2013 Medicare Physician Fee Schedule
Proposed Rule

PAYMENT POLICY REVISIONS

SGR: For CY 2013, CMS projects a payment update reduction of 27 percent with a conversion factor of 24.7124, which includes the BN adjustment. For 2012, the conversion factor was $34.0367 after congressional fixes to prevent payment reductions from going into effect last year.

Relative Value Units: CMS is completing its four-year transition to using the Physician Practice Information Survey data for practice expense RVUs. The CY 2013 proposed PE RVUs were developed based entirely on the PPIS data with certain exceptions.

To calculate the payment for each physician’s service, the components of the fee schedule (work, PE, and MP RVUs) are adjusted by geographic practice cost indices (GPCIs). The GPCIs reflect the relative costs of physician work, PE, and MP in an area compared to the national average costs for each component.

RVUs are converted to dollar amounts through the application of a Conversion Factor, which is calculated by CMS’ Office of the Actuary (OACT). The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

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

GPCIs: Concurrent with the agency’s CY 2012 rulemaking cycle, the Institute of Medicine released the final version of its first of two anticipated reports entitled “Geographic Adjustment in Medicare Payment: Phase I: Improving Accuracy, Second Edition” on September 28, 2011. This report included an evaluation of the accuracy of geographic adjustment factors for the hospital wage index and the GPCIs, as well as the methodology and data used to calculate them. Several of the policies that were finalized in CY 2012 rulemaking addressed several of the recommendations contained in the Institute of Medicine’s first report.

CMS has included a discussion in this proposed rule about the recommendations that were not implemented or discussed in the CY 2012 final rule with comment period. The Institute of Medicine’s second report, expected in summer 2012, will evaluate the effects of geographic adjustment factors (hospital wage index and GPCIs) on the distribution of the healthcare workforce, quality of care, population health, and the ability to provide efficient, high value care. CMS did not receive the Institute of Medicine’s Phase II report in time for consideration for this CY 2013 proposed rule. The agency intends to address the Institute of Medicine’s recommendations in the Phase II report once it has had an opportunity to fully evaluate the report and its recommendations.

CY 2013 is the final year of the sixth GPCI update and, because CMS will propose updates next year, it is not including any proposals related to the GPCIs in this proposed rule. In response to
public inquiries about exceptions to the calculated GPCIs, CMS has provided a brief discussion about the permanent 1.0 PE floor for frontier States, the 1.5 work floor for Alaska, the GPCIs for the Puerto Rico payment locality, and the expiration of the GPCI 1.0 work floor.

**Primary Care:** The Centers for Medicare & Medicaid Services (CMS) issued its proposed rule that would increase payments to family physicians by approximately 7 percent and other practitioners providing primary care services between 3 and 5 percent. CMS proposes for the first time to explicitly pay for the care required to help a patient transition back to the community following a discharge from a hospital or nursing facility. The proposal calls for CMS to make a separate payment to a patient’s community physician or practitioner—which generally is the primary care physician—to coordinate the patient’s care in the 30 days following a hospital or skilled nursing facility stay.

Although Medicare traditionally pays for care management services in conjunction with a face-to-face visit, the proposed 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 proposes to address the significant non-face to face work involved in coordinating services for a beneficiary after discharge from a hospital (inpatient stay, outpatient observation, and partial hospitalization) or skilled nursing facility. CMS will create a G code to describe the transitional care. CMS considers this proposal to be part of a multiple year strategy exploring the best means to encourage care coordination. This service would include:

- Assuming responsibility for the beneficiary’s care without a gap. Such as:
  - Obtaining and reviewing the discharge summary.
  - Reviewing diagnostic tests and treatments.
  - Updating of the patient’s medical record based on a discharge summary to incorporate changes in health conditions and on-going treatments related to the hospital or nursing home stay within 14 business days of the discharge.

- Establishing or adjusting a plan of care to reflect — An assessment of the patient’s health status, medical needs, functional status, pain control, and psychosocial needs following the discharge — particularly in light of the services furnished during the stay at the specified facility and to reflect result of communication with beneficiary.

- Communication (direct contact, telephone, electronic) with the beneficiary and/or caregiver, including education of patient and/or caregiver within 2 business days of discharge based on a review of the discharge summary and other available information such as diagnostic test results, including each of the following tasks:
  - An assessment of the patient’s or caregiver’s understanding of the medication regimen as well as education to reconcile the medication regimen differences between the pre and post-hospital, CMHC, or SNF stay.
  - Education of the patient or caregiver regarding the on-going care plan and the potential complications that should be anticipated and how they should be addressed if they arise.
  - Assessment of the need for and assistance in establishing or re-establishing necessary home and community based resources.
++ Addressing the patient’s medical and psychosocial issues, and medication reconciliation and management.

When indicated for a specific patient, the post-discharge transitional care service would also include:

- Communication with other health care professionals who will (re)assume care of the beneficiary, education of patient, family, guardian, and/or caregiver.
- Assessment of the need for and assistance in coordinating follow up visits with health care providers and other necessary services in the community.
- Establishment or reestablishment of needed community resources.
- Assistance in scheduling any required follow-up with community providers and services.

The transitional care service would be paid only once in the 30 days following a discharge and would be distinct from services furnished by the discharging physician or qualified non-physician reporting CPT code 99238, 99239 (hospital discharge), 99217 (observation discharge day), or 99234-99236 (observation or inpatient care)

The G code (Post discharge transitional care management) would have the following elements:

- Communication (direct contact, telephone, electronic) with the patient or caregiver within 2 business days of discharge.
- Medical decision making of moderate or high complexity during the service period.
- To be eligible to bill the service, physicians or qualified non-physician practitioners must have had a face-to-face E/M visit with the patient in the 30 days prior to the transition in care or within 14 business days following the transition in care.

CMS proposes that a physician or qualified non-physician practitioner who bills for discharge management during the time period covered by the transitional care management services code may not also bill for HCPCS code GXXX1. The CPT discharge management codes are 99217, 99234-99236, 99238-99239, 99281-99285, or 99315-99316, home health care plan oversight services (HCPCS code G0181), or hospice care plan oversight services (HCPCS code G0182). CMS believes these codes describe care management services for which Medicare makes separate payment and should not be billed in conjunction with GXXX1, which is a comprehensive post-discharge transitional care management service.

Further, CMS proposes that a physician or qualified non-physician practitioner billing for a procedure with a 10- or 90-day global period would not also bill HCPCS code GXXX1 in conjunction with that procedure because any follow-up care management would be included in the post-operative portion of the global period. Many of the global surgical packages include discharge management codes. CMS believes that any physician or qualified non-physician practitioner billing separately for the discharge management code that also is the community physician or non-physician practitioner for the beneficiary would be paid for post-discharge transitional care management through the discharge management code.

To establish a physician work relative value unit (RVU) for the proposed post-discharge transitional care management, HCPCS code GXXX1, CMS compared GXXX1 with CPT code 99238 (Hospital discharge day management; 30 minutes or less) (work RVU = 1.28). CMS recognizes that, unlike CPT code 99238, HCPCS code GXXX1 is not a face-to-face visit. However, the agency believes that the physician time and intensity involved in post-discharge community care management is
most equivalent to CPT code 99238 which, like the proposed new G-code, involves a significant number of care management services. Therefore, CMS proposes a work RVU of 1.28 for HCPCS code GXXX1 for CY 2013. CMS also proposes the following physician times: 8 minutes pre-evaluation; 20 minutes intra-service; and 10 minutes immediate post-service.

According to CMS, this care coordination will become increasingly important as Medicare implements the Readmissions Reduction Program beginning Oct. 1, 2012. This program, which was mandated by the Affordable Care Act, reduces payment to hospitals when they have excess readmissions for certain conditions.

Payment for the post-discharge transition care management services (transitional care) will have a negative impact on all non-primary care specialties due to the application of the budget neutrality adjustment to reflect the new payment policy (reflected on page 683, table 84).

**Potentially Misvalued Codes:** According to CMS, more than 1,000 misvalued codes have been identified and within CY 2012 the agency “intends to enter into a contract to assist us in validating RVUs of potentially misvalued codes that will explore a model for the validation of physician work under the physician fee schedule, both for new and existing services.” Of the identified codes, 650 are surgical and CMS has completed a review of 450 of those codes. In addition, 36 codes were publicly nominated as potentially misvalued.

CMS seeks comments on methods of obtaining accurate and current data on E/M services furnished as part of a global surgical package. The agency invites comments on “a claims-based data collection approach that would include reporting E/M services furnished as part of a global surgical package, as well as other valid, reliable, generalizable, and robust data to help us identify the number and level of E/M services typically furnished in the global surgical period for specific procedures.”

In addition to reviewing publicly nominated codes, CMS proposes two new categories of potentially misvalued codes for review: “Harvard-valued” CPT codes with Medicare annual allowed charges of $10 million or more; and services with stand alone practice expense procedure times. Within this latter category of codes, CMS proposes to reduce the procedure time assumptions used in developing RVUs for intensity modulated radiation treatment (IMRT) delivery and stereotactic body radiation therapy (SBRT) delivery, which would more accurately pay for these radiation therapy services.

**Interest Rate Assumptions:** CMS proposes to revise interest rate assumptions used to establish payment for practice expense from 11 percent to a range from 5.5 to 8 percent based on the Small Business Administration maximum interest rates for different categories of loan size (equipment cost) and maturity (equipment useful life).

**Multiple Procedure Payment Reduction Policy:** CMS proposes 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 by 25 percent.
DME Face-to-Face: CMS proposes to implement a face-to-face requirement as a condition of payment for certain high-cost DME covered items. This list includes many items that have been historically targets of Medicare fraud as identified by the OIG, MACs, GAO, and the HEAT Strike Forces. According to CMS,

the requirement is one of the anti-fraud provisions in the Affordable Care Act and is consistent with similar face-to-face requirements for the Medicare home health and Medicaid DME benefit.

According to CMS, “as a condition of payment for certain covered items of DME, a physician must have documented and communicated to the DME supplier that the physician or a PA, an NP, or a CNS has had a face-to-face encounter with the beneficiary no more than 90 days before the order is written or within 30 days after the order is written.”

CMS proposes that when the face-to-face encounter is performed by a physician, the submission of the pertinent portion(s) of the beneficiary’s medical record, containing sufficient information to document that the face-to-face encounter meets CMS requirements, would be considered sufficient and valid documentation of the face-to-face encounter when submitted to the supplier and made available to CMS or its agents upon request.

Some examples of pertinent parts of the beneficiary's medical record that can demonstrate that a face-to-face encounter has occurred can include: history; physical examination; diagnostic tests; summary of findings; diagnoses; treatment plans; or other information as appropriate. As an alternative, CMS is requesting comments on a second option for physicians to document the face-to-face encounter when it is performed by the physician, by requiring this physician documentation to be identical to what is required for a PA, a NP, or a CNS. CMS states that they “strive to find the option that strikes a balance between minimizing the effect on physicians, while still meeting the statutory objective to limit fraud, waste, and abuse.”

CMS proposes the introduction of a G-code, estimated at $15, to compensate a physician who documented that a physician assistant, a nurse practitioner, or a clinical nurse specialist practitioner has performed a face-to-face encounter for the list of specified covered items. Only a physician who does not bill an E/M code for the beneficiary in question would be eligible for this G-code.

Elimination of Prepayment Medical Review Limitation: Pursuant to the Affordable Care Act, CMS proposes to remove a limitation placed on contractors to continue complex prepayment medical review if a provider or supplier has failed to reduce its individual error rate.

Payment for Molecular Pathology Services: CMS invites comments on whether newly created molecular pathology CPT codes should be paid under the MPFS or the Clinical Laboratory Fee Schedule (CLFS). If CMS determines that new molecular pathology CPT codes should be paid under the MPFS for CY 2013, CMS proposes that Medicare contractors would price these codes because the price of tests can vary locally and because this would allow more time for CMS to gather information on these codes to price them nationally.

Telehealth Services: CMS proposes to add a series of preventive services to the list of Medicare telehealth services for CY 2013. These include: annual alcohol misuse screening, brief behavioral counseling for alcohol misuse, annual face-to-face intensive behavioral therapy for cardiovascular
According to CMS, all coverage guidelines continue to apply when these services are furnished via telehealth, and “…when the national coverage determination requires that the service be furnished to beneficiaries in a primary care setting, the qualifying originating telehealth site must also qualify as a primary care setting. Similarly, when the national coverage determination requires that the service be furnished by a primary care practitioner, the qualifying primary distant site practitioner must also qualify as primary care practitioner.”

**Therapy Data Collection:** As required by the Middle Class Tax Relief and Jobs Creation Act of 2012, CMS proposes to implement a claims-based data collection process for therapy services to gather data about patient function and condition. Under the proposal, therapists will be required to include new codes and modifiers on claims for therapy services that will not affect payment, but will convey information about patients’ functional limitations at the outset of therapy, periodically throughout therapy, and at discharge from therapy. Information on therapist-established patient goals will also be collected under this proposal. Proposed frequency of reporting is consistent with existing requirements for therapy progress notes. This system is proposed to be implemented on January 1, 2013. After a six-month testing period, CMS proposes not to process any claims that do not contain the required information for dates of service beginning July 1, 2013. The data collected will be used primarily to design a new payment system for therapy services.

**Removing Barriers to Midlevel Providers:** CMS proposes to revise the conditions of coverage and payment regulations to allow nonphysician practitioners (NPPs) and limited-license physicians to order portable x-ray services within the scope of their Medicare benefit and state scope of practice laws. Currently, CMS regulations limit ordering of portable x-ray services to a doctor of medicine or osteopathy. In addition, CMS proposes to clarify that “anesthesia and related care” for purposes of the CRNA benefit means services related to anesthesia that are within the state scope of practice for CRNAs in the state in which the services are furnished.

**PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)**
Beginning in 2015, a payment adjustment applies to Eligible Professionals (EPs) who do not satisfactorily report data on quality measures for covered professional services. For purposes of this program, EPs are identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN). In the CY 2013 MPFS proposed rule, CMS proposes the following updates to the PQRS related to the 2013 and 2014 PQRS incentives and the 2015 and 2016 PQRS payment adjustments:

**Summary of Proposed PQRS Measures:** Over CYs 2013 and 2014, CMS proposes to include a total of 264 individual measures that EPs can choose from, including 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 proposes to include 26 measures groups for reporting. With respect to proposed measures for reporting via the Group Practice Reporting Option (GPRO) web-interface, CMS proposes to align these measures with the measures required under the Medicare Shared Savings Program.
Reporting PQRS Measures as Individual EPs:
• Reporting PQRS Measures for the 2013 and 2014 PQRS Incentive: CMS proposes criteria similar to the criteria for satisfactory reporting for the 2012 incentive. Notable proposed changes include:
  • Criteria for reporting using the EHR-based reporting mechanism that would align with the proposed reporting criteria for meeting the clinical quality measure (CQM) component of meaningful use for the Medicare EHR Incentive Program.
  • For the proposed 12-month 2013 and/or 2014 incentive reporting period, decrease 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, propose the following criteria for satisfactory reporting for the 2015 and/or 2016 payment adjustments: Report 1 PQRS measure or measures group.
  • Propose option to elect using the proposed administrative claims-based reporting option for proposed set of administrative claims-based measures.

Reporting PQRS Measures as a Group Practice under the Group Practice Reporting Option (GPRO):
• Definition: CMS proposes 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 proposes to expand the use of the claims, registry, and EHR-based reporting mechanisms to groups of 2-99 EPs, in addition to groups of 25 or more EPs.
  • CMS proposes to use an assignment methodology similar to the one used under the Medicare Shared Savings Program for groups that report using the GPRO web-interface.

• Reporting PQRS Measures for the 2015 and 2016 PQRS Payment Adjustments:
  • CMS proposes to allow group practices to elect using the proposed administrative claims-based reporting option.

• Medicare Shared Savings Program:
  • CMS proposes 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.

ELECTRONIC PRESCRIBING INCENTIVE PROGRAM
For purposes of this program, EPs are identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN). The requirements for the 2013 eRx incentive and 2014 eRx payment adjustment were established in the CY 2012 MPFS final rule with comment period. In the CY 2013 proposed rule:
• CMS proposes new criteria for being a successful electronic prescriber for groups of 2-24 EPs using the eRx GPRO

• CMS proposes two additional significant hardship exemptions to the 2013 and 2014 payment adjustments related to participation in the EHR Incentive Program: 1) Eligible professionals or group practices who achieve meaningful use during certain eRx payment adjustment reporting periods; 2) Eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology.

• CMS proposes to establish an informal review process

**PQRS-Medicare Electronic Health Records (EHR) Incentive Pilot**
Under the CY 2013 MPFS proposed rule, CMS proposes to continue for CY 2013 the attestation method and the Physician Quality Reporting System-Medicare EHR Incentive Pilot for reporting CQMs that was established in the CY 2012 MPFS final rule with comment period.

**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. In the 2012 MPFS 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 MPFS proposed rule outlines the next phase of the plan to publicly report physician performance information on Physician Compare. In this next phase, CMS proposes to 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 also proposes to 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 MPFS proposed 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).

**Value Modifier for Services Paid Under the MPFS**
According to CMS, the value-based payment modifier will help transform Medicare from a passive payer to an active purchaser of higher quality, more efficient care. Only group practices of 25 or more physicians would be subject to the value modifier in 2015, and that the maximum penalty would not exceed 1 percent for that year. The ACA requires Medicare to apply the value modifier to all physicians by 2017.

CMS intends to base the value modifier in 2015 on physician performance in 2013. CMS proposes that group practices of 25 physicians or more simply need to successfully report quality measures in
PQRS in 2013. Groups that comply with PQRS would have their value modifier automatically set at 0.0%. Their fee-for-service rates would go neither up nor down.

CMS also would give PQRS-compliant groups an option with a potential for gain or loss. They could ask CMS to grade them on the basis of quality and cost, which would result in either a value-modifier bonus or penalty. At this point CMS has not proposed a specific bonus because due to budget neutrality, the positive adjustments would be offset by negative adjustments to other groups and the total sum of the negative adjustments is unknown at this time.

However, for groups of 25 physicians or more that do not satisfy PQRS reporting requirements in 2013, including groups that do not report to the program at all, the value modifier would be set at -1% in 2015. That Medicare pay cut would come on top of the −1.5% penalty in 2015 for not successfully participating in PQRS. The net effect would be a 2.5% reduction, all because a group either skipped PQRS or did not participate successfully in the eyes of CMS.

CMS’ proposals are also designed to align with other CMS quality initiatives to reduce the burden of submitting information, and promote shared physician accountability for beneficiaries.

Proposed Performance Period
CMS previously established CY 2013 as the performance period for the determination of the Value Modifier to be applied in CY 2015 and proposes to use CY 2014 as the performance period for the Value Modifier to be applied in CY 2016. CMS proposes to apply the Value Modifier at the Tax Identification Number (TIN) level to items and services paid under the MPFS to physicians under that TIN. This means that if a physician moves from one group to another between the performance period (2013) and the payment adjustment period (2015), the physician’s payment will be adjusted based on the Value Modifier earned by the TIN where the physician is practicing in 2015.

Proposals for Measuring Quality of Care and Cost in the Value Modifier
The law requires CMS to measure quality of care furnished as compared to cost using composites of appropriate quality and cost measures. In the MPFS final rule for CY 2012, CMS adopted both a total per capita cost measure for all beneficiaries, as well as four total per capita cost measures for beneficiaries with certain chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes) to be used under the Value Modifier.

To obtain the quality data, CMS proposes that groups of physicians with 25 or more eligible professionals satisfactorily submit data using one of the proposed PQRS quality reporting mechanisms for groups of physicians: (1) a common set of quality measures based on clinical data and that focus on preventive care and care for prevalent and costly chronic conditions in the Medicare population; (2) quality measures of their own selection that they report through claims, registries, or EHRs, or (3) a common set of quality measures that focus on preventive care and care for chronic conditions that CMS would calculate from administrative claims data that require no action for the physician group beyond notifying CMS that the group elects this option.

Additionally, CMS proposes to assess each such group of physicians with 25 or more eligible professionals on quality measures relating to reducing potentially preventable hospital admissions for
specific chronic and acute conditions, reducing hospital readmission rates, and increasing the frequency of hospital post-discharge visits.

To balance the goals of beginning the implementation of the Value Modifier in a way that is consistent with the legislative requirements and to give CMS and the physician community experience in its operation, CMS proposes to separate groups of physicians into two categories. The first category would include those groups of physicians that have met the criteria for satisfactory reporting for an incentive under the options available to groups of physicians under the PQRS Group Practice Reporting Option. In addition, this category includes groups that elect the new PQRS administrative claims-based reporting option. CMS proposes to set the Value Modifier at 0.0 percent for these groups of physicians, meaning that the Value Modifier would not affect their payments under the MPFS, unless such groups of physicians elect the further evaluation of quality and cost of care described below.

CMS proposes to provide groups of physicians that are satisfactory PQRS reporters with the choice of having their value-based payment modifier calculated using a quality tiering approach. Choosing this option would allow these groups of physicians to earn an upward payment adjustment for high performance (high-quality tier and low-cost tier), and be at risk for a downward payment adjustment for poor performance (low-quality tier and high-cost tier). In 2013, CMS will provide Physician Feedback reports to groups of physicians with 25 or more eligible professionals that preview their Value Modifier (based on 2012 data), prior to the deadline for electing the quality-tiering approach.

The second proposed category would include those groups of physicians with 25 or more eligible professionals that have not met the PQRS satisfactory reporting criteria identified above, including those groups that do not submit any data on quality measures. Because CMS would not have quality measure performance rates on which to assess the quality of care furnished by these groups of physicians, CMS proposes to set their Value Modifier at -1.0 percent. This downward payment adjustment for the 2015 Value Modifier would be in addition to the -1.5 percent payment adjustment that is required under the PQRS for failing to meet the satisfactory reporting criteria. Groups of physicians with 25 or more eligible professionals that fail to meet the PQRS satisfactory reporting criteria would, therefore, be subject to downward adjustments during 2015 of 1.5 percent (for not being a satisfactory reporter under the PQRS) and 1.0 percent (for the Value Modifier). See CMS chart below:

**Physician Feedback Reports**
Since 2010, CMS has provided confidential Physician Feedback reports to certain physicians and groups of physicians. The reports quantify and compare the quality of care furnished and costs among physicians and physician group practices, relative to the performance of their peers. Starting
in 2013, CMS anticipates using these reports to inform groups of physicians about their Value Modifier score.

In September 2011, CMS provided Physician Feedback reports (also known as “Quality and Resource Use Reports”) to the 35 large medical group practices (each with 200 or more physicians) that participated in the Physician Quality Reporting System Group Practice Reporting Option in 2010. In March 2012, CMS disseminated feedback reports to 23,730 individual Medicare fee-for-service physicians in Iowa, Kansas, Missouri, and Nebraska. The individual physician reports, in summary, showed that approximately 20 percent of beneficiaries received care from multiple physicians without a single physician directing their overall care, based on proportion of visits or costs. These beneficiaries were also the highest risk and highest cost populations. CMS believes the proposals for the Value Modifier encourage high quality and less fragmented care for these beneficiaries.

CMS intends to include episode-based cost measures for several conditions in the Physician Feedback reports. CMS is studying how “episode groupers” that would connect all claims for a beneficiary during a certain timeframe may be used in the reports and will seek input from stakeholders on the development and use of episode groupers before phasing these measures into the Value Modifier.

Public Comments
The proposed rule will appear in the July 30, 2012 Federal Register. CMS will accept comments on the proposed rule until Sep. 04, 2012, and will respond to them in a final rule with comment period to be issued by Nov. 1, 2012.

For more information, see: