires manufacturers and group purchasing organizations to report ownership and investment interests held by physicians and their immediate family members, as well as payments and other transfers of value made to physician owners and investors. CMS makes this information publicly available on the agency's Open Payments website. CMS published the first set of data collected in 2013 on the Open Payments website on September 30, 2014.<sup>20</sup>

### ***Q. What changes does the Final Rule make to the Open Payments program?***

**A.** The Final Rule makes several changes to the regulations governing the Open Payments reporting program. Most significantly, CMS removed the reporting exemption for payments made to physicians for serving as speakers at continuing medical education programs.<sup>21</sup> Currently, the regulation exempts the reporting of such payments when:

- 1) the event at which the physician is speaking meets certain accreditation and/or certification standards;
- 2) the manufacturer does not pay the speaker directly; and
- 3) the manufacturer does not select the speaker or provide the sponsor of the event with a list of physicians to be considered as speakers.<sup>22</sup>

<sup>19</sup> ACA, Pub. L. No. 111-148, § 6002, 124 Stat. 119, 689-96.

<sup>20</sup> CMS, Open Payments Data: Fact Sheet (Oct. 1, 2014), <http://www.cms.gov/OpenPayments/Downloads/Fact-Sheet-Sept-30-2014-Published-Data.pdf>.

<sup>21</sup> 79 Fed. Reg. at 68,000 (codified at 42 C.F.R. § 403.904).

<sup>22</sup> 79 Fed. Reg. at 67,758.

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CMS notes that it is eliminating the continuing education exemption to achieve greater consistency in the reporting requirements for all events involving physician speakers.

### III. Payment Policies Impacting All Medicare Part B Physician Services

#### ***Q. What is SGR and how does it affect the Final Rule?***

**A.** SGR is a statutory formula that ties Medicare reimbursement for physician services to the growth rate of the national economy. The adjustment that results from the SGR formula is automatically implemented through the annual PFS rulemaking and can only be averted through Congressional action.<sup>23</sup> In the past, application of the SGR formula has required payment cuts to the PFS and Congress has intervened repeatedly to prevent these cuts from going into effect.<sup>24</sup> In these situations, Congress has either maintained or improved prior Medicare reimbursement rates.

For the 2015 PFS, Congress has once again acted to prevent drastic physician payment cuts from going into effect, but so far only for the first quarter of the year. Specifically, in April, Congress enacted the Protecting Access to Medicare Act of 2014 (PAMA), which provides for a zero percent PFS update for services furnished between January 1, 2015 and March 31, 2015.<sup>25</sup> Note that, for all of 2014, Medicare physicians received a 0.5% increase in the PFS.

<sup>23</sup> 42 U.S.C. § 1395w-4(d).

<sup>24</sup> Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 601 117 Stat. 2300 (Dec. 8, 2003); Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5104, 120 Stat. 40 (Feb. 8, 2006); Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 101, 120 Stat. 2975 (Dec. 20, 2006); Medicare, Medicaid and SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 101, 121 Stat. 2493 (Dec. 29, 2007); Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 131, 122 Stat. 2520 (July 15, 2008); ACA, § 3101; Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, Pub. L. No. 111-192, § 101, 124 Stat. 1280 (June 25, 2010); Physician Payment and Therapy Relief Act of 2010, Pub. L. No. 111-286, § 2, 124 Stat. 3056 (Nov. 30, 2010); Medicare and Medicaid Extenders Act, Pub. L. No. 111-309, § 101, 124 Stat. 3285 (Dec. 15, 2010); Temporary Payroll Tax Cut Continuation Act of 2011, Pub. L. No. 112-78, § 301, 125 Stat. 1280 (Dec. 23, 2011); Middle Class Tax Relief and Job Creation Act of 2012, Pub. L. No. 112-96, § 3003, 126 Stat. 156 (Feb. 22, 2012); American Tax Relief Act of 2012, Pub. L. No. 112-240, § 601, 126 Stat. 2313 (Jan. 2, 2013); Pathway for SGR Reform Act of 2013, Pub. L. No. 113-67, § 1101, 127 Stat. 1165 (Dec. 26, 2013); Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 101, 128 Stat. 1040 (Apr. 1, 2014).

<sup>25</sup> Protecting Access to Medicare Act of 2014, § 101.

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Absent further Congressional intervention, beginning on April 1, 2015, CMS estimates that physician payment rates will be reduced by 21.2% as a result of the SGR formula.<sup>26</sup>

**Q. Does the Final Rule include any other changes that will impact reimbursement for Part B physician services?**

**A.** Yes, but the impact of these proposals would be minor compared to the projected SGR adjustment that would apply beginning on April 1, 2015 if Congress does not act.

*Malpractice RVUs*

Malpractice RVUs measure the professional liability expenses associated with services under the PFS. They are generally the smallest component of the total RVUs for a given code. As required by law, the Final Rule updates the malpractice RVUs associated with services payable under the PFS based on CMS's comprehensive review, which takes place every five years.<sup>27</sup> The resource-based malpractice RVUs for 2015 are based on updated specialty-specific professional liability premium data.

*Geographic Practice Cost Indices (GPCIs)*

GPCIs are a measurement of resource cost differences among localities compared to the national average for each of the three fee schedule components: work, practice expense, and malpractice. The Final Rule implements certain statutory provisions related to GPCIs for 2015, including the permanent extension of the 1.5 GPCI work floor in Alaska and the 1.0 practice expense floor for the "frontier" states (Montana, Nevada, North Dakota, South Dakota, and Wyoming).<sup>28</sup> The latest extension of the 1.0 work GPCI floor established under PAMA for all other payment localities, however, is not permanent and only applies through March 31, 2015.<sup>29</sup> The 1.0 work floor limits the downward geographic adjustment of physician work in payment localities with physician work input costs that are less than the national average (e.g., in rural areas with lower costs of living). The GPCIs included with the Final Rule reflect the elimination

<sup>26</sup> 79 Fed. Reg. at 67,742.

<sup>27</sup> 79 Fed. Reg. at 67,596.

<sup>28</sup> 79 Fed. Reg. at 67,597.

<sup>29</sup> 79 Fed. Reg. at 67,597.

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of the 1.0 work floor for all affected payment localities from April 1, 2015 through December 31, 2015.<sup>30</sup>

### *Potentially Misvalued Codes*

The Final Rule continues CMS's efforts to identify and review potentially misvalued codes under the PFS, as required by law.<sup>31</sup> Among other categories of potentially misvalued codes for 2015, CMS had proposed to review a category of codes that accounts for the majority of Part B spending under the PFS. To develop this list, CMS identified the top 20 codes by specialty in terms of allowed Medicare charges (excluding certain types of services). This methodology generated a list of 65 potentially misvalued codes associated with high Medicare expenditures, which is found in Table 10 of the 2015 Proposed Rule.<sup>32</sup> Notably, this list includes several drug administration CPT codes, including the following:

- 96372 – Therapeutic, prophylactic or diagnostic injection, sc or im;
- 96375 – Therapeutic, prophylactic or diagnostic iv push, new substance/drug;
- 96401 – Chemo administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic; and
- 96409 – Chemo administration; intravenous push, single or initial substance/drug.<sup>33</sup>

In the Final Rule, CMS decided not to move forward with reviewing this “high expenditure” code category at this time, but stated that it may use this methodology to identify potentially misvalued codes in the future.<sup>34</sup> Thus, the drug administration codes listed above will not be part of this round of CMS's review of potentially misvalued codes.

### *Enhanced Transparency in PFS Rate Setting*

The Final Rule modifies CMS's process for implementing changes to the payment rates for new, revised, or potentially misvalued codes under the PFS by ensuring that stakeholders have an

<sup>30</sup> CMS, Addendum E, Final CY 2015 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html?DLPage=1&DLSort=2&DLSortDir=descending>.

<sup>31</sup> 79 Fed. Reg. at 40,334-36.

<sup>32</sup> 79 Fed. Reg. at 40,337-38 tbl.10.

<sup>33</sup> 79 Fed. Reg. at 40,337-38 tbl.10.

<sup>34</sup> 79 Fed. Reg. at 67,578.

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opportunity to provide input before such changes go into effect. Specifically, CMS will include proposed values for all new, revised, and potentially misvalued codes for which CMS has complete recommendations from the Relative Value Update Committee (RUC) in the PFS Proposed Rule, allowing stakeholders an opportunity to comment before they take effect.<sup>35</sup> For those codes for which CMS does not receive RUC recommendations in time to include in the Proposed Rule, CMS will delay revaluing the code for a year and include the proposed value in the following year's proposed rule, creating G-codes, if necessary, to continue payment for the intervening year. At the request of various physician groups, however, CMS is delaying the full implementation of this process until 2017, with a transition in 2016. This delay allows certain new and modified codes to take effect in 2016, consistent with the expectations of those requesting these coding changes.<sup>36</sup>

**Q. Does the Final Rule include new data collection efforts related to hospital-based physicians?**

**A.** Yes. To better understand the growing trend of hospitals acquiring physician practices, and the subsequent treatment of these sites as off-campus outpatient departments of a hospital, CMS will begin to collect data from both physicians and hospitals that will allow the agency to analyze the shift toward hospital-based physician practices, as follows:

- Hospitals will be required to report a modifier on their claim forms for Part B hospital outpatient services furnished at provider-based sites beginning January 1, 2016. This data collection will be *voluntary* for hospitals in 2015.
- Physicians will be required to report a place-of-service (POS) code on their professional claim form that identifies the specific hospital outpatient location where the physician service was furnished. To facilitate this data collection effort, CMS is deleting POS code 22 (outpatient hospital department) and replacing it with two new (more specific) POS codes. Physicians will be required to use the new POS codes as soon as they become available and integrated into CMS's claims systems. CMS does not expect that the new POS codes will be available before July 1, 2015.<sup>37</sup>

<sup>35</sup> 79 Fed. Reg. at 67,607-08.

<sup>36</sup> 79 Fed. Reg. 67,607-08.

<sup>37</sup> 79 Fed. Reg. at 67,572.

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CMS plans to issue additional instructions and provider education materials to hospitals and physicians on these new reporting requirements in future sub-regulatory guidance.

#### **IV. Medicare Part B Payment for Drugs and Drug Administration Services**

***Q. In general, does the Final Rule change how Medicare pays for chemotherapy and other biologicals provided in physician offices under Part B buy-and-bill rules?***

**A.** No. The Final Rule does not change the use of Average Sales Price (ASP) plus 6% as the standard payment rate in physician offices for 2015. The ASP payment methodology that applies to Part B drugs is specified in law.<sup>38</sup> Note, however, that the 2% payment reduction due to sequestration will continue to apply to Medicare's share of payment for Part B drugs (as well as other Part B services paid under the PFS) in 2015 absent Congressional intervention.<sup>39</sup>

***Q. How does the Final Rule affect drug administration codes and payment?***

**A.** The Final Rule does not make any specific policy changes to the drug administration codes. It should be noted, however, that broader PFS changes impact these codes as well. For example, any potential SGR reduction would apply to drug administration codes, as it would to all codes payable under the PFS. A crosswalk of final 2015 drug administration rates for relevant services is attached as Appendix 2.

<sup>38</sup> 42 U.S.C. § 1395w-3a.

<sup>39</sup> CMS, Medicare Learning Network, CMS Medicare FFS Provider e-News (Mar. 8, 2013), <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-08-standalone.pdf> (last visited Nov. 18, 2014); Letter from Marilyn Tavenner, Ctrs. for Medicare & Medicaid Services, to Rep. Pete Sessions, U.S. House of Representatives (June 3, 2013).

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## Appendix 2: Final 2015 (01-Jan through 31-Mar) Medicare Coding & Payment\* for Drug Administration Services under the Physician Fee Schedule

CPT® Codes	Description	2014 Final \$ Rates <sup>1</sup>	2015 Final (Jan-Mar) \$ Rates <sup>2</sup>
<b>Hydration Infusion</b>			
96360	IV infusion, hydration, 31 minutes to 1 hour	56.96	58.00
96361	IV infusion, hydration; each additional hour	15.05	15.39
<b>Therapeutic/prophylactic/diagnostic infusion</b>			
96365	IV infusion, for therapy/ prophylactic/ diagnostic, initial, up to 1 hr	68.78	69.81
96366	IV infusion for therapy/prophylaxis/diagnosis; each additional hour	18.63	18.97
96367	Additional sequential infusion of a new drug/substance, up to 1 hr	30.09	30.43
96368	Concurrent infusion	20.42	20.76
96379	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	N/A <sup>3</sup>	N/A <sup>3</sup>
<b>Chemotherapy &amp; complex biologic infusion</b>			
96413	Cemo administration, intravenous infusion; up to 1 hour, single or initial substance or drug	133.26	136.04
96415	Cemo administration, intravenous infusion; each additional hour	27.94	27.93
96417	Cemo iv; each additional sequential infusion (different substance/drug) up to 1 hour	61.97	62.65
96422	Chemotherapy, intra-arterial infusion technique up to 1 hour	167.65	171.49
96423	Chemotherapy, intra-arterial infusion technique; each additional hour	77.38	79.12
96416	Cemo, initiation of prolonged iv infusion (>8 hrs) requiring portable/ implantable pump	138.99	141.42
<b>IV push technique</b>			
96374	Therapeutic, prophylactic or diagnostic intravenous push; single or initial substance or drug	56.24	56.92
96375	Therapeutic, prophylactic or diagnostic iv push, new substance/drug	22.21	22.55
96373	Therapeutic, prophylactic or diagnostic injection, intra-arterial	19.34	19.69
96409	Cemo administration, intravenous push, single or initial substance/drug	108.90	110.98
96411	IV push, each additional chemo substance/drug	61.26	62.29
96420	Chemotherapy, intra-arterial, push technique	104.24	104.90
<b>Injection</b>			
96372	Therapeutic, prophylactic or diagnostic injection, sc or im	25.08	25.42
96401	Cemo administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	73.79	74.82
96402	Cemo administration, subcutaneous or intramuscular; hormonal anti-neoplastic	31.88	32.22
<b>Other chemotherapy administration codes</b>			
96425	Cemo initiation of prolonged ia infusion (>8 hrs) requiring use of a portable/ implantable pump	180.56	181.51
96405	Cemo intralesional, up to and including 7 lesions	81.32	82.70
96406	Cemo intralesional, more than 7 lesions	113.56	119.58

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\* **NOTE:** All reimbursement is presented as national rates, without application of geographic adjustment factors (GPCI). Actual provider payment rates will vary according to the geographic location of the practice. The rates displayed have not been adjusted for any impact of sequestration.

<sup>1</sup> The "2014 Final Rates" are calculated using: 1) the legislatively adjusted conversion factor of 35.8228, as authorized by the *Protecting Access to Medicare Act of 2014 [Pub Law 113-93]*, and 2) the final 2014 Total RVUs, comprised of: work RVU (wRVU), non-facility (NF) Practice Expense RVU (peRVU), and malpractice RVU (mRVU) weights, as published in *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Final Rule, 78 Fed. Reg. 74,230 (Dec. 10, 2013)*. Addendum B, available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html>

Calculated dollar amounts reflect national rates before geographic adjustment.

<sup>2</sup> The "2015 Final (01-Jan through 31-Mar) Rates" are calculated using: 1) the published conversion factor of 35.8013 (includes the budget neutrality adjustment, but does not reflect the 21.2% sustainable growth rate reduction scheduled to take effect on April 1, 2015, if there is no intervening Congressional action); and 2) the final 2015 Total RVUs, comprised of: work RVU (wRVU), non-facility (NF) Practice Expense RVU (peRVU), and malpractice RVU (mRVU) weights, as published in *CMS-1612-FC. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final Rule*, displayed October 31, 2014, available at: [www.ofr.gov/OFRUpload/OFRData/2014-26183\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2014-26183_PI.pdf)

Calculated dollar amounts reflect national rates before geographic adjustment.

<sup>3</sup> This code is not payable under the Medicare Physician Fee Schedule

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