Final Medicare fee schedule expands DPP, boosts care coordination

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Troy Parks
News Writer

The Centers for Medicare and Medicaid Services (CMS) has made considerable changes to policies in its proposed Medicare Physician Fee Schedule with the Wednesday release of its final rule. The most notable revisions aligned with physician recommendations and occurred in areas that will improve patient care and reduce the physician reporting load.

Commenting on the proposed rule, the AMA earlier this year submitted a letter to CMS urging changes and highlighting areas of agreement. The Association's comments covered issues such as diabetes treatment expansion, less burdensome data collection and improved care coordination opportunities.

"This annual policy fine-tuning is an opportunity for CMS to improve treatment options for patients and streamline bureaucratic demands on physicians," said AMA President Andrew W. Gurman, MD. "By expanding coverage … and revising data collection efforts, CMS is ensuring that patients and physicians will benefit from better care and more rational directives."

Diabetes Prevention Program expanded

A key provision in the final rule expands coverage of the Medicare DPP model to include Medicare patients who are at risk of developing type 2 diabetes. This ensures that more at-risk seniors and people with disabilities have access to a DPP to help them lower risk factors and prevent or delay progression to type 2 diabetes.

In a three-year demonstration project of the YMCA of the USA funded by the Center for Medicare and Medicaid Innovation (CMMI), the AMA partnered with local YMCAs and 26 physician practice sites in eight states to increase the number of physician referrals of patients with prediabetes to evidence-based DPPs. The pilot program projected $1.3 billion in savings as a result of expanded coverage, which is an example of how the CMMI's waiver authority can work as intended—improving the health

of millions of seniors with prediabetes.

Data collection on surgical global codes

In its proposed rule, CMS proposed a series of eight G-codes that would have asked surgeons and their staff to use 10-minute increments to document all their non-operating room patient care activities. This would have added a significant burden to physician practices of all sizes.

The final rule reduces that reporting burden on physicians by requiring reporting of postoperative visits only for high-volume and high-cost procedures using existing CPT codes instead of the eight proposed G-codes.

Care management, collaboration

Coordination is vital to the delivery of care in the modern medical landscape and the final rule reflects input from the AMA Specialty Society RVS Update Committee (RUC) on the Current Procedural Terminology Panel and physician recommendations to ease administrative reporting and expand the opportunity to perform and report chronic care management services.

Other new codes allow payment for assessing and planning care for patients with cognitive impairment, as well as pay for new care collaboration models between primary care physicians and psychiatrists. This includes separate payments for existing CPT codes describing non-face-to-face prolonged evaluation and management services.

These three major provisions are just a few of the changes CMS made to incorporate physician recommendations. Read a fact sheet from CMS for more on policy, payment and quality provisions in the agency’s final rule on the Medicare Physician Fee Schedule.