On July 15, 2016, The Centers for Medicare & Medicaid Service (CMS) released the Proposed Rule for the CY2017 Medicare Physician Fee Schedule. The publication revealed a medley of small but effective gains for physicians in the form of newly covered services, better review processes for the government’s incentive program, and (under separate rulemaking) a 90-day reporting period for meaningful use in 2016.

Let’s start with Medicare reimbursement: the update factor for 2017 is a mandated 0.5% increase; however, the net reduction in expenditures resulting from proposed adjustments to mid-valued codes is a negative 0.51%. Combined with some reductions to imaging services, the conversion factor for 2017 drops from 35.8043 to 35.7551, for a very slight (0.1%) decrease. As specialties go, family medicine is projected to see the highest gain (+3%) while interventional radiology takes the most significant hit at -7%. Pathology and vascular surgery are also on the chopping block, but using much duller blades, each with a projected 2% overall decrease. Please see the full chart by specialty on our website.

CMS continues to expand its long list of covered telehealth services, proposing to pay for end-stage renal disease (ESRD) related services, advance care planning and new critical care consultation codes (GTTT1 and GTTT2). CMS also announced its intention to establish a new place of service (POS) code for telehealth services performed at the “receiving” site.

CMS is targeting zero-day global services that are commonly billed with an evaluation and management (E/M) service appended with modifier 25. Nineteen percent of the codes with a 0-day global service were billed over 50% of the time with an E/M and modifier 25. Many of the 83 cited codes under review are dermatologic services, but simple pulmonary, otolaryngology, and orthopedic procedures are also on the list.

Also under scrutiny are home dialysis services and global surgical packages, which the government has committed to review to “improve the accuracy of valuation of surgical services.” This impacts the 4,200 codes with a 10- or 90-day global period; the analysis to re-value all of the codes will be complete by January 1, 2019. The government is asking for your help: eight new G codes were established to measure pre- and post-operative care, as well as non-face-to-face services. The government has proposed the use of these codes starting on January 1, 2017, asking you to submit the codes on claims, but for informational purposes only. However, CMS is seeking feedback about the potential burden of this approach to data collection, as well as its proposed potential 5% withhold for surgeons who choose not to participate. (There are also plans underway to take a deep dive via an intense analysis using a cohort of 5,000 selected surgeons.)

The G codes don’t stop there. In 2017, CMS is proposing a series of new care management codes, including assessment and care planning for patients with cognitive impairment (GPPP6) and behavioral health integration in the primary care setting (psychiatric collaborative care model, GPPP1, 2 and 3; and general behavioral health integration, GPPPX).

Two more G codes may pique your interest: GPPP7, comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, which is an add-on code meant to give you a boost in pay when you address chronic issues; and GDDD1, another add-on code, but this time for patients using mobility-assistive technology.

Chronic care management (CCM) - 99490 - the code you can bill for 20+ minutes per month has been underutilized, according to
the government. Responding to complaints, CMS is easing the requirements for the initiating visit, 24/7 access to the care plan, format and sharing of the care plan and clinical summaries, patient consent and documentation. Please see the complete proposal summary on our website.

The government has also proposed to cover two new codes, 99487 and 99489, for complex CCM. These two new CCM codes, as well as GPPP1, 2, and 3, will require only general supervision by the physician or advanced practice provider. Furthermore, rural health clinics (RHCs) and federally qualified health centers (FQHCs) were also lifted from the burden of direct supervision, the new requirement is only for general supervision.

Prolonged care codes for time caring for a patient outside of the in-person office visit - 99358 and 99359 - have existed for a number of years, but have never been paid. That is proposed to change in 2017, with CMS paying for the codes when rendered to Medicare patients.

The government is proposing an expansion of opportunities to be paid for diabetes self-management training (DSMT), G0108 and G0109, and has introduced the framework for an entirely new initiative - the Medicare Diabetes Prevention Program (MDPP).

Effective for services furnished beginning January 1, 2017, federal law reduces the payment amount by 20% for the technical component (TC) (including the TC portion of a global service) of imaging services that are X-rays taken using film. CMS proposes to require a modifier --XX - on claims for the technical component of the X-ray service, including when the service is billed globally.

Participants in an accountable care organization (ACO) have not had to submit data for the Physician Quality Reporting System (PQRS), but occasionally that proves disadvantageous, for example, in the event of poor ACO management. Therefore, CMS is proposing to allow eligible professionals (EPs) who bill under the tax identification number (TIN) of an ACO participant to have the option of reporting separately as individual EPs or group practices for PQRS, as of 2016. These groups are proposed to be exempt from the group reporting registration process for this calendar year, since the deadline was June 30. The informal review for penalties based on failure to successfully report for PQRS is also eased for affected physicians.

After a series of hiccups, the informal review process is being streamlined for the Value-based Payment Modifier (VBPM). CMS proposes to update the informal review policies and establish a protocol for how the quality and cost composites under the VBPM would be affected if unanticipated issues arise (e.g., CMS made an error in calculation or a mistake is made by a third-party such as a vendor).

Under separate rulemaking that was also issued in July, the government is proposing a 90-day reporting period in 2016 for all EPs attesting to Meaningful Use in the Electronic Health Record (EHR) Incentive Program. The reporting period would be any continuous 90-day period between January 1, 2016, and December 31, 2016.

CMS has proposed to make these changes effective January 1, 2017. In the meantime, the agency is seeking comment about its recommendations. These will be confirmed in the late fall. We will outline the final 2017 Medicare payment rules in the December issue.