SOCIETY FOR VASCULAR ULTRASOUND

The VOICE for the Vascular Ultrasound Profession since 1977

July 9, 2014

Franklin W. West, BSN, RN, RVT, RVS, FSVU, CHC

Director, Practice Support, Compliance and Health Policy

Society for Vascular Ultrasound

On July 3, 2014, the Centers for Medicare & Medicaid Services (CMS) released a display copy of the CY 2015 Physician Fee Schedule (PFS) notice of proposed rulemaking (NPRM). The proposed rule can be viewed at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-P.html*. This page also links to all associated addenda and the NPRM will further be published in the 7/11/14 Federal Register.

Most notably, CMS has acknowledged our "stakeholder" (SVU & SVS) comments regarding AAA screening (G0389), which had an approximate 50% decrease in reimbursement under the 2014 PFS and, for 2015, CMS has announced their intent to revert to the 2013 practice expense (PE) relative value units (RVUs), thus restoring reimbursement to approximately the 2013 levels. Furthermore, CMS now believes that G0389 should undergo revaluation including "... the full PE RVU methodology." On a personal note, we should thank Anne Jones (Chair, Advocacy) & Bill Sarraille for successfully presenting our case at CMS. Additionally, SVS met separately with CMS regarding this issue.

On the other hand, 93978 has been selected as potentially misvalued and CMS proposes it, along with a number of other codes, be revalued. However, the selection process included codes that have not been through the revaluation process since 2009 or before. In this case, 93978 was revalued earlier this year and, as such, should not be considered as part of this group of potentially misvalued codes.

Unfortunately, CMS provides no comment in the NPRM regarding changes to the direct inputs for vascular room time for the vascular study family of codes that CMS requested be reviewed. CMS has received the requested data but, given there is no response, it is difficult to judge the CMS intent. Considering the highly significant ramifications of decreasing the vascular room time, it is of paramount importance that this issue be resolved prior to publication of the final rule.

William Sarraille
Partner
Sidley Austin LLP
1501 K Street, N.W.
Washington, DC 20005
+1.202.736.8195

PFS CY 2015 Proposed Rule Summary

Executive Summary

On July 3, 2014, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule with comment period regarding Revisions to Payment Policies under the Physician Fee Schedule (PFS), Clinical Laboratory Fee Schedule, and Other Revisions to Part B for calendar year (CY) 2015 (the Proposed Rule). Below we provide an overview of certain issues that may be of interest to you and your colleagues. We hope you find this information helpful, and please let us know if you have any questions. According to CMS, the Proposed Rule will be published in the Federal Register on July 11, 2014.

In the Proposed Rule, CMS projects that the specialties experiencing the greatest impact will be radiation therapy centers and radiation oncology, which are expected to see payment decreases of 8 and 4 percent, respectively. CMS states that the projected impact on those specialties stems primarily from a proposal to consider an equipment item as an indirect rather than direct practice expense. CMS expects payments for chronic care management services to have a positive effect on family practice, internal medicine, and geriatrics.

CMS also includes several proposals relating to imagining and other provider policies that are notable for SVU. In the sections below, we provide a brief overview of the following topics:

1. Recent Legislation Affecting the PFS
2. Sustainable Growth Rate
3. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

4. Valuing New, Revised, and Potentially Misvalued Codes
5. Definition of Colorectal Cancer Screening Tests
6. Payment of Secondary Interpretation of Images
7. "Sunshine Act": Reports of Payments or Other Transfers of Value to Covered Recipients
8. Medicare Shared Savings Program
9. Value-Based Payment Modifier and Physician Feedback Program
10. Physician Compare Website
11. Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

Recent Legislation Affecting the PFS

- Following publication of the CY 2014 PFS final rule, the Pathway for SGR Reform Act of 2013 (Pub. L. 113-67) was enacted on December 26, 2013. This law established a 0.5 percent update to the PFS conversion factor (CF) through March 31, 2014. Congress then passed the Protecting Access to Medicare Act of 2014 (Pub. L. 113-93) (PAMA), enacted on April 1, 2014, which extended this 0.5 percent update through December 31, 2014. The PAMA provides for a 0.0 percent update to the PFS for services furnished from January 1 through March 31, 2015.
- Among other things, the Pathway for SGR Reform Act and PAMA together also extended, through March 31, 2015, certain Medicare provisions that otherwise would have expired at the end of 2013. These include, but are not limited to, the exceptions process for outpatient therapy caps. The PAMA also requires the Secretary to make publicly available the information considered when establishing the multiple procedure payment reduction (MPPR) policy.

Sustainable Growth Rate (SGR)

- CMS submitted estimates of the SGR and CF for CY 2015 Medicare physician payments to the Medicare Payment Advisory Commission on March 5, 2014, as required by statute. CMS states that the actual values used to compute physician payments for CY 2015 will be based on later data and are scheduled to be published in November 2014 as part of the CY 2015 PFS final rule.

SOCIETY FOR VASCULAR ULTRASOUND

The VOICE for the Vascular Ultrasound Profession since 1977

Practice Expense (PE) Relative Value Unit (RVU) Proposals

- Migration From Film To Digital Imaging PE Inputs. CMS proposes to accept the RUC recommendation to remove film supply and equipment items from all imaging codes' PE inputs. (46-49)
- Inclusion of Task-Level Clinical Labor Time For All Codes. To increase transparency, CMS is considering whether it should include task-level clinical labor time information for every code in the PE input database, which is publicly available on CMS' website, to enable CMS to more accurately allocate equipment minutes to clinical labor tasks in a more consistent and efficient manner. (51)

- CMS seeks comments on the feasibility of this proposal but notes that it is not proposing to make any changes to PE inputs for CY 2015 based on this proposal. (51-52)

- Radiation Vault. CMS proposes to remove the radiation treatment vault as a direct PE input from various radiation treatment codes, because CMS believes that the vault itself is not medical equipment and, therefore, is accounted for in the indirect PE methodology. (54)

- Contrast Imaging's New Standard Supply Package. CMS proposes to accept the RUC's recommendation to create a new direct PE input standard supply package for contrast enhanced imaging with a price of $6.82, but is seeking comments on whether all of the items included in CMS' proposed package are used in the typical case. (58)

- Intravascular Ultrasound. CMS seeks comments on whether it should establish a non-facility PE RVU for CPTs 37250 and 37251 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (list separately in addition to code for primary procedure)). (60)

- Collection of HOPPS/ASC Data for PFS Comparison. In light of the increased hospital acquisition and integration of physician practices, beginning January 1, 2015, CMS proposes to gather information across the two payment systems by creating a HCPCS modifier to be reported with every code for physician and hospital services in an off-campus provider-based department of a hospital under CMS's new authority found in section 1834(c)(2)(M) of the Social Security Act (SSA). (64-65)

    - CMS also seeks comments on possible uses of Medicare hospital outpatient cost data in potential revisions of the PFS PE methodology, such as validation or in setting the relative resource cost assumptions. (63)
    - Abdominal Aortic Aneurysm (AAA) Ultrasound Screening (G0389). CMS acknowledges that it finalized changes to G0389's RVUs without discussing these changes in the proposed rule, yet, subsequently, a stakeholder brought this issue to CMS' attention, arguing that G0389's current crosswalk to 76775 is inappropriate and suggesting an alternative crosswalk to 76705. Having considered this issue, CMS proposes to classify G0389 as a potentially misvalued code and seeks recommendations from the public and the RUC on appropriate inputs to develop G0389 RVUs. (87-88)
    - Until the new RVU information is received, CMS proposes to maintain the work RVU for G0389 and revert back to this code's CY 2013 PE RVUs, adjusted for budget neutrality. (89) As you can see in the attached ultrasound chart, with credit to all of SVU's hard work, CMS' interim proposal increases G0389's PFS' reimbursement rate by more than $50.

Valuing New, Revised and Potentially Misvalued Codes

- High-Expenditure, Potentially Misvalued Codes. The PAMA expanded the categories of services that HHS must examine to identify potentially misvalued codes, such as (among others) codes with a significant difference in payment for the same service between different sites of service and codes with high PE RVUs. In the Proposed Rule, CMS identifies 65 codes as potentially misvalued for further review, including a number of imaging and radiation codes, such as 93978 (Vascular Study). (77-80)

- Process for Reviewing/Updating Misvalued Codes. CMS proposes to change its process for reviewing and updating potentially misvalued codes, in order to provide more meaningful opportunities for stakeholder input. CMS acknowledges drawbacks of the current process.
    - In particular, although the public may receive notice of the codes under consideration for revaluation, CMS nevertheless reimburses providers for a year at the rates selected without prior public review. (152-55)
    - CMS explains that this "drawback" arises from the timing of the RUC recommendation process. CMS proposes three alternatives to its current approach and seeks comment on the proposals and on the merits of a proposed new framework. (158-166)

Definition of Colorectal Cancer Screening Tests

- To improve patient access to screening colonoscopies, CMS proposes to revise the definition of "colorectal screening tests" to include anesthesia that is separately furnished in conjunction with screening colonoscopies. If finalized, Medicare would reimburse 100% of the fee schedule amounts for screening colonoscopies, including portions attributable to anesthesia services furnished by a separate practitioner. (187-88)

Payment of Secondary Interpretation of Images

- CMS seeks to update its policy on when Medicare reimburses for a second professional component (PC) of an imaging service. In particular, CMS hopes to leverage advances in imaging technology by clarifying and expanding the circumstances when it will be considered appropriate to bill for a second PC, rather than ordering a duplicative image. CMS seeks comments on this proposal. (192-94)

"Sunshine Act": Reports of Payments or Other Transfers of Value to Covered Recipients

- CMS proposes to make a number of changes to the regulations implementing the federal Physician Payment Sunshine Act. For example, CMS proposes to remove the definition of a "covered device" because it is duplicative of the definition of "covered drug, device, biological or medical supply." (241)

- CMS also proposes to remove the reporting exemption for payments made to speakers at certain continuing medical education (CME) events. CMS considered either expanding the list of CME organizations subject to the exclusion or articulating certain accreditation or certification standards that would apply to all exempt organizations; CMS seeks comments on these alternatives. (242-43)
- CMS proposes to require applicable manufacturers to report the marketed name for all covered and non-covered drugs, devices, biological or medical supplies. Manufacturers still would have the option to report the product category or therapeutic area in addition to the market name for devices and medical supplies. (244)
- CMS proposes to disaggregate the nature of payment category for reporting stock, stock option, or any other ownership interest; instead, CMS would require manufacturers to report such payments as separate, distinct payment categories. CMS seeks comments on this approach. (244)

Medicare Shared Savings Program

- Rewarding Quality Improvement. CMS proposes to reward Accountable Care Organizations (ACOs) that make year-to-year improvements in quality performances scores on individual measures through a new measure that adds bonus points for improvement within each quality domain. (434) CMS seeks comment on potential alternative approaches. (440)

- Proposed Changes to the Quality Measures. CMS proposes to revise existing quality measures to reflect up-to-date clinical guidelines, including measure to address avoidable admissions for patients with diabetes mellitus, heart failure, or multiple chronic conditions; all-cause skilled nursing facility readmissions; and stewardship of patient resources (among others). Existing composite measures for diabetes and coronary artery disease would also be updated. (394-402) CMS also seeks comments on measures to consider in future rulemaking, including (among others) measures for retirement, utilization, health outcomes, and public health. (411-414)

Value-Based Payment Modifier (VM) and Physician Feedback Program

- CMS proposes to apply the VM to all physicians and non-physician eligible professionals (EPs) in groups with two or more EPs and to solo practitioners starting in CY 2017. (452). CMS also proposes to expand the application of the VM to physicians and non-physician EPs participating in the MSSP, Pioneer ACO Model, or other CMS initiatives, starting in CY 2017. (465-466, 479-481)
- For the CY 2017 VM, CMS proposes to make quality-tiering mandatory for groups and solo practitioners that fall into Category 1. (445)
    - Under this proposal, groups with two to nine EPs and solo practitioners would not be subject to downward adjustments determined under the quality-tiering method.
    - For groups with two or more EPs and solo practitioners that fall into Category 2, CMS proposes to increase the downward adjustment under the VM by doubling the amount of payment at risk from 2.0 percent in CY 2016 to 4.0 percent in CY 2017. (456, 485)
- All-Cause Hospital Readmissions Measure. After investigating the reliability of the all-cause hospital readmissions measure, CMS is proposing to increase the minimum number of cases required for such measure to be included in the quality composite for the VM from 20 cases to 200 cases, beginning with the calendar year 2017 payment adjustment period. (494)
- Total Per Capita Cost Measures. CMS proposes several modifications to its methodology for calculating a cost composite for each group subject to the VM, and also seeks comments on suggested methods for including Part D data in the total per capita cost measures. (500-505)
- Hospital-Based Physicians. CMS is considering allowing groups with hospital-based physicians or solo practitioners to elect the inclusion of Hospital Value-Based Purchasing Program performance scores in their VM calculations. (505) CMS seeks comments on various aspects of this proposal. (507-12)

Physician Compare Website

CMS makes a number of proposals to expand public reporting on the Physician Compare Website (the Website). Among these proposals is a proposal to make all 2015 Physician Quality Reporting System (PQRS) Group Practice Reporting Option measure sets across group reporting mechanisms available for public reporting on the Website beginning in CY 2016. (257) Similarly, all measures reported by Medicare Shared Savings Program ACOs would be available on the Website. (257) Under another

proposal, CMS would expand the PQRS measures for individual eligible professionals (EPs) collected via registry, electronic health records, or claims for reporting in late 2015. (262)

Updating the Physician Quality Reporting System (PQRS)

- For the reporting period for the 2017 PQRS payment adjustment, CMS's proposed criteria for satisfactory reporting and participation generally require EPs to report nine measures covering three National Quality Strategy (NQS) domains. (270, 281, 292-93)
- For the 2017 PQRS payment adjustment, CMS proposes that individual EPs who see at least one Medicare patient in a face-to-face encounter and choose to report quality measures via claims and registry would be required to report at least two measures in a new cross-cutting measure set. (281)
- For the Group Practice Reporting Option (GPRO), CMS proposes to change the number of patients for which the practice would report measures using the GPRO web interface. Specifically, CMS proposes to require reporting for 248 patients for all group practices with 25 or more EPs. For group practices of 100 or more EPs, CMS proposes that the practice also report all CAHPS for PQRS survey measures via a certified survey vendor. (289-90)

CMS invites public comment on whether it should allow more frequent data submissions, rather than the current process that only allows one opportunity to submit quality measures. (272, 279)

CMS proposes to increase the number of PQRS measures in a group from four to six. (358) Tables 26 to 48 of the Proposed Rule specify the proposed measure groups and solicit public comments. (361-72)

CMS also seeks comments on a proposal to modify the payment adjustment informal review deadline to within 30 days of releasing feedback reports, to allow for limited corrections to PQRS data. (381)