Issue Brief

AMERICAN COLLEGE of NURSE-MIDWIVES
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Medicare's Proposed CY 2016 Physician Fee Schedule

Background

On July 15, 2015, the Centers for Medicare and Medicaid Services (CMS) published in the *Federal Register* the proposed CY 2016 Medicare Physician Fee Schedule (PFS). This document proposes changes to coverage and reimbursement policies and methodologies applicable to Medicare physician services provided on or after January 1, 2016. CMS published a press release and fact sheet in association with this proposed rule, providing a basic overview of key provisions. The discussion below covers items of specific interest to midwifery contained in the proposed rule.

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 commercial and Medicaid payers and many of them will also adopt Medicare coverage policies as well. For these reasons, midwives should familiarize themselves with the content of this annual regulation. For those who are unfamiliar with the basics of the fee schedule payment calculation, a concise summary is provided at the bottom of this document.

Payment Update

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 established payment update factors for calendar years 2015 through 2025. These factors may be adjusted slightly because of statutory requirements that other changes in reimbursement be executed on a budget-neutral fashion. For 2015, MACRA calls for a 0.5 percent increase in payments. CMS estimates that a budget neutrality adjustment of 0.9999 will be required, yielding a conversion factor of $36.1096. The existing 2015 conversion factor is $35.9335.

Key Codes for Midwives

The table below provides the facility and non-facility payment amounts in place at the end of 2015 and proposed for 2016 for codes commonly billed by midwives. Modifications to payments arise from changes in RVU values and the conversion factor. As can be seen from the data in the table, proposed changes are relatively small. These amounts are national payment amounts. Reimbursement will vary from these amounts based on the geographic area where the service is rendered. To find geographically adjusted RVUs and payment amounts, you can visit CMS' Physician Fee Schedule Look Up Tool.

CPT/ HCPCS	Description	Final 2015 Non-Facility National Payment	Proposed CY 2016 Non-Facility Total Payment	Difference Proposed 2016 and Final 2015 Non-Facility Payments	Final 2015 Facility National Payment	Proposed CY 2016 Facility Total Payment	Difference Proposed 2016 and Final 2015 Facility Payments
11981	Insert drug implant device	$143.37	$144.80	$1.42	$85.52	$86.30	$0.78
11982	Remove drug implant device	$162.06	$164.30	$2.24	$103.13	$104.00	$0.87
11983	Remove/insert drug implant	$226.74	$227.85	$1.11	$179.31	$179.83	$0.52
57420	Exam of vagina w/scope	$120.02	$120.97	$0.95	$94.15	$94.61	$0.46
57421	Exam/biopsy of vag w/scope	$160.62	$162.13	$1.51	$127.56	$128.55	$0.99
58100	Biopsy of uterus lining	$111.39	$111.58	$0.18	$89.83	$89.91	$0.08
58300	Insert intrauterine device	$71.15	$74.39	$3.24	$52.46	$55.61	$3.15
58301	Remove intrauterine device	$96.66	$96.77	$0.11	$69.35	$69.33	-$0.02
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	Facility Only	Facility Only	Facility Only	$2,168.59	$2,172.35	$3.77
59409	Vaginal delivery only (with or without episiotomy and/or forceps)	Facility Only	Facility Only	Facility Only	$849.11	$849.30	$0.19
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	Facility Only	Facility Only	Facility Only	$1,082.68	$1,083.29	$0.61
59425	Antepartum care only; 4-6 visits	$470.37	$470.87	$0.50	$371.19	$370.48	-$0.71
59426	Antepartum care only; 7 or more visits	$842.28	$843.52	$1.24	$655.07	$653.94	-$1.12
59430	Postpartum care only (separate procedure)	$191.17	$191.74	$0.58	$145.17	$145.16	-$0.01
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery.	Facility Only	Facility Only	Facility Only	$2,272.08	$2,285.74	$13.66
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)	Facility Only	Facility Only	Facility Only	$952.96	$958.35	$5.39
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	Facility Only	Facility Only	Facility Only	$1,184.37	$1,191.62	$7.25
99201	Office/outpatient visit new	$43.84	$44.78	$0.94	$26.95	$27.08	$0.13
99202	Office/outpatient visit new	$75.10	$76.55	$1.45	$50.67	$51.64	$0.97
99203	Office/outpatient visit new	$109.60	$110.13	$0.54	$77.98	$78.36	$0.38

CPT/ HCPCS	Description	Final 2015 Non-Facility National Payment	Proposed CY 2016 Non-Facility Total Payment	Difference Proposed 2016 and Final 2015 Non-Facility Payments	Final 2015 Facility National Payment	Proposed CY 2016 Facility Total Payment	Difference Proposed 2016 and Final 2015 Facility Payments
99211	Office/outpatient visit est	$20.12	$20.58	$0.46	$9.34	$9.39	$0.05
99212	Office/outpatient visit est	$43.84	$44.41	$0.58	$25.87	$25.64	-$0.23
99213	Office/outpatient visit est	$73.30	$74.02	$0.72	$51.38	$52.00	$0.61
99214	Office/outpatient visit est	$108.16	$109.05	$0.89	$79.05	$79.44	$0.39
99215	Office/outpatient visit est	$146.61	$147.33	$0.72	$112.83	$113.02	$0.19
99217	Observation care discharge	Facility Only	Facility Only	Facility Only	$73.30	$74.02	$0.72
99218	Initial observation care	Facility Only	Facility Only	Facility Only	$101.69	$101.47	-$0.22
99219	Initial observation care	Facility Only	Facility Only	Facility Only	$137.63	$137.58	-$0.05
99220	Initial observation care	Facility Only	Facility Only	Facility Only	$187.93	$188.49	$0.56
99234	Observ/hosp same date	Facility Only	Facility Only	Facility Only	$135.83	$136.13	$0.30
99235	Observ/hosp same date	Facility Only	Facility Only	Facility Only	$171.40	$171.52	$0.12
99236	Observ/hosp same date	Facility Only	Facility Only	Facility Only	$220.63	$220.99	$0.36
99384	Prev visit new age 12-17	$137.27	$137.94	$0.67	$103.49	$104.00	$0.51
99385	Prev visit new age 18-39	$132.95	$133.61	$0.65	$99.54	$99.66	$0.13
99386	Prev visit new age 40-64	$154.87	$155.27	$0.40	$121.46	$121.33	-$0.13
99387	Init pm e/m new pat 65+ yrs	$167.81	$168.27	$0.46	$130.44	$130.36	-$0.08
99394	Prev visit est age 12-17	$117.50	$117.72	$0.21	$88.40	$88.47	$0.07
99395	Prev visit est age 18-39	$120.02	$120.61	$0.59	$90.91	$91.00	$0.08
99396	Prev visit est age 40-64	$127.92	$128.19	$0.27	$98.82	$98.94	$0.12
99397	Per pm reeval est pat 65+ yr	$137.27	$138.30	$1.03	$103.49	$104.00	$0.51

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Changes to the Incident-To Requirements

Supervision by the Billing Physician or Practitioner

Under existing Medicare policy, services and supplies commonly provided in a physician or practitioner's office that are actually rendered by auxiliary personnel "incident to" the services of the physician or other practitioner may be billed under the physician or practitioner's number if certain requirements are met, including, among others, that the services or supplies are "Furnished under direct supervision (as specified under § 410.26(a)(2)) of a physician or other practitioner eligible to bill and directly receive Medicare payment." The regulatory definition of "direct supervision" is thus:

> *Direct supervision* in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

CNMs may provide services that are billed incident to under a physician's number, or they may bill services under their own number when those services are provided by some auxiliary personnel incident to the CNM's own service.

The major reason that services are billed incident to is to obtain payment at the physician level. If there is a differential between what the physician or practitioner receives and what the auxiliary personnel would receive, there is a strong economic incentive to bill services incident to. For example, Medicare pays NPs at 85% of physician rates, so it is advantageous for NPs to bill their services incident to, under a physician's number because when they do, they are paid at 100%.

Under Medicare, the economic incentive for CNMs to bill incident to does not exist since CNMs are paid at 100% of physician rates. However, many other payers reimburse CNMs/CMs at less than 100% of physician rates, and insofar as those payers follow Medicare's lead, the economic incentive for CNMs to bill under the physician's number is substantial.

Current regulation permits the supervision to be provided by a physician or provider other than the one billing for the incident to services. So, for example, if Dr. Jones establishes out a plan of treatment and a CNM then implements that plan by providing a prenatal visit, that prenatal visit can be billed under Dr. Jones' number and this can occur even if Dr. Jones was not present in the office suite when the prenatal visit occurred, but there was another physician available in the office suite to provide the required direct supervision.

CMS is proposing to modify this requirement to state that the physician or other practitioner who bills for incident to services must also be the physician or other

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practitioner who directly supervises the auxiliary personnel who provide the incident to services.

This is a serious problem for physician/CNM groups. To go to our example, if Dr. Jones initiates a plan of care that involved prenatal visits, but then goes off to a hospital to attend births, a CNM who renders one of those prenatal visits cannot bill the service incident to. Rather, she/he would have to bill it under her/his own number. Under Medicare, as noted above, this doesn't matter economically since CNMs are reimbursed at physician rates, however, where other payers allow incident to billing, follow Medicare's policies, and reimburse CNMs at a lower rate, it would mean that the CNM would have to bill under her own number and accept lower reimbursement, or would have to render the prenatal care when Dr. Jones had come back to the office to provide the direct supervision. This would be the case even if Dr. Smith was present in the office to provide direct supervision during the times when Dr. Jones was at the hospital.

If CMS were to continue existing policy, the CNM could render the service when Dr. Jones was in the hospital, so long as another physician (Dr. Smith) was present in the office to provide the requisite direct supervision.

Qualification of Auxiliary Personnel

CMS proposes to amend the regulation to explicitly prohibit auxiliary personnel from providing incident to services if those auxiliary personnel have either been excluded from Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or who have had their enrollment revoked for any reason. These excluded or revoked individuals are already prohibited from providing services to Medicare beneficiaries, so this proposed revision is an additional safeguard to ensure that these excluded or revoked individuals are not providing incident to services and supplies under the direct supervision of a physician or other authorized supervising practitioner.

A Summary of the Basic Elements of the Medicare Physician Fee Schedule
An excellent, concise 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

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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 December 31, 2017, at which time, many of the 89 fee schedule localities will experience a reduction in their work GPCI.

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

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