Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule Final Ruling (with comment period), CY2013

PATHOLOGY/LABORATORY

Rick Oliver, JD, CHCO, CPC, MT(ASCP)

Compliance

McKesson Revenue Management Solutions (RMS)

(The Revenue Management Solutions business unit is one of several business units within McKesson Technology Solutions. We refer to ourselves as “RMS” or “Revenue Management Solutions” for internal communications and certain external communications, such as media releases. PST Services, Inc. is the legal entity RMS uses with contracts with its clients or third party vendors.)
Overview

On November 1, the Centers for Medicare & Medicaid Services (CMS) released their final ruling with comment period that will update payment policies and payment rates for the Physician Fee Schedule (PFS) on or after Jan. 1, 2013 (CY2013). The final rule also confirms changes to several of the quality reporting initiatives that are associated with PFS payments – the Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, and the PQRS-EHR Incentive Pilot – as well as changes to the Physician Compare tool on the Medicare.gov website. Finally, the final rule includes decisions for implementing the physician value-based payment modifier (Value Modifier) required by the Affordable Care Act that will affect payment rates to physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare Fee-for-Service program.

The final rule with comment period appeared in the November 16 Federal Register. CMS will accept comments on the rules until December 31. More information of the final rule

The PFS Final Rule in its entirety is available by clicking CY 2013 Medicare Physician Fee Schedule Final Rule with comment period

CMS Fact Sheet

This review of the CMS final rulings will provide the various section(s) that were listed in the ruling that may affect or be of interest to the Pathology/Laboratory specialty. It will not include a comprehensive review of all components of the final rule. This document is for “informational use only” and it is not intended to provide legal advice or counseling on the various rulings from CMS. If the reader has concerns or questions they should consult with their compliance and/or legal counsel for advice.
CY2013 PFS FINAL RULING NOTABLE HIGHLIGHTS:
The Pathology and Laboratory specialties have many items included in the CY2013 PFS final ruling. This brief summary will provide the most notable items for these specialties. Detailed information for these items and others that may impact these specialties is provided further in this document.

Notable Fee Schedule Payment Actions
As with every year that CMS presents the PFS final payment rulings, the conversion factor and resulting overall percent of reduction applied to the PFS is presented. This year is no different; CMS stated that in the absence of Congressional action to override the regulatory requirement utilizing the Sustainable Growth Rate (SGR) formula, the projected conversion factor for CY2013 will be 25.0008. This is a decrease from the 34.0066 currently in place. This will result in a reduction of overall physician payments of 26.5% unless Congress intervenes once again.

In addition to the above conversion factor reduction, CMS will apply the following reductions to the Pathology Specialty:
- 1% overall reduction as a result of the end of the practice expense methodology change phase-in (Physician Practice Information Survey - PPIS).
- 1% reduction for Pathology to counteract the 7% increase given to the Primary Care Physician specialty.
- CMS periodically requests review of certain CPT codes that they label as “misvalued codes” in order to re-evaluate whether those codes should be increased or decreased due to various changes in the healthcare business arena. For CY2013 several pathology codes were re-evaluated that resulted in significant reductions in the Technical Component (TC) portion of the global CPT code. While the TC was reduced in several of the codes, the Professional Component (PC) portion was increased in the vast majority of the pathology codes. In addition, the vast majority of the pathology codes, overall, did receive an increase in payment for the TC and PC components.

Several of the most common pathology codes are listed in the Attachment A table at the end of this document, which shows the overall percentage of reduction or increase in payment that CMS projects for CY2013. Of particular note are the drastic reductions in the TC payment for CPT 88300, 88302, 88304 and 88305. Please note that this table does not include the conversion factor reduction, the geographic practice cost index (GPCI) calculation, the PPIS reduction nor the reduction for balancing the increased payment to the Primary Care Physician specialty. The table specifically provides only the impact from the practice expense (PE), facility/non facility rate adjustment (if applicable) and the malpractice insurance (MP) expense used in the SGR formula calculation, therefore these percentages may be lower when the overall calculations are finalized.

CMS projects that the Pathology Specialty will receive an overall 6% reduction in payments. Laboratories performing the TC of services for pathology will be hit the hardest since the drastic reductions are tied to the TC of these services.

For the Independent Clinical Laboratory Specialty, CMS has not published the Clinical Laboratory Fee Schedule (CLFS) to date for CY2013, but CMS projects that this specialty will receive an overall reduction in payments of 14% due in large part to the practice expense (PE) recalculation.

Independent laboratories performing the TC of pathology services will be greatly impacted by the drastic reductions in the TC payments for the above-mentioned codes (see Attachment A table for details). Since the reductions are tied to the TC of these services, the laboratory will get the blunt of these payment reductions.
CMS Decision for Molecular Pathology New Codes
CMS announced that it will place the new Molecular Pathology codes under the clinical laboratory fee schedule. CMS will not publish national payment amounts for the codes, as reimbursement for CY2013 will be set by the gap filling method. The payments for these codes will be published at a later date as the Medicare contractor (MAC, Carrier) complete the gap filling methodology. With the deletion of the 83912-26 code by the AMA for CY2013, CMS introduced a new G-code to replace the 83912-26. G0452-26 will be used by pathologists when an interpretation of a molecular pathology test is performed. There will be no billing of this code without modifier 26, since it is an interpretation code only. CMS designated the G code as an interim code, and CMS stated that they will be monitoring the use of the code, likely for accuracy and volume. The RVU established for this professional-component-only service is 0.37 which is an increase from the CY2012 RVU established for the 83912-26 code.

PQRS Updates
CMS finalized several items in the PQRS program; most notably for Pathology is a 0.5% bonus of the total Part B allowed charges for those pathologists that successfully report PQRS measures. There were no new measure changes from CY2012 (all five measures appear in CY2013). CMS stated that CY2013 data will be used to determine those pathologists that are subject to the 1.5% deduction in overall Part B Medicare payments when this PQRS program becomes mandatory in 2015. Pathologists who do not participate in 2013, or do so unsuccessfully, will face this 1.5% penalty in 2015 based on their overall Part B Medicare payments.

Other PQRS changes beginning next year include new group reporting options. Group practices with between 2 and 99 members may report on measures for all the practice’s patients as a group, with all members of the group getting credit regardless of which individuals provided the service. In addition, providers in group practices of 100 or more will be subject to a value-based payment modifier adjustment in 2015 determined by their 2013 PQRS participation.

Confirmation of the Termination of the TC Grandfather Clause
CMS confirmed that the TC Grandfather Clause was terminated as of July 1, 2012 and that all TC services performed on hospital inpatients or outpatients must be billed by the hospital where that given patient was when the sample/service was delivered. Independent Laboratories or Pathology groups must bill back the hospital for any TC that they performed; they are prohibited from directly billing the Medicare Part B carrier for those services as of July 1, 2012.

The following pages provide detailed information on the above plus additional topics that may affect the Pathology and/or Laboratory Specialty.
BACKGROUND OF THE MEDICARE PHYSICIAN FEE SCHEDULE
PAYMENT METHOD

Since 1992, Medicare has paid for the services of physicians, non-physician practitioners (NPPs), and certain other suppliers under the Medicare Physician Fee Schedule (PFS). This payment system pays for covered physicians' services furnished to a beneficiary enrolled under Medicare Part B. The payment calculation for the PFS, in general, is based on a relative value unit (RVU) assigned to each of the designated physician services to capture the amount of work involved in the services. This includes the direct and indirect (overhead) practice expenses (PE), and the malpractice (MP) insurance expenses typically involved in furnishing the services. The higher the number of RVUs assigned to a service produces a higher payment for that given service. The RVUs for a particular service are then multiplied by a fixed-dollar conversion factor (CF) and a geographic practice cost index (GPCI) adjustment factor to determine the payment amount for each service. The current formula used for this calculation is expressed as:

\[ \text{PFS Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU PE} \times \text{GPCI PE}) + (\text{RVU Malpractice} \times \text{GPCI Malpractice})] \times \text{CF}. \]

I. Calendar Year (CY) 2013 PFS Proposed Changes in Payment Rates
A. CONVERSION FACTOR

CMS states the CY2013 conversion factor (CF) to be \$25.0008 (includes Budget Neutrality). This is a reduction of 26.5% for CY2013 and CMS is required by law to include this reduction in these calculations. However, Congress has acted to avert the cuts every year since 2003. CMS stated they are committed to fixing the Sustainable Growth Rate (SGR) formula in a fiscally responsible way.

<table>
<thead>
<tr>
<th>Conversion Factor in effect in CY 2012</th>
<th>$34.0376</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2012 Conversion Factor had statutory increases not applied</td>
<td>$24.6712</td>
</tr>
<tr>
<td>CY 2013 Medicare Economic Index</td>
<td>0.8% (1.008)</td>
</tr>
<tr>
<td>CY 2013 Update Adjustment Factor</td>
<td>0.6% (1.006)</td>
</tr>
<tr>
<td>CY 2013 RVU Budget Neutrality Adjustment</td>
<td>-0.1% (0.99932)</td>
</tr>
<tr>
<td>CY 2013 Conversion Factor</td>
<td>$25.0008</td>
</tr>
</tbody>
</table>

B. PAYMENT CHANGES

CMS issued a final rule that would increase payments to family physicians and other practitioners providing primary care services. Most of this increased reimbursement would result from a separate payment that Medicare would make to physicians for coordinating a patient's care for the first 30 days after discharge from a hospital, skilled nursing facility, or certain outpatient services. (See section Primary Care and Care Coordination below for details). Under CMS' final ruling, Medicare will increase some specialty pay while decreasing other specialties. Below is the percentage impact projected with this ruling:

Specialties with an increase:
- Family Physicians +7%
- Internists +4%
- Geriatric +5%
- Nurse Practitioner +4%
- Physician Assistant +3%
- Anesthesiology +1%
- Allergy/Immunology +3%
To pay for these increases, CMS states that it has to reduce reimbursement for other clinician specialties to achieve budget neutrality.

Specialties with a decrease:
- Cardiac Surgery -1%
- Cardiology -2%
- Interventional Radiology -3%
- Multispecialty Clinic-other physicians -1%
- Neurology -7%
- Nuclear Medicine -3%
- Ophthalmology -3%
- **Pathology -6%**
- Physical Medicine -4%
- Radiation Oncologists -7%
- Radiology -3%
- Thoracic Surgery -1%
- Urology -1%
- Vascular Surgery -2%
- Audiologist -4%
- Clinical Psychologist -2%
- Clinical Social Workers -2%
- Diagnostic Testing Facility -7%
- **Independent Laboratory -14%**
- Radiation Therapy Centers -9%

Sample of Specialties with no anticipated change in reimbursement:
- Gastroenterology
- General Surgery
- Rheumatology
- Neurosurgery

C. PATHOLOGY AND INDEPENDENT LABORATORY CUTS
- The first table below provides the specific cuts for the specialties **Pathology and Independent Laboratory** based on only the payment impact on PFS services. CMS noted that the impacts in the first table do not include the effects of the January 2013 conversion factor change under current law, which would further reduce the overall payment.
- The second table represents the impact when specific updates are included in the calculation. CMS noted that the impacts in the second table do not include the effects of the January 2013 conversion factor change under current law, which would further reduce the overall payment.
- Table three shows the estimated impact on total payments for selected high volume procedures for all of the changes. CMS included CY2013 payment rates with and without the effect of the CY2013 negative PFS CF (post update column shows total reduction) update for comparison purposes.
### TABLE 1: CY2013 PFS Final Rule Estimated Impact on Total Allowed Charges by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (in millions)</th>
<th>Impact of Work and MP RVU Changes</th>
<th>Impact of PE RVU Changes</th>
<th>Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology</td>
<td>$1,210</td>
<td>0%</td>
<td>-6%</td>
<td>-6%</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>$1,073</td>
<td>-0%</td>
<td>-14%</td>
<td>-14%</td>
</tr>
</tbody>
</table>

### TABLE 2: CY2013 PFS Final Rule Estimated Impact on Total Allowed Charges by Specialty by Selected Proposals

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (mil)</th>
<th>Impact of End of PPIS Transition</th>
<th>New &amp; Revised Codes, MPPR, New Utilization Other Factors</th>
<th>Updated Equipment Interest Rate Assumption</th>
<th>Transition Care Management</th>
<th>Input Changes for Certain Radiation Therapy Procedures</th>
<th>Total (Cumulative Impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology</td>
<td>$1,185</td>
<td>-1%</td>
<td>-5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>-6%</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>$1064</td>
<td>-2%</td>
<td>-12%</td>
<td>1%</td>
<td>-1%</td>
<td>0%</td>
<td>-14%</td>
</tr>
</tbody>
</table>

### TABLE 3: Impact of Final Rule on CY2013 Payment for Selected Procedures (Based on the March 2012 Preliminary Physician Update)

<table>
<thead>
<tr>
<th>CPT® / HCPCS Code¹ MOD</th>
<th>Short Descriptor</th>
<th>Facility Rate</th>
<th>Non-Facility Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CY 2012²</td>
<td>CY 2013³ (pre Update)</td>
</tr>
<tr>
<td>88305</td>
<td>Tissue exam by Pathologist</td>
<td>$36.08</td>
<td>$36.73</td>
</tr>
</tbody>
</table>

1. CPT® codes and descriptions are copyright 2012 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2. Payments based on the 2012 conversion factor of 34.0376
3. Payments based on the 2012 conversion factor of 34.0376, adjusted to 34.0066 to include the Budget Neutrality (BN) adjustment.
4. Payments based on the 2013 conversion factor of 25.0008, which includes the Budget Neutrality (BN) adjustment.

### D. POTENTIALLY MISVALUED SERVICES UNDER THE PHYSICIAN FEE SCHEDULE
The Affordable Care Act (ACA) Section 3134(a) requires the Secretary to periodically identify potentially misvalued services using certain criteria, and to review and make appropriate adjustments to the relative values for those services. The ACA directed the Secretary to specifically examine potentially misvalued services in seven categories as follows:

- Codes and families of codes for which there has been the fastest growth.
- Codes or families of codes that have experienced substantial changes in practice expenses.
- Codes that are recently established for new technologies or services.
- Multiple codes that are frequently billed in conjunction with furnishing a single service.
• Codes with low relative values, particularly those that are often billed multiple times for a single treatment.
• Codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes').
• Other codes determined to be appropriate by the Secretary.

For CY2013 CMS finalized the proposal of the review of several pathology codes. Most notably CPT® 88309-TC, 88307-TC, 88305-TC, 88304-TC, 88302-TC, and 88300-TC. Please see Attachment A Table for a summary of the impact of the re-evaluation of these codes and payment impact. CMS also finalized the proposal to reduce the procedure time assumptions in developing RVUs for intensity modulated radiation treatment (IMRT) delivery and stereotactic body radiation therapy (SBRT) delivery. CMS will continue this work as well as examine options for bundled or episode-based payments, which will be included in a report to Congress scheduled for submission by Jan. 1, 2013.

E. INTEREST RATE ASSUMPTIONS
CMS finalized the proposal to improve the accuracy of payment rates to reflect current economic conditions by revising interest rate assumptions by using a “sliding scale” approach, which varies the interest rate based on the equipment cost, useful life, and SBA (Small Business Administration) maximum interest rates for different categories of loan size and maturity. They confirmed that use of the previous interest rate for practice expense of 11% will change to a range from 5.5% to 8% based on the “sliding scale” approach.

F. MULTIPLE PROCEDURE PAYMENT REDUCTION (MPPR) POLICY
Medicare has a longstanding policy to reduce payment by 50% for the second and subsequent surgical procedures furnished to the same patient by the same physician on the same day. This reduction is largely based on the presence of efficiencies in the practice expense (PE) and pre- and post-surgical physician work.
For CY2013, CMS finalized the proposal to apply a multiple procedure payment reduction policy to the technical component of certain cardiovascular and ophthalmology diagnostic services. CMS would make full payment for the highest paid cardiovascular or ophthalmology diagnostic service and reduce the technical component payment for subsequent cardiovascular or ophthalmological diagnostic services furnished by the same physician or group practice to the same patient on the same day. CMS decided to apply a 20% reduction instead of a 25% reduction announced in the initial proposal for ophthalmology services but retained the 25% reduction for cardiovascular services. CMS continues to indicate they will consider implementing more expansive payment reduction policies. Specifically, CMS “hints” at applying the MPPR to the technical component (TC) of all diagnostic tests in the future.

G. EXPIRATION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES
CY2013 final ruling confirms the termination of the “grandfather clause” effective July 1, 2012 for the technical component of anatomic pathology performed on hospital inpatients and outpatients. This termination results in the requirement that the independent laboratory would no longer be allowed to bill the Part B carrier directly for the technical component of any physician fee schedule service, the laboratory would be forced to bill the hospital for those services.

H. PAYMENT FOR MOLECULAR PATHOLOGY SERVICES
CMS invited comments on whether newly created molecular pathology CPT codes should be paid under the Medicare PFS or the Clinical Laboratory Fee Schedule (CLFS). CMS finalized the decision to pay for the services under the Clinical Laboratory Fee Schedule with CY2013 payment set by the gap filling method. Detailed discussion occurred on those molecular tests that do have physician interpretation involvement. CMS states that a new HCPCS code will be used to
report those molecular diagnostic services that are interpreted by the physician (e.g. Pathologist) and will be paid from the PFS. This new “G” code (G0452-26 - Molecular diagnostics; interpretation and report) will replace the 2013 deleted CPT code 83912-26. CMS goes on to state that the current requirements as noted in section 60 of the Claims Processing Manual (IOM 100-04, Ch. 12, section 60.E.) specify certain requirements for billing the professional component of certain clinical laboratory services including that the interpretation must
1. Be requested by the patient’s attending physician,
2. Result in a written narrative report included in the patient’s medical record
3. Exercise the medical judgment by the consultant physician. CMS noted that a hospital’s standing order policy can be used as a substitute for the individual request by a patient’s attending physician.

CMS also states that it will monitor the utilization of the use of G0452 and collect data on billing patterns to ensure that the code is being used only when interpretation and report by a physician is medically necessary and is not duplicative of laboratory reporting paid under the CLFS.

CMS states that since the G0452 code will replace the 2013 deleted CPT code 83912-26, it will assign the RVU of 0.37 which it believes appropriately reflects the work of HCPCS code G0452. The RVU of 0.37 and 5 minutes of pre-service time, 10 minutes of intra-service time, and 5 minutes of post-service time will be assigned to HCPCS code G0452 on an interim final basis for CY2013. This decision will result in a payment for HCPCS G0452 just slightly above the current payment for the CPT code 83912-26 (this CPT code is deleted as of Jan. 1, 2013). CMS did state they request public comment on the interim final values for HCPCS code G0452.

CMS has noted that the two clinical consultation codes, 80500 and 80502, will continue to receive payment when the regulatory requirements associated with those two codes are met, and that this includes the clinical consultations associated with molecular pathology codes. Please note that standing orders are NOT allowed for these two clinical consultation codes, and each time a consultation is requested, there must be a separate order from the treating/ordering practitioner. Hospital standing orders are NOT allowed.

CMS also confirms that it will not have a separate code assigned for the interpretation services that are performed by non-physician practitioners (e.g. Clinical Scientist, PhD level). CMS confirms that the code for the individual service includes any payment associated with a non-physician practitioner service. Therefore, non-physician practitioners (e.g. Clinical Scientist, PhD level) CANNOT bill HCPCS code G0452 for any interpretation service they may perform.

I. PRIMARY CARE AND CARE COORDINATION

In recent years, CMS and Health and Human Services (HHS) have recognized primary care and care coordination as critical components in achieving better care for individuals, better health for populations, and reduced expenditure growth. Accordingly, CMS has prioritized the development and implementation of a series of initiatives designed to help ensure accurate payment for, and encourage long-term investment in, primary care and care coordination services. For CY2013, CMS finalized the ruling to create a new procedure code to recognize the additional resources required for a community physician to coordinate a patient’s care in the 30 days following discharge to the community from an inpatient hospital stay, skilled nursing facility (SNF) stay, and specified outpatient services. Medicare already pays separately for care management services for individuals with an inpatient admission who are discharged to SNF, home health, or hospice. Although Medicare traditionally pays for care management services in conjunction with a face-to-face visit, the finalized ruling for the new procedure code would establish a separate payment for care management services for the beneficiary that occur outside a face-to-face encounter with the community physician.

CMS believes that recognizing the work of community physicians and practitioners with the new code will help ensure better continuity of care for these patients and support the agency’s
readmission reduction initiatives. This care coordination will become increasingly important as Medicare implements the Readmissions Reduction Program that began October 1. This program, which was mandated by the Affordable Care Act, reduces payment to hospitals when they have excessive readmissions for certain conditions.

The changes in care coordination payment and other changes in the rule are expected to increase payment to family practitioners by 7% and other primary care practitioners between 3% and 5% if Congress averts the statutorily required reduction in Medicare’s physician fee schedule.

J. ELIMINATION OF PREPAYMENT MEDICAL REVIEW LIMITATION
To implement the ACA, CMS will remove a limitation imposed on Medicare contractors to continue complex prepayment medical review if a provider or supplier has failed to reduce its individual error rate.

K. REMOVAL OF MIDLEVEL PROVIDER BARRIERS
CMS finalized the proposal to align the diagnostic testing services associated with portable x-rays with other diagnostic services (i.e. laboratory) in regard to who may order such services. CMS’ final ruling is to allow non-physician practitioners and limited-license physicians to order portable x-ray services within the scope of their Medicare benefit and state scope of practice laws. CMS notes that documentation supporting the “order” of such services would be required to be in the patient’s medical record. With respect to the certified registered nurse anesthetist (CRNA) benefit, there is a proposal to clarify that “anesthesia and related care” means services related to anesthesia that are within the scope of practice for CRNAs in the state in which the services are rendered.

L. OTHER AREAS OF PHYSICIAN, NON PHYSICIAN PAYMENT
1. Durable Medical Equipment (DME) Face-to-Face Requirement. To combat fraud and abuse, CMS finalized the rule to implement a face-to-face requirement as a condition of payment for certain durable medical equipment (DME) items for orders written on or after July 1, 2013.

2. Telehealth Services. A series of preventative services will be added to the list of Medicare covered telehealth services, including: annual alcohol misuse screening, brief behavioral counseling for alcohol misuse, annual face-to-face intensive behavioral therapy for cardiovascular disease, annual depression screening, behavioral counseling for obesity, and semi-annual high-intensity behavioral counseling to prevent sexually transmitted infections. Alcohol and/or substance abuse assessment and intervention services will also be added to the list.

3. Therapy Data Collection. A claims-based data collection process for therapy services will be implemented to gather data regarding patient function and condition. New codes and modifiers will be required to be added to therapy service claims to report information regarding the patient’s functional limitations at the inception of therapy, during therapy, and at end of therapy. The data reported through these codes will, according to CMS, be used to design a new payment system for therapy services.
II. Physician Quality Reporting System (PQRS), Electronic Health Report (EHR) and Electronic Prescribing (e-Rx)

Brief Summary of PQRS: The PQRS bonus incentive remains at 0.5% through 2013. Eligible Professionals (EPs) who successfully report quality data for the quality reporting period designated by the Secretary for the applicable year will receive a bonus in 2013.

PQRS penalty: The 2013 reporting period data will be used to establish the 2015 payment penalty adjustment. EPs who do not successfully report quality data during the 2013 reporting period will have their Medicare payments reduced by 1.5% in 2015 and by 2.0% in 2016 and each subsequent year. The payment incentives and reductions are based on the Medicare fee schedule amounts (determined after applicable adjustments) for all covered services furnished by the EPs. The penalty applies to the applicable year and is not cumulative. Eligible professionals include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physical and occupational therapists, qualified speech language pathologists and qualified audiologists.

- The reporting period continues as a 12-month reporting period (January 1 through December 31) for all three reporting mechanisms (claims, registries, and EHR) except for measures groups reported through a registry, which will retain a six-month reporting period option. Successful reporting requirements for the program will remain as they were in 2012 requiring that participants report minimum of three individual measures or one group measure via claims-based reporting on 50% or more of all eligible Medicare patients
- A minimum of three individual measures or one group measure via registry reporting on 80% or more of all eligible Medicare patients.

CY2013 PQRS Final ruling for Pathology Specialty:
- No new measures for the pathology specialty
- Pathology retains all five measures currently in place

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>#99</td>
<td>Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade and</td>
</tr>
<tr>
<td>#100</td>
<td>Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade</td>
</tr>
<tr>
<td>#249</td>
<td>Barrett’s Esophagus - Esophageal biopsies with a diagnosis of Barrett’s esophagus that also include a statement on dysplasia.</td>
</tr>
<tr>
<td>#250</td>
<td>Radical Prostatectomy Pathology Reporting - Reports include the pT category, the pN category, the Gleason score and a statement about margin status.</td>
</tr>
<tr>
<td>#251</td>
<td>Immunohistochemical (IHC) Evaluation of HER2 for Breast Cancer Patients -Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines.</td>
</tr>
</tbody>
</table>

For CY2013, pathology continues to qualify under the claims reporting option, registry reporting option and the Group Practice Reporting Option (GPRO).

Independent Laboratories (Specialty 69) continue to be excluded from participating in PQRS bonus incentives.
Overview of the CY2013 PFS final rule for Quality Reporting Initiatives

In the CY2013 PFS proposed rule, CMS finalized the following updates to the PQRS related to the 2013 and 2014 PQRS incentives and the 2015 and 2016 PQRS payment adjustments:

A. SUMMARY OF FINALIZED PQRS MEASURES
Over CYs 2013 and 2014, CMS finalized the proposal to include over 250 individual measures that EPs can choose from, including finalizing the proposals to align the PQRS measures that would be available for EHR-based reporting with the measures available for reporting under the EHR Incentive Program. In addition, CMS finalized the proposal to include 26 measure groups for reporting. With respect to measures for reporting via the Group Practice Reporting Option (GPRO) web-interface, CMS will align these measures with the measures required under the Medicare Shared Savings Program.

B. REPORTING PQRS MEASURES AS INDIVIDUAL EPS

Reporting PQRS Measures for the 2013 and 2014 PQRS Incentive: CMS is finalizing the criteria, which will be similar to the criteria for satisfactory reporting for the 2012 incentive. Notable changes include:

- Criteria for reporting using the EHR-based reporting mechanism that would align with the reporting criteria for meeting the clinical quality measure (CQM) component of meaningful use for the Medicare EHR Incentive Program.
- For the 12-month 2013 and/or 2014 incentive reporting period, decrease to the minimum threshold of patients on which EPs are required to report using measures groups via registry from 30 to 20.

Reporting PQRS Measures for the 2015 and 2016 PQRS Payment Adjustments:
- For the applicable payment adjustment reporting period, the following criteria for satisfactory reporting for the 2015 and/or 2016 payment adjustments:
  - Report one PQRS measure or measures group.
  - Option to elect using the administrative claims-based reporting option for the set of administrative claims-based measures.

C. REPORTING PQRS MEASURES AS A GROUP PRACTICE UNDER THE GROUP PRACTICE REPORTING OPTION (GPRO)

Definition: CMS finalized the ruling to expand the definition of group practice to include groups of 2-24 EPs.

Reporting PQRS Measures for the 2013 and 2014 PQRS Incentives:
- CMS will expand the use of the claims, registry, and EHR-based reporting mechanisms to groups of 2-24 EPs, in addition to groups of 25 or more EPs.
- CMS will use an assignment methodology similar to the one used under the Medicare Shared Savings Program for groups that report using the GPRO web interface. In addition, CMS will allow a self-reporting mechanism for GPRO with a submission deadline of October 15 of the given reported year.

Medicare Shared Savings Program: CMS will use the satisfactory reporting criteria for the Physician Quality Reporting System payment adjustment that would apply to EPs within group practices in accountable care organizations (ACOs) under the Medicare Shared Savings Program.

D. PHYSICIAN VALUE-BASED MODIFIER

Included in the health care reform law, the value-based modifier (VBM) adjusts payments to individual physicians or groups of physicians based on the quality of care furnished to Medicare beneficiaries compared to costs. The VBM program is scheduled to be phased in over three years from 2015-2017. For the first year, the final rule will apply the VBM to all groups of physicians with 100 or more eligible professionals (CMS changed this from 25 or more eligible professionals). The final rule also provides an option for these groups to choose how the VBM would be calculated based on whether they participate in the PQRS. For groups of 100 or more not participating in the PQRS, CMS is adopting
their proposed policy, with one modification, to categorize groups of physicians eligible for the value-based payment modifier into two categories.

- The first category of groups of physicians includes those that have
  - Self-nominated for the PQRS as a group and reported at least one measure or
  - Elected the PQRS administrative claims option for CY2013.
  These physicians will receive a 0.0% payment reduction in CY2015
- The second category is for those groups of physicians that do not fit within the first category. These physicians will receive a 1% payment reduction in CY2015.

E. ELECTRONIC PRESCRIBING INCENTIVE PROGRAM

The Electronic Prescribing (eRx) Incentive Program is a reporting program that uses a combination of incentive payments and downward payment adjustments to encourage electronic prescribing by EPs. The program provides incentive payments through 2013 to individual EPs and group practices that are successful e-prescribers for covered professional (PFS) services furnished to Medicare Part B fee-for-service beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer).

From 2012 through 2014, the program applies a payment adjustment to those EPs who are not successful electronic prescribers. For purposes of this program, EPs are identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN). Please note that the requirements for the 2013 eRx incentive and 2014 eRx payment adjustment were established in the CY 2012 PFS final rule with comment period. In the CY2013 rule:

- CMS will implement new criteria for being a successful electronic prescriber for groups of 2-24 EPs using the eRx GPRO
- CMS added two additional significant hardship exemptions to the 2013 and 2014 payment adjustments related to participation in the EHR Incentive Program
- CMS will establish an informal review process

F. PQRS-MEDICARE ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE

EPs, eligible hospitals, and Critical Access Hospitals (CAHs) that choose to participate in the Medicare and Medicaid EHR Incentive Programs are required to electronically submit clinical quality measure (CQM) results as calculated by certified EHR technology. Under the CY2013 PFS final rule, CMS intends to continue for CY2013 the attestation method and the Physician Quality Reporting System-Medicare EHR Incentive Pilot for reporting CQMs that was established in the CY 2012 PFS final rule with comment period. Other proposals related to Stage 1 and Stage 2 of the EHR Incentive Program were included in a separate rule published on March 7, 2012 (77 FR 13698).

G. PHYSICIAN COMPARE WEBSITE

Section 10331 of Affordable Care Act requires CMS to implement a plan for making information on physician performance publicly available no later than Jan. 1, 2013. This provision supports CMS’s overarching goals of providing consumers with quality of care information to make informed decisions about their health care, while encouraging clinicians to improve the quality of the care they provide to their patients. In the 2012 PFS final rule, CMS finalized a plan to report performance rates for group practices participating in the 2012 Physician Quality Reporting System GPRO on the Physician Compare website.

The CY2013 PFS final rule outlines the next phase of the plan to publicly report physician performance information on Physician Compare. In this next phase, CMS will post performance rates on the quality measures submitted by group practices participating in the Physician Quality Reporting System GPRO and ACOs participating under the Medicare Shared Savings Program, respectively, where technically feasible, starting with measures submitted in 2013. CMS will also post patient experience survey data - such as the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) - for group practices participating in the PQRS GPRO and ACOs participating in the Medicare Shared Savings Program, starting with survey data for 2013.
The CY2013 PFS final rule also seeks comment on a number of additional group-level measures that CMS is considering publically reporting in the future on the Physician Compare website. These include measures from carefully selected specialty societies, as well as ambulatory care sensitive condition measures of potentially preventable hospitalizations that were developed by the Agency for Healthcare Research and Quality (AHRQ).

For more information on:
- PQRS
- eRx Incentive Program
- Medicare and Medicaid EHR Incentive Programs
- Physician Compare
- Physician Value-Modifier & Physician Feedback Program
## ATTACHMENT A
Select Pathology CPT Codes CY2013 Fee Payments
N/A – Payment is not applicable in facility setting

<table>
<thead>
<tr>
<th>Code</th>
<th>Component</th>
<th>Active (A) or New (N)</th>
<th>Code Description</th>
<th>Non Facility</th>
<th>Facility</th>
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<td>Surgical path gross</td>
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<td>Surgical path gross</td>
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