The Proposed Rule and Payments for 2017: The Good, the Bad, and the Ugly

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PRACTICE **POINTS**

- The Proposed Rule outlines the probable payment levels for calendar year 2017.
- The rule also announces how the Medicare Access and CHIP Reauthorization Act (MACRA) may be implemented.

Just as Charlie Brown looks forward to the coming of the Great Pumpkin each Halloween, those of us who dance in the minefields of payment policy await the publication of the Proposed Rule, more formally known as the "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017."[1,2] You could read the entire tome—a mere 316 pages (excluding the hundreds of pages of granular supplement data discussed in the last few columns)—or simply read what I have outlined as the good, the bad, and the ugly for the Proposed Rule for 2017.

The Good

In 2017, dermatology will increase its share of the pie by 1% to $3.505 billion of a total $89.467 billion expected to be expended for physician services.[1] The effect on individual providers will vary by geographic location and practice mix. Half is from the 0.5% increase that has come to all physicians across the board as mandated by the Medicare Access and CHIP Reauthorization Act (MACRA).[3]

Current Procedural Terminology (*CPT*) codes for reflectance confocal microscopy (96931–96936) will have Centers for Medicare & Medicaid Services valuations beginning in 2017, and individuals performing this service should be able to report it and be paid for their efforts.[1] The values are below the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) recommendations.

The Bad

Payment rates for 2017 will be based on a conversion factor of 35.7751,[1] a drop from the 2016 conversion factor of 35.8043. Cuts will be made for some specialties. Gastroenterology, nephrology, neurosurgery, radiology, urology, and radiation therapy centers will take a 1% hit; ophthalmology, pathology, and vascular surgery will take 2% cuts; and interventional radiology will lose 7%.[1] A special case within dermatology and pathology is a 15% cut to the technical component of slide preparation for *CPT* code 88305[4] due to a redefinition of the valuation of eosin stains.[2] While the accuracy and precision of the value of these practice expense inputs can be debated, the government by definition makes the rules and involved specialties had an opportunity to appeal this change through the comment process that ended on September 6, 2016. The government can take comments into account, but substantial changes usually are not made from the Proposed Rule to the Final Rule, which usually arrives around the beginning of November; however, in an election year, the Final Rule can be a few weeks late.

The Ugly

The government will increase its unfunded mandates with the creation of new Medicare G codes (global services codes) that will allow the government to

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track the provision of postoperative care for all 010 and 090 global service periods (Table 1). The codes look mostly at time and do not clearly take into account the severity or complexity of the conditions being cared for and will be reported on claim forms as an unfunded mandate with more confusion and cost.[1] Because not all claim-paying intermediaries are likely to have these G codes smoothly set up in their systems, there will still be a cost to filing the claim. Unless changes occur in the Final Rule, which is unlikely, there will be no payment for the time and effort of submitting these claims. The goal of the US Government is to hone in on postoperative services and parse them down so they can cut payments wherever possible beginning in 2019.[1] Everyone wants to save money, from the consumer[5] to the payer, and the ultimate payer is playing hardball. Additional validation efforts likely will lower physician fee-for-service payments further.

The US Government also is taking a shot at what they call "misvalued services" that have not had recent refinement within the RUC process.[1] The work list for 2017 includes a number of 000 global period codes where additional evaluation and management services are reported using modifier -25, which implies a substantial, separately identifiable cognitive service performed by the same physician on the day of a procedure above and beyond other services provided or beyond the usual preservice and postservice care associated with the procedure that was performed. Although codes such as biopsies (11100 and 11101) and premalignant destructions (17000–17004) have an adjustment built in and dermatologists who provide services on the same day are actually penalized for the multiple built-in reductions that are already additive, the government is concerned that 19% of the 000 global services were billed more than 50% of the time with an evaluation and management code with modifier -25. Eighty-three codes met the criteria for which the government believes it may be overpaying[1]; the codes of interest to dermatology are shown in Table 2.[1]

The refinement of global periods will be an ongoing exercise through 2017, and beyond, with results likely to play an important role in the 2019 fee schedule. These global period reviews combined with some Stark law refinement relating the leasing of space at market rates while disallowing the landlord physician from receiving patient referrals from the tenant may also affect practitioner income.[1,6] I never cease to be amazed that former Congressman Fortney Hillman "Pete" Stark (D), who has an antikickback

Table 1.

Proposed Global Service Codes[1]

Global Service Code	Description
Inpatient	
GXXX1	Inpatient visit, typical, per 10 minutes, included in surgical package
GXXX2	Inpatient visit, complex, per 10 minutes, included in surgical package
GXXX3	Inpatient visit, critical illness, per 10 minutes, included in surgical package
Office or other outpatient	
GXXX4	Office or other outpatient visit, clinical staff, per 10 minutes, included in surgical package
GXXX5	Office or other outpatient visit, typical, per 10 minutes, included in surgical package
GXXX6	Office or other outpatient visit, complex, per 10 minutes, included in surgical package
Via phone or Internet	
GXXX7	Patient interactions via electronic means by physician/NPP, per 10 minutes, included in surgical package
GXXX8	Patient interactions via electronic means by clinical staff, per 10 minutes, included in surgical package

Abbreviation: NPP, nonphysician practitioner.

Table 2.

0-Day Global Services Billed With an E/M Service With Modifier -25[1]

HCPCS	Long Descriptor
11000	Removal of inflamed or infected skin, up to 10% of body surface
11100	Biopsy of single growth of skin or tissue
11300	Shaving of ≤0.5 cm skin growth of the trunk, arms, or legs
11301	Shaving of 0.6–1.0 cm skin growth of the trunk, arms, or legs
11302	Shaving of 1.1–2.0 cm skin growth of the trunk, arms, or legs
11305	Shaving of ≤0.5 cm skin growth of scalp, neck, hands, feet, or genitals
11306	Shaving of 0.6–1.0 cm skin growth of scalp, neck, hands, feet, or genitals
11307	Shaving of 1.1–2.0 cm skin growth of scalp, neck, hands, feet, or genitals
11310	Shaving of ≤0.5 cm skin growth of face, ears, eyelids, nose, lips, or mouth
11311	Shaving of 0.6–1.0 cm skin growth of face, ears, eyelids, nose, lips, or mouth
11312	Shaving of 1.1–2.0 cm skin growth of face, ears, eyelids, nose, lips, or mouth
11740	Removal of blood accumulation between nail and nail bed
11755	Biopsy of fingernail or toenail
11900	Injection of ≤7 skin growths
11901	Injection of >7 skin growths
12001	Repair of wound (≤2.5 cm) of the scalp, neck, underarms, trunk, arms, or legs
12002	Repair of wound (2.6–7.5 cm) of the scalp, neck, underarms, genitals, trunk, arms, or legs
12004	Repair of wound (7.6–12.5 cm) of the scalp, neck, underarms, genitals, trunk, arms, or legs
12011	Repair of wound (≤2.5 cm) of the face, ears, eyelids, nose, lips, or mucous membranes
12013	Repair of wound (2.6–5.0 cm) of the face, ears, eyelids, nose, lips, or mucous membranes
17250	Application of chemical agent to excessive wound tissue
40490	Biopsy of lip
67810	Biopsy of eyelid

Abbreviations: E/M, evaluation and management; HCPCS, health care common procedure coding system.

scheme that keeps expanding, never went after the banking and brokerage industries. The founder of the $1.1 billion Security National Bank, a small bank in Walnut Creek, California,[7] never focused on regulating banks. In his 40-year congressional career, he decided physicians make better targets. His efforts have not helped physicians but have helped lawyers, as he is quick to acknowledge.[8]

Final Thoughts

I end this column with an appeal to the dermatologists of America. Go to the American Academy of Dermatology Association Political Action Committee website (https://skinpac.org/), the home page for the only political action committee that represents the dermatology specialty, and consider making a donation. Emergency medicine physicians created the "Giving a Shift" campaign, which is a donation to their national political action committee of one shift's earnings, and most of us could easily donate a half day's income, as the only way to potentially change the increasingly onerous burdens on practitioners is through political action. As we say at RUC meetings, you can eat lunch or be lunch. The choice is yours.

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