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## Important Changes for Physicians from the 2016 Medicare Physician Fee Schedule: Part II (Non-Stark Changes)

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### In this Series:

[Important Changes for Physicians from the 2016 Medicare Physician Fee Schedule Part I \(Stark Changes\)](#)

**O**n November 16, 2015 the Centers for Medicare and Medicaid Services (CMS) published the final Medicare Physician Fee Schedule (Final MPFS).<sup>1</sup> The Final MPFS addresses changes to the physician fee schedule and related policies, reflecting the continued shift away from fee-for-service to a value-based reimbursement system. Except for the changes to the Stark definition of “ownership or investment interest,” which goes into effect January 1, 2017, the provisions in the Final MPFS are effective January 1, 2016. Comments will be accepted on the Final MPFS through December 29, 2015. Summarized below are select highlights that address the non-Stark law changes in the Final MPFS.

#### **1. Medicare Telehealth Services.**

In the Final MPFS, CMS added the following services to the list of CPT codes approved for reimbursement as telehealth services, subject to specific conditions: prolonged service inpatient CPT codes 99356 and 99357 and end-stage renal disease services 90963-90966. Despite commenters' proposals to include certain critical care and medication management services, CMS did not approve these new telehealth services.<sup>2</sup> CMS also finalized its proposal to include certified registered nurse anesthetists (CRNAs) to the list of practitioners authorized to furnish services via telehealth. Finally, CMS increased slightly the reimbursement amount for a telehealth-related originating site facility fee (Q3014) to \$25.10.

#### **2. “Incident to” Services.**

CMS finalized two key changes to the “incident to” billing rules that will impact physicians and other practitioners. First, in response to numerous

<sup>1</sup> 80 Fed. Reg. 70886 (November 16, 2015).

<sup>2</sup> The deadline for submission of new service approval requests for the CY 2017 Physician Fee Schedule is December 31, 2015.



comments, CMS finalized a new requirement that the billing practitioner and the supervising practitioner (not the ordering physician) be the same individual. Second, CMS finalized its proposed prohibition against practitioners utilizing “auxiliary personnel,” who are excluded from federally funded health care programs. Finally, CMS solicited comments from the provider community regarding its future enforcement of “incident to” rules and regulations.

### **3. Physician Compare Website.**

The Final MPFS included the following key changes related to the Physician Compare Website:

- Decision not to include a value modifier attributed to individuals and group practices
- Inclusion of an indicator for individuals who satisfactorily report the new Cardiovascular Prevention measures group
- Continued inclusion of all PQRs group practice level and ACO Shared Savings Program measures available for public reporting annually, including making the 2016 PQRs group practice and ACO data available for public reporting on Physician Compare in late 2017
- Expansion of qualified clinical data registry (QCDR) reporting to group practices
- Public reporting of items, measure-level, and benchmarks derived using the ABC™ methodology annually based on the PQRs performance rates most recently available stratified by reporting mechanism for both group practice and individual Eligible Professionals (EP) level measures
- In addition to the specialties reported by the American Board of Medical Specialties, inclusion of indicators for specialties represented by the American Board of Optometry and American Osteopathic Association

### **4. Physician Quality Reporting System.**

The Final MPFS focuses on matters relating to the 2018 PQRs payment adjustment, which will be based on an EP’s or a group practice’s reporting of quality measures data during the 12-month calendar year reporting period occurring in 2016. CMS clarified that EPs in CAH-IIs reimbursed by Medicare may now participate in the PQRs and neither EPs who practice in Rural Health Clinics and/or Federally Qualified Health Clinics nor EPs who perform services for an Independent Diagnostic Testing Facility or Labs will not be subject to the PQRs payment adjustment. CMS also clarified what must be reported, establishing 12 categories of reporting information for group practices that have registered to participate in the PQRs GPRO. CMS clarified that certain specialties, including diagnostic radiology, pathology, anesthesiology, and podiatry, and hospitals are excluded from selection as focal provider. Beginning in 2016, a Qualified Clinical Data Registry (QCDR) must provide substantial information to CMS to ensure that QCDR data is valid, and PQRs participants and their vendors will be subject CMS audit.

### **5. EHR Incentive Reporting.**

In association with meaningful use incentive payments for the adoption and use of certified EHR technology, the Secretary for DHHS selects CQMs for EPs to report in order to receive incentive payments. If done electronically, this reporting is conducted using Certified Electronic Health Record Technology (CEHRT), and EPs who use CEHRT are required to test and certify to the most recent version to ensure that the data successfully transmits. The Final MPFS revises the definition of CEHRT to require certification be, at a minimum, compliant with the Quality Reporting Document Architecture (QRDA) Category I and Category III standards





created by the Office of the National Coordinator for Health Information Technology (ONC).

Additionally, under the Comprehensive Primary Care (CPC) initiative, CMS pays participating primary care practices a care management fee to support enhanced, coordinated services, and CPC practice sites are required to report to CMS a subset of the CQMs that were selected in the EHR Incentive Program. For a practice site that has demonstrated meaningful use for more than one year, CMS has expanded the requirements of one of the reporting options for practice sites participating in meaningful use for more than a year to require that the practice site to successfully report at least nine electronically specified CQMs across three domains for the relevant reporting period, starting in 2016. In addition, CMS will allow practice sites in their first year of participation to use this reporting method, although they have to submit a longer reporting period (one year rather than 90 days).

#### **6. Medicare Shared Savings Program.**

The Final Rule makes changes to the quality measures and performance standards and provisions of the program regarding assignment of beneficiaries to an Accountable Care Organization (ACO). For quality measures and performance standards, the Final Rule adds a new pay-for-reporting measure called “Statin Therapy for the Prevention and Treatment of Cardiovascular Disease” to the Preventive Health domain; adds a right to maintain a measure as pay for reporting, or revert a pay-for-performance measure to pay for reporting, if a measure owner determines the measure no longer meets best clinical practices due to clinical guideline updates or clinical evidence suggests that continued application of the measure may result in harm to patients; requests comments to several questions related to its quality measure for PCPs who successfully meet meaningful use requirements, focusing on whether the measure could be expanded and updated to reward providers who have achieved higher levels of health IT adoption; and modifies PQRS language to treat “ACO providers” the same as any other physician group electing to report via PQRS. Additionally, CMS implemented two revisions to the list of codes that constitute primary care services under the Shared Savings Program related to: (i) assignment of beneficiaries

based on certain evaluation and management services in skilled nursing facilities (SNFs); and (ii) assignment of beneficiaries to ACOs that include Electing Teaching Assistant (ETA) hospitals.

#### **7. Value-Based Payment Modifier and Physician Feedback Program.**

Under the value-based payment modifier (VM) program and Physician Feedback Program, payments for items and services reimbursed under the MPFS are subject to positive, negative, or neutral payment adjustments based on the quality of care provided compared to the cost of care during an applicable performance period. The VM will expire at the end of CY 2018 at which time, it will be replaced by the Merit-Based Incentive Payment System (MIPS). The Final MPFS includes the following changes for the VM program’s CY 2017 payment adjustment period including revising the criteria for groups to avoid the PQRS payment adjustment for CY 2017 to provide an additional opportunity for quality data reported by individuals EPs in the group to be taken into account; increase the minimum number of episodes required for inclusion for the Medicare Spending Per Beneficiary (MSPB) measure; applying the quality composite score of an ACO that has the highest numerical quality composite score where a TIN is participating in multiple Shared Savings Program ACOs; waiving application of the VM for physicians in groups with two or more eligible EPs and physicians who are solo practitioners participating in the Pioneer ACO Model, CPC Initiative, and other similar Innovation Center models; and applying an additional upward payment adjustment to Shared Savings Program ACO participant TINs that are classified as “high quality” under the quality-tiering methodology upon achievement of certain beneficiary risk scores. The Final MPFS also sets



certain standards beginning in the CY 2018 payment adjustment period outlined in detail throughout the Final Rule including, for example, applying the VM to nonphysician EPs

such as physician assistants, nurse practitioners, clinical nurse specialist, and certified registered nurse anesthetists who are solo practitioners or are in groups 2 or more EPs.<sup>3</sup> ■



### For More Information

For more information regarding this alert, please contact one of the authors, a member of the Polsinelli's Health Care practice, or your Polsinelli attorney.

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<sup>3</sup> 80 Fed. Reg. at 71273-71300.





## About Polsinelli's Health Care Practice

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The Polsinelli Health Care practice represents one of the largest concentrations of health care attorneys and professionals in the nation. From the strength of its national platform, the firm advises clients on the full range of hospital-physician lifecycle and business issues confronting health care providers across the United States.

Recognized as a leader in health care law, Polsinelli is ranked as "Law Firm of the Year" in Health Care by *U.S. News & World Report* (November 2014), no. 1 by *Modern Healthcare* (June 2015) and nationally ranked by *Chambers USA* (May 2015). Polsinelli's attorneys work as a fully integrated practice to seamlessly partner with clients on the full gamut of issues. The firm's diverse mix of attorneys enables our team to provide counsel that aligns legal strategies with our clients' unique business objectives.

One of the fastest-growing health care practices in the nation, Polsinelli has established a team that includes former in-house counsel of national health care institutions, the Office of Inspector General (OIG), and former Assistant U.S. Attorneys with direct experience in health care fraud investigations. Our group also includes current and former leaders in organizations such as the American Hospital Association. Our strong Washington, D.C., presence allows us to keep the pulse of health care policy and regulatory matters. The team's vast experience in the business and delivery of health care allows our firm to provide clients a broad spectrum of health care law services.

## About Polsinelli

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Polsinelli is an Am Law 100 firm with more than 750 attorneys in 17 offices, serving corporations, institutions, entrepreneurs and individuals nationally. Ranked in the top five percent of law firms for client service\*, the firm has risen more than 100 spots in Am Law's annual firm ranking over the past six years. Polsinelli attorneys provide practical legal counsel infused with business insight, and focus on health care and life sciences, financial services, real estate, technology and biotech, mid-market corporate, and business litigation. Polsinelli attorneys have depth of experience in 100 service areas and 70 industries. The firm can be found online at [www.polsinelli.com](http://www.polsinelli.com). Polsinelli PC. In California, Polsinelli LLP.

\* 2016 BTI Client Service A-Team Report

## About this Publication

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