OVERVIEW:

- The Centers for Medicare and Medicaid Services (CMS) released the proposed 2014 Medicare Physician Fee Schedule in July.
- Final code values will appear in the final 2014 Medicare Physician Fee Schedule in November.
- Based on the programmatic changes that CMS is proposing on practice expense calculations, it is estimated that dermatology as a specialty will see a 2 percent cut in payments.
- Most dermatology codes will likely see an increase or decrease in payment of 3 percent or less.
- In general, all Practice Expense (PE) Relative Value Unit (RVUs) values are estimated to decrease by 5 percent or more.
- If Congress does not repeal the flawed sustainable growth rate formula (SGR), the projected conversion factor (CF) will decrease from 34.0230 in 2013, to an estimated 26.8199 in 2014 — resulting in a decrease in total physician payments of 24.4 percent.
- If Congress repeals the flawed SGR formula, the projected conversion factor (CF) will be increased from 34.0230 in 2013, to an estimated 35.6653 in 2014 — an increase of about 4.8 percent. This would result in no change in total payments to physicians, since PE is being reduced.

CODING AND REIMBURSEMENT:

- **Pathology**
  - CMS identified more than 200 codes for which the total payment when furnished in an office or other nonfacility setting would exceed the total Medicare payment when the service is furnished in a facility — either a hospital outpatient department or an ambulatory surgery center.
  - **Effect on dermatology:** Negative
  - **Explanation:** This policy could significantly reduce the technical component of pathology services, including common dermatopathology codes.

- **Potentially Misvalued Codes**
  - The proposed rule includes a list of codes identified by Medicare contractor medical directors as potentially misvalued.
  - CMS identified more than 200 codes for which the total payment when furnished in an office or other nonfacility setting would exceed the total Medicare payment when the service is furnished in a facility — either a hospital outpatient department or an ambulatory surgery center.
  - Using this screen to identify potentially misvalued codes, CMS is also proposing to cut:
    - 17311, Mohs micrographic technique, first stage, -7.64%
    - 96910, Photochemotherapy with uv-b, -48.52%
    - 96912, Photochemotherapy with uv-a, -59.82%
  - CMS identified exceptions to the misvalued codes for those with a volume of 5 percent or less in the facility setting
  - **Effect on dermatology:** Negative
  - **Explanation:** The overall impact of these changes for all of dermatology is 0 percent, although there is potential for serious negative consequences to practices with high volumes of the affected codes.
AADA Response: The AADA expressed concern that CMS used contractor medical directors — the majority of whom are not involved in the American Medical Association Specialty Society Relative Value Update Committee process — to identify several codes as potentially misvalued (Mohs Micrographic surgery 17311, 17313). The AADA also opposed CMS’s proposal to use fees from ambulatory surgery centers or hospital outpatient prospective payment systems to value physician services — reducing fees for first stage Mohs micrographic technique (17311), Photochemotherapy with UV-B (96910), and Photochemotherapy with UV-A (96912).

PROGRAMMATIC PROPOSALS:

➢ TELEHEALTH SERVICES

• CMS proposes to change several components of the telehealth services for rural Health Professional Shortage Areas (HPSAs) by:
  o Redefining HPSAs as those located in rural census tracts as determined by the U.S. Department of Health and Human Services Office for Human Research Protections;
  o Including geographic areas located in rural census tracts within Metropolitan Statistical Areas;
  o Establishing/maintaining geographic eligibility on an annual basis; and,
  o Adding transitional care management services (CPT codes 99494 and 99496) to the list of Category 1 telehealth services (i.e. professional consultations, office visits and office psychiatry services).

Effect on dermatology: Positive
Explanation: These policy changes would expand health care services and access to health care services for Medicare beneficiaries located in rural areas.

➢ PHYSICIAN QUALITY REPORTING SYSTEM

• CMS proposed updates to the Physician Quality Reporting System (PQRS) - raising the number of measures that providers must report to earn a 2014 incentive from three to nine, but lowered the reporting threshold from 80 percent to 50 percent.

Effect on dermatology: Negative and positive
Explanation: The jump from the 2013 requirement to report on at least three measures to reporting nine measures in 2014 does not reflect the pace of measure development for the majority of specialties. Particular to dermatology, there are too few applicable measures to allow physicians to successfully participate in PQRS with the proposed increase in reporting requirements. However, lowering the reporting threshold from 80 to 50 percent reduces the physician administrative burden.

AADA Response: The AADA opposed the proposed changes to the Physician Quality Reporting System (PQRS) that would raise the number of measures that providers must report on to both earn the 2014 incentive and avoid the 2016 penalty. The AADA supports decreasing the reporting threshold from 80 to 50 percent as it reduces the physician administrative burden.

• CMS also proposed the addition of two dermatology-related measures, including one for atopic dermatitis and another for psoriasis, bringing the total number of dermatology-related measures to six for the 2014 reporting year.

  o The atopic dermatitis measure, “Atopic Dermatitis: Overuse: Role of Antihistamine,” would gather data on the “percentage of patients aged 25 years or younger seen at one or more visits
within a 12-month period with a diagnosis of atopic dermatitis, who did not have a diagnosis of allergic rhinitis or urticaria, who were prescribed oral non-sedating antihistamines.”

- The psoriasis measure, “Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier,” would evaluate “whether providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient’s history to determine if they have had appropriate management for a recent or prior positive test.”

**Effect on dermatology: Positive**
**Explanation:** These measures provide additional evidence-based standards against which physicians can assess themselves, as well as financial incentives to physicians who report their use of measures.

- **Value-Based Payment Modifier (VBPM)**
  - The proposed rule would more than double the number of physicians who are subject to the VBPM and would also increase penalties under the program from a maximum of 1 percent to a maximum of 2 percent.
  - **Effect on dermatology: Negative**
  - **Explanation:** The proposed rule would more than double the number of physicians who are subject to the VBPM and would also increase penalties under the program.
  - **AADA Response:** The AADA urged CMS to reconsider its planned implementation of the physician VBPM that would apply the 2016 modifier to groups of 10 or more eligible professionals (EPs) and require large groups to assume risk through the quality-tiering component of the program. The AADA expressed concern about the doubling of the potential penalty, as the increase comes before anything is known about the first year of the VBPM’s implementation. The AADA is concerned that CMS is basing adjustments in any given year on a “performance year” two years earlier, which means that any requirements attached to the 2016 payment adjustment essentially take effect in 2014. Therefore, the AADA advocated that CMS eliminate the two-year lag between performance and adjustment years. Also, the AADA opposed CMS’ proposal to use cost/resource measures, evaluations which are notoriously complex and difficult to assess, that have not been approved by the NQF.

- **INCIDENT TO SERVICES**
  - CMS proposes to amend the "incident to" regulations to require that services and supplies be furnished in accordance with applicable state law, and that the individual performing "incident to" services meet any applicable requirements to provide the services, including state licensure requirements.
  - **Effect on dermatology: Neutral**
  - **Explanation:** Ensures that providers must be working within state scope of practice laws to get Medicare reimbursement.
  - **AADA Response:** The AADA believes that states are best able to determine scope of practice for health care providers.

- **COMPLEX CHRONIC CARE MANAGEMENT SERVICES**
  - CMS is proposing to expand its coverage of care coordination services and establish a separate payment under the Physician Fee Schedule for complex chronic care management services. Complex chronic care management services would be furnished to patients with multiple complex, life-threatening, chronic conditions for at least 12 months or until the death of the patient. CMS would create two separate alphanumeric G-codes: 1. Initial services/90 days 2. Subsequent services/90 days.
  - This would require:
Access to address patient’s chronic care needs 24 hours, seven days a week, continuity of care with a designated practitioner, coordination with home/community-based clinical service providers.

- Use of certified electronic health records for care, employment of advanced practice registered nurses/physicians assistants with written job descriptions.
- Informed consent from the beneficiary

**Effect on dermatology:** Positive

**Explanation:** This would advance payment for non face-to-face care; while most physicians billing these codes will be primary care physicians, specialties are not precluded from billing as long as requirements met.

**AADA Response:** The AADA commended CMS for recognizing the physician work and resource costs involved in providing non face-to-face services, which are not adequately captured in the current Evaluation and Management (E/M) codes.

**Coverage of Investigational Device Exemption Clinical Studies**

- CMS proposes the establishment of 13 standards for Category A and Category B investigational device studies to ensure that the device studies conform to appropriate scientific and ethical standards.
- CMS would determine whether or not the device meets those standards in order for the costs of routine care items and services to be covered.

**Effect on dermatology:** Potentially negative

**Explanation:** Some aspects of the proposal will make the process more burdensome and limit Medicare beneficiary access to innovative therapies. Medicare beneficiaries, who choose to participate in IDE trials approved by the FDA, may be at risk for non-coverage of “routine care items and services.”

**Clinical Laboratory Fee Schedule**

- CMS proposed a new methodology for reviewing laboratory tests paid under the Clinical Laboratory Fee Schedule (CLFS) to determine whether payments should be adjusted as a result of efficiencies gained through technological advances.
- Technological changes are defined as changes to the tools, machines, supplies, labor, instruments, skills, techniques, and devices by which laboratory tests are produced and used.

**Effect on dermatology:** Neutral for now

**Explanation:** There is concern that technology reviews will expand to other areas/fee schedules.

**Liability for Overpayments**

- CMS proposes revising regulations to change the timing of the triggering event for the “without fault” and “against equity and good conscience” presumptions so:
  - The rebuttable "without fault" presumption for the provider would apply if the Medicare claims based fee-for-service overpayment determination is made subsequent to the fifth year (instead of the third year) following the year in which the notice was sent to the individual that such amount has been paid.
  - The timeframe for the presumption "against equity and good conscience" for certain types of denials for an individual who is "without fault" would apply if the overpayment determination is made subsequent to the fifth year (instead of the third year) following the year in which the notice of payment was sent to the individual.

**Effect on dermatology:** Negative
Explanation: The AADA opposes provisions of the proposed rule which implement changes enacted by the American Taxpayer Relief Act of 2012 that give Medicare more time to recover overpayments. This provision extends the three-year time limit to five years. Previously, the law allowed a three-year look-back period. CMS retains its authority to reopen claims at any time in cases of fraud, whether this look-back period is set at three or five years. Providers, however, face significant administrative burdens by the extension of the look-back period.

AADA Response: The AADA strongly opposed any extension of the look-back period and urges CMS to align this look-back period with other program integrity look-backs of three years.

- PHYSICIAN COMPARE WEBSITE
  - For calendar year 2014, CMS proposed to:
    - Expand quality measures posted on the Physician Compare website by publicly reporting performance on all measures collected through the GPRO web interface for groups participating in 2014 under the PQRS GPRO, and for ACOs participating in the Medicare Shared Savings Program.
    - Include measure performance rates for measures reported that met the minimum sample size of 20 patients and that prove to be statistically valid and reliable.
    - Provide a 30-day preview period prior to publication of quality data so group practices and ACOs can view their data prior to the public.
    - Publicly report comparable data collected for CY 2014 PQRS via claims EHR or registry from individual eligible professionals as early as CY 2015.
    - Additionally, seek comment on publicly reporting participation by individual eligible healthcare professionals on initiatives such as Choosing Wisely an initiative of the American board of internal medicine foundation.

Effect on dermatology: Mixed

Explanation: The AADA asked for a longer preview period than the proposed 30 days. The AADA is concerned that CMS will not fund the surveys required under the CG-CAHPS proposal. The AADA also does not believe that publicly reporting on participation in Choosing Wisely is appropriate, and that reporting should be based on measures that are within the physician’s control.

For more information, contact the American Academy of Dermatology Association (AADA) Government Affairs Department at govtaffairs@aad.org.