Issue Brief

AMERICAN COLLEGE of NURSE-MIDWIVES
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Medicare's Final CY 2015 Physician Fee Schedule

Background
On November 13, 2014, the Centers for Medicare and Medicaid Services (CMS) published in the *Federal Register* the final CY 2015 Medicare Physician Fee Schedule. This document establishes reimbursement updates and policy changes applicable to Medicare physician services provided on or after January 1, 2015. CMS released three fact sheets related to this proposed rule, providing a basic overview of the rule, information on quality programs and information on the physician value based payment modifier. The discussion below covers items of specific interest to midwifery contained in the final rule.

On Overview of Medicare's Physician Payment Methodology
Medicare beneficiaries make up a very small part of any given midwife's patient population. However, Medicare's physician fee schedule is used as the basis for payment by most payers, including Medicaid programs. In addition, other payers will often mirror Medicare's coverage and reimbursement policies. For these reasons, midwives should familiarize themselves with the content of this annual regulation.

An excellent, precise summary of Medicare's physician payment methodology is available from the Medicare Payment Advisory Commission (MedPAC).

For each of the 7,000+ physician services covered by Medicare, "relative value units" (RVUs) are calculated for the "physician work," "practice expense" and "malpractice costs" involved in providing that service.

Physician work RVUs represent the relative amount of physician time, effort, skill and stress involved in a given service. Practice expense RVUs measure the cost of office space, supplies, equipment and administrative and clinical staff involved. Malpractice RVUs measure the cost of insurance premiums associated with the service.

As the term indicates, RVUs are mean to be "relative" to each other. For example, the physician work RVU for a mid-level office visit (CPT code 99213) is assigned a value of 0.97, while the physician work for a six vein coronary artery bypass graft (CPT code 33516) is assigned a physician work RVU of 49.76, meaning that it takes roughly 50 times as much work for the bypass graft as it does for the mid-level office visit.

Each of the RVUs is multiplied by a "Geographic Practice Cost Index" (GPCI) to adjust for regional variations in costs. The national average GPCI is set at 1.0. Higher cost areas have higher GPCIs and lower costs areas have lower GPCIs. For example, the San Francisco Practice Expense GPCI is 1.388 while the West Virginia Practice

Expense GPCI is 0.836, meaning that the practice expense portion of Medicare's payment would be just over 55 percent higher in San Francisco than in West Virginia.

For some time, Congress has imposed a floor for the physician work GPCI so that no area falls below the national average GPCI. This provision is currently set to expire after March 31, 2015, at which time, 51 of the 89 fee schedule localities will experience a reduction in their work GPCI, ranging from -0.001 to -0.087.

There are 89 different Medicare physician fee schedule localities, each with its own set of GPCIs. Most fee schedule localities cover an entire state, though in some states there are multiple localities. It is important to know which locality your commercial payers are using to calculate their rates. The GPCIs for each fee schedule locality are available in Addendum E of the fee schedule.

Once all of the RVUs are multiplied by their respective GPCI, they are totaled and then multiplied by the Conversion Factor (CF). The CF is a dollar figure that is updated each year.

To put it in mathematical terms, Medicare's physician payments are calculate thus:

[(Work RVU * Work GPCI) + (PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * CF = Payment

Payment Update

Ordinarily, CMS updates the CF every year, based on a complicated formula established in law. A key aspect of this formula is the establishment of spending targets and a comparison between actual spending and the target. If actual spending exceeds the target, then the formula calls for cuts the next year to recoup the spending that exceeds the target. The formula has an aggregating function, so that if there are several years running when excess spending occurs, then the following year is supposed to recoup all of the excess by imposing significant cuts. Congress has consistently applied patches to this situation, without revising the underlying formula. Thus, when their patch expires, the law requires a reversion to the underlying formula which calls for greater cuts than the prior year because of its aggregating function. That just makes the problem worse than it was and gives Congress even more motivation to stave off the cut.

For 2015, the CF has been set at $35.8015 for services occurring January 1, 2015, to March 31, 2015. This is a very slight reduction from the 2014 conversion factor of 35.8228. This relative flat payment shift is a result of current law that puts off an otherwise applicable reduction. However, for services occurring April 1, 2015 to December 31, 2015, current law requires a conversion factor of $28.2239, a reduction of 21.2%. The only question is whether the congressional "fix" will be for a short period of time or will be a longer-term solution.

Keep in mind that any contracts with commercial payers that base their payment rates on Medicare's fee schedule may be impacted, depending on how those contracts are worded.

Key Codes for Midwives

The table below provides the facility and non-facility RVUs and associated payments for several codes of interest to CNMs/CMs. Please keep in mind that this table shows national RVU and payment amounts. These amounts will be adjusted based on the geographic location where the care is rendered. To find geographically adjusted RVUs and payment amounts, you can visit CMS' Physician Fee Schedule Look Up Tool.

CPT/ HCPCS	Status[1]	Description	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Total Non-Facility RVUs	Total Facility RVUs	Conversion Factor Jan-March 2015	National Facility Payment Jan - March 2015	National Non-Facility Payment Jan - March 2015	Conversion Factor April - Dec 2015	National Facility Payment April - Dec 2015	National Non-Facility Payment April - Dec 2015
11981	A	Insert drug implant device	1.48	2.25	0.64	0.26	3.99	2.38	35.8015	$85.21	$142.85	28.2239	$67.17	$112.61
11982	A	Remove drug implant device	1.78	2.44	0.80	0.29	4.51	2.87	35.8015	$102.75	$161.46	28.2239	$81.00	$127.29
11983	A	Remove/insert drug implant	3.30	2.58	1.26	0.43	6.31	4.99	35.8015	$178.65	$225.91	28.2239	$140.84	$178.09
57420	A	Exam of vagina w/scope	1.60	1.49	0.77	0.25	3.34	2.62	35.8015	$93.80	$119.58	28.2239	$73.95	$94.27
57421	A	Exam/biopsy of vag w/scope	2.20	1.94	1.02	0.33	4.47	3.55	35.8015	$127.10	$160.03	28.2239	$100.19	$126.16
58100	A	Biopsy of uterus lining	1.53	1.37	0.77	0.20	3.10	2.50	35.8015	$89.50	$110.98	28.2239	$70.56	$87.49
58300	N	Insert intrauterine device	1.01	0.91	0.39	0.06	1.98	1.46	35.8015	$52.27	$70.89	28.2239	$41.21	$55.88
58301	A	Remove intrauterine device	1.27	1.26	0.50	0.16	2.69	1.93	35.8015	$69.10	$96.31	28.2239	$54.47	$75.92
59400	A	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	32.16	NA	20.27	7.92	NA	60.35	35.8015	$2,160.62	NA	28.2239	$1,703.31	NA
59409	A	Vaginal delivery only (with or without episiotomy and/or forceps)	14.37	NA	5.75	3.51	NA	23.63	35.8015	$845.99	NA	28.2239	$666.93	NA
59410	A	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	18.01	NA	7.70	4.42	NA	30.13	35.8015	$1,078.70	NA	28.2239	$850.39	NA
59425	A	Antepartum care only; 4-6 visits	6.31	5.26	2.50	1.52	13.09	10.33	35.8015	$369.83	$468.64	28.2239	$291.55	$369.45
59426	A	Antepartum care only; 7 or more visits	11.16	9.65	4.44	2.63	23.44	18.23	35.8015	$652.66	$839.19	28.2239	$514.52	$661.57
59430	A	Postpartum care only (separate procedure)	2.47	2.26	0.98	0.59	5.32	4.04	35.8015	$144.64	$190.46	28.2239	$114.02	$150.15
59610	A	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery.	33.87	NA	20.75	8.61	NA	63.23	35.8015	$2,263.73	NA	28.2239	$1,784.60	NA
59612	A	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)	16.09	NA	6.33	4.10	NA	26.52	35.8015	$949.46	NA	28.2239	$748.50	NA
59614	A	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	19.73	NA	8.22	5.01	NA	32.96	35.8015	$1,180.02	NA	28.2239	$930.26	NA
99201	A	Office/outpatient visit new	0.48	0.70	0.23	0.04	1.22	0.75	35.8015	$26.85	$43.68	28.2239	$21.17	$34.43
99202	A	Office/outpatient visit new	0.93	1.09	0.41	0.07	2.09	1.41	35.8015	$50.48	$74.83	28.2239	$39.80	$58.99

CPT/ HCPCS	Status[1]	Description	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Total Non-Facility RVUs	Total Facility RVUs	Conversion Factor Jan-March 2015	National Facility Payment Jan - March 2015	National Non-Facility Payment Jan - March 2015	Conversion Factor April - Dec 2015	National Facility Payment April - Dec 2015	National Non-Facility Payment April - Dec 2015
99203	A	Office/outpatient visit new	1.42	1.48	0.60	0.15	3.05	2.17	35.8015	$77.69	$109.19	28.2239	$61.25	$86.08
99204	A	Office/outpatient visit new	2.43	1.99	1.02	0.21	4.63	3.66	35.8015	$131.03	$165.76	28.2239	$103.30	$130.68
99205	A	Office/outpatient visit new	3.17	2.36	1.31	0.28	5.81	4.76	35.8015	$170.42	$208.01	28.2239	$134.35	$163.98
99211	A	Office/outpatient visit est	0.18	0.37	0.07	0.01	0.56	0.26	35.8015	$9.31	$20.05	28.2239	$7.34	$15.81
99212	A	Office/outpatient visit est	0.48	0.70	0.20	0.04	1.22	0.72	35.8015	$25.78	$43.68	28.2239	$20.32	$34.43
99213	A	Office/outpatient visit est	0.97	1.01	0.40	0.06	2.04	1.43	35.8015	$51.20	$73.04	28.2239	$40.36	$57.58
99214	A	Office/outpatient visit est	1.50	1.42	0.61	0.09	3.01	2.20	35.8015	$78.76	$107.76	28.2239	$62.09	$84.95
99215	A	Office/outpatient visit est	2.11	1.81	0.87	0.16	4.08	3.14	35.8015	$112.42	$146.07	28.2239	$88.62	$115.15
99217	A	Observation care discharge	1.28	NA	0.68	0.08	NA	2.04	35.8015	$73.04	NA	28.2239	$57.58	NA
99218	A	Initial observation care	1.92	NA	0.75	0.16	NA	2.83	35.8015	$101.32	NA	28.2239	$79.87	NA
99219	A	Initial observation care	2.60	NA	1.04	0.19	NA	3.83	35.8015	$137.12	NA	28.2239	$108.10	NA
99220	A	Initial observation care	3.56	NA	1.43	0.24	NA	5.23	35.8015	$187.24	NA	28.2239	$147.61	NA
99234	A	Observ/hosp same date	2.56	NA	1.01	0.21	NA	3.78	35.8015	$135.33	NA	28.2239	$106.69	NA
99235	A	Observ/hosp same date	3.24	NA	1.30	0.23	NA	4.77	35.8015	$170.77	NA	28.2239	$134.63	NA
99236	A	Observ/hosp same date	4.20	NA	1.65	0.29	NA	6.14	35.8015	$219.82	NA	28.2239	$173.29	NA
99384	N	Prev visit new age 12-17	2.00	1.70	0.76	0.12	3.82	2.88	35.8015	$103.11	$136.76	28.2239	$81.28	$107.82
99385	N	Prev visit new age 18-39	1.92	1.66	0.73	0.12	3.70	2.77	35.8015	$99.17	$132.47	28.2239	$78.18	$104.43
99386	N	Prev visit new age 40-64	2.33	1.82	0.89	0.16	4.31	3.38	35.8015	$121.01	$154.30	28.2239	$95.40	$121.65
99387	N	Init pm e/m new pat 65+ yrs	2.50	2.00	0.96	0.17	4.67	3.63	35.8015	$129.96	$167.19	28.2239	$102.45	$131.81
99394	N	Prev visit est age 12-17	1.70	1.46	0.65	0.11	3.27	2.46	35.8015	$88.07	$117.07	28.2239	$69.43	$92.29
99395	N	Prev visit est age 18-39	1.75	1.48	0.67	0.11	3.34	2.53	35.8015	$90.58	$119.58	28.2239	$71.41	$94.27
99396	N	Prev visit est age 40-64	1.90	1.54	0.73	0.12	3.56	2.75	35.8015	$98.45	$127.45	28.2239	$77.62	$100.48
99397	N	Per pm reeval est pat 65+ yr	2.00	1.70	0.76	0.12	3.82	2.88	35.8015	$103.11	$136.76	28.2239	$81.28	$107.82

[1] Status - A = Active code. These codes are separately payable under the fee schedule. N = Non-covered service. These codes are non-covered services. Medicare payment is not made for these codes. RVUs shown are not used for Medicare payment.

Specific Policy Changes

Elimination of the Global Period for Certain Codes

In the final rule, CMS discusses problems associated with payments for 10-day and 90-day global codes. Specifically, the agency has received reports and data to the effect that follow up visits after surgeries, which are covered under a global period, are not occurring with the frequency accounted for under the payment made for those codes. Further, because of the way the methodology for determining payment works, the allowance for the post-operative visits under the global fee differs from the reimbursement for an equivalent evaluation and management visit offered outside the global period.

To address these two issues, CMS has finalized a policy under which the agency will eliminate the global period for codes that have a current 10-day or 90-day global period. By 2017, the 10-day codes will be revalued, based on a 0-day assumption. The 90-day global codes will be revalued as of 2018. Under the revaluation, the post-operative visits will be taken out of the global code and billed as separate evaluation and management visits.

None of the codes listed in the table above would be subject to this revision. This is because, as maternity codes, they are not subject to the global surgical policy. However, the importance of this step is that CMS recognizes that global billing sometimes obscures what is taking place in practice. They specifically noted the evolution of new payment methodologies that require a greater level of precision in the data used to determine who has done what. The policy may be a harbinger of future steps by the agency in this direction that could potentially impact codes billed by CNMs/CMs.

Incident-To Services Provided in a Federally Qualified Health Center or Rural Health Center

In a recent final rule, CMS removed a regulatory requirement that nurse practitioners (NPs), physician assistants (PAs), certified nurse-midwives (CNMs), clinical nurse specialists (CNSs) and clinical psychologists (CPs) furnishing services in a rural health center (RHC) must be employees of the RHC. RHCs are now allowed to contract with NPs, PAs, CNMs, CSWs, and CPs, as long as at least one NP or PA is employed by the RHC.

Services furnished in RHCs and federally qualified health centers (FQHCs) by nurses, medical assistants, and other auxiliary personnel are considered “incident to” a RHC or FQHC visit furnished by an RHC or FQHC practitioner. Current regulations state that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC. Since there is no separate benefit under Medicare law that specifically authorizes payment to nurses, medical assistants, and other auxiliary personnel for their professional services, they cannot bill the program directly and receive payment for their services, and can only be remunerated when furnishing services to Medicare patients in an “incident to” capacity.

To provide RHCs and FQHCs with as much flexibility as possible, CMS has finalized a proposal to remove the requirement that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC. This allows nurses, medical assistants, and other auxiliary personnel to furnish incident to services under contract in RHCs and FQHCs.

Physician Compare

For some years, CMS has been making public data related to Medicare providers, including CNMs (note that CMs are not yet recognized Medicare providers). These data are available through the agency's Physician Compare website. The site already offers a significant array of data on these providers. For 2015, CMS will include results of a broader array of measures than previously available, including those reported by groups as small as two providers. CMS will also report on measures collected under the Medicare Shared Savings program (the program for Accountable Care Organizations). Data related to consumer experience of care, as gathered through CAHPS surveys will be made available as well. Finally, CMS will make available on Physician Compare, 2015 Qualified Clinical Data Registry (QCDR) measure data, aggregated to the individual level or a higher level of the QCDR's choosing. Note that as of now, there are 2,264 CNMs whose data appears in the Physician Compare website.

Physician Quality Reporting System (PQRS)

CMS has, for several years, required providers under Medicare to report quality measures. Providers select a subset of measures on which to report from an extensive list of measures supplied by CMS and may report through a variety of mechanisms. For 2015, CMS proposed to remove two measures related to maternity care from the list of measures which providers might potentially report. The first was a measure of early elective delivery without medically indicated justification prior to 39 weeks of gestation. The second measure related to the percent of patients who were seen postpartum. The reason for the removal of these measures was that the entity that had stewardship over the measure was no longer going to keep it updated. However, CMS was able to identify a steward for the measures and as a result both will be retained in the PQRS for 2015.

Also of note, particularly for CNMs who see a significant number of Medicare beneficiaries, failure to participate in PQRS in 2015 will result in a reduction in 2017 Medicare reimbursement of 2 percent. To learn more about this program, visit CMS' site.

Physician Value Based Payment Modifier

A provision of the Affordable Care Act requires CMS to begin modifying Medicare payments to physicians based on the comparative quality and cost of the care they provide. The law allows the agency to extend this same value based payment modifier to other practitioners, including CNMs, as early as 2017.

In the proposed fee schedule, CMS indicated a plan to apply the value based modifier to all eligible professionals, including CNMs, as of 2017. However, in the final rule,

CMS opted to apply the modifier to CNMs (and other eligible professionals who are not physicians) as of 2018. In general, as of 2018, all aspects of the value based modifier program would apply to CNMs participating in Medicare as of that year. CNMs who treat Medicare beneficiaries should keep in mind that the performance period for the 2018 payment adjustment is 2016. CMS maintains a website dedicated to the value-based modifier, where extensive information about the program is available.

CMS had proposed to adjust payments for all providers impacted by the value-based modifier by up to 4.0 percent in 2017, however, in the final rule CMS indicated the adjustment in payments for solo practitioners and groups of up to 9 eligible professionals would not exceed 2.0 percent. Groups of 10 or more eligible professionals would be subject to an adjustment of up to 4.0 percent in 2017. The performance period, upon which the 2017 adjustment is based, is 2015. For CNMs, this limitation in the application of the modifier is something of a non-issue. Per the policy outlined in the previous paragraph, the payment adjustment would not apply to CNMs until 2018. However, CMS stated that when this modifier applies to CNMs (and other eligible practitioners) all other aspects of the policy would apply as well, meaning that in 2018, CNMs are likely to see adjustments to their payments that could range higher than 2.0 percent set for 2017. The reason for this is that CMS has statutory authority to increase the percent of payments subject to the modifier as they see fit. The agency has received comment that they should put at least 10 percent of payments at risk and their discussion in the preamble of this rule and others, as well as their aggressive implementation activity are indicative of a propensity to move in that direction.