| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 2653** | **Date: February 6, 2013** |
| | **Change Request 8191** |

**Transmittal 2631, dated January 9, 2013, is being rescinded and replaced by Transmittal 2653, dated February 6, 2013, to change the implementation date to January 25, 2013, as previously instructed by CMS. All other information remains the same.**

**SUBJECT: Summary of Policies in the CY 2013 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 2013 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. The attached Recurring Update Notification applies to Pub. 100-04, chapter 12, section 190.6 and Pub. 100-02, chapter 15, section 270.5.

**EFFECTIVE DATE: January 1, 2013**
**IMPLEMENTATION DATE: January 25, 2013 (Contractors shall implement this change request no later than January 25, 2013, as previously instructed by CMS.)**

***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

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

**III. FUNDING:**
**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

**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: 2653 | Date: February 6, 2013 | Change Request: 8191 |
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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 2013 Medicare Physician Fee Schedule (MPFS). Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish 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 1, 2012, 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 2013.

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 and Other Revisions to Part B for CY 2013," (displayed July 6, 2012, and published in the Federal Register on July 30, 2012). 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 on November 16, 2012). The final rule assigns interim final values for new and revised codes for CY 2013 and requests comments on these values. CMS accepted comments on those items open to comment in the final rule with comment period until December 31, 2012. The CY 2013 MPFS final rule does not reflect subsequent revisions to the MPFS created by the American Taxpayer Relief Act of 2012 passed on January 1, 2103.

**B. Policy:** Payments to Primary Care Physicians increase in 2013. The Medicare final rule for the physician fee schedule for 2013 includes a new policy to pay a patient's physician or practitioner, to coordinate the patient's care in the 30 days following a hospital or skilled nursing facility stay. Recognizing the work of community physicians and practitioners in treating a patient following discharge from a hospital or nursing facility will ensure better continuity of care for these patients and help reduce patient readmissions. The changes in care coordination payment and other changes in the rule are expected to increase payment to family practitioners by 7 percent and other primary care practitioners between 3 and 5 percent.

In addition, the final rule with comment period continues the careful implementation of the physician value-based payment modifier by phasing in application of the modifier and enabling physicians in larger groups to choose how to participate. The value modifier provides differential Medicare payments to physicians based on comparison of the quality of care furnished to beneficiaries and the cost of care. The statute allows CMS to phase in the value modifier over 3 years from 2015 to 2017. For 2015, the final rule applies the value modifier to groups of physicians with 100 or more eligible professionals, a change from the proposed rule, which would have set the group size at 25 or above. This change was adopted to gain experience with the methodology and

approach before expanding to smaller groups. The final rule also provides an option for these groups of physicians to choose how the value modifier is calculated based on whether they participate in the Physician Quality Reporting System (PQRS). For physicians and groups of physicians who elect to participate in 2015, common sense incentives will improve the care that beneficiaries receive; physicians with higher quality and lower costs will be paid more, and those with lower quality and higher costs will be paid less. The performance period for the application of the value modifier in CY 2015 was previously established as CY 2013 in the CY 2012 MPFS final rule.

The final rule continues efforts by CMS to align quality reporting across programs to reduce burden and complexity. The rule makes changes to the PQRS and the Electronic Prescribing (eRx) Incentive Program, the two quality reporting programs applicable to the MPFS, and updates the Medicare Electronic Health Records (EHR) Incentive Pilot Program. These changes will simplify reporting and align the various programs' quality reporting approaches so they support the National Quality Strategy. The final rule also lays out next steps to enhance the Physician Compare website, including posting names of practitioners who, as part of the Million Hearts campaign, successfully report measures to prevent heart disease. These are recommended measures under PQRS as well.

Among other changes, the final rule also expands access to services that can be provided by NPPs. The rule allows certified registered nurse anesthetists (CRNAs) to be paid by Medicare for providing all services that they are permitted to furnish under state law. This change will allow Medicare to pay CRNAs for services to the full extent of their state scope of practice. The rule also allows Medicare to pay for portable x-rays ordered by nurse practitioners, physician assistants and other NPPs. The CY 2013 Final Rule explains how Medicare will pay for molecular pathology services—the next innovation of clinical laboratory tests that will foster the development of personalized medicine. These tests will be paid under the Clinical Laboratory Fee Schedule with 2013 payment set by the gap filling method. The final rule also requires a face-to-face encounter as a condition of payment for certain durable medical equipment items for orders written on or after July 1, 2013.

Section 3005(g) of Middle Class Tax Relief and Jobs Creation Act requires CMS to implement a claims-based data collection strategy on January 1, 2013, to gather information on beneficiary function and condition, therapy services furnished, and outcomes achieved. This information will be used in assisting CMS in reforming the Medicare payment system for outpatient therapy services.

Also for CY 2013, a Multiple Procedure Payment Reduction will apply a 25 percent reduction to the Technical Component (TC) of the second and subsequent diagnostic cardiovascular service, and a 20 percent reduction to the TC of the second and subsequent diagnostic ophthalmology service, furnished by the same physician (or physicians in the same group practice) to the same beneficiary, on the same day.

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 Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for 2013 is 0.8 percent. Therefore, for CY 2013, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $24.43. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance). More information on CY 2013 changes in telehealth can be found in CR 7900.

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement.*

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| 8191.1 | Effective for dates of service January 1, 2013 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 $24.43, as described by HCPCS code Q3014 “Telehealth facility fee.” | X | X | | X | X | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Other |
| | | Part A | Part B | | | | | |
| 8191.2 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 | X | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**
*Use "Should" to denote a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| | |

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** Christina Ritter, 410-786-4636 or Christina.Ritter@cms.hhs.gov, Larry Chan, 410-786-6864 or Larry.Chan@CMS.hhs.gov

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

## VI. FUNDING

**Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:**
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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