Issue Brief

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KEY POINTS

The rule contains many changes, including, but not limited to:

- PFS telehealth services
- Phase-in of significant RVU reductions
- FQHR revisions
- Medicare Part C and D medical loss ratio data

CMS Finalizes Changes to the PFS and Other Part B Services for CY 2017

The Centers for Medicare and Medicaid Services issued a final rule regarding revisions to payment policies and payment rates under the Medicare Physician Fee Schedule for calendar year 2017. A copy of the 1,401 page document is available on the *Federal Register* website at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-26668.pdf.

The rule is scheduled for publication on November 15. The above link will change upon publication.

In addition, the rule includes provisions regarding: payment policy changes for Rural Health Clinics and Federally Qualified Health Centers; expansion of the Medicare Diabetes Prevention Program model; policy changes related to the Medicare Shared Savings Program; and release of pricing data submitted to CMS by Medicare Advantage organizations; and medical loss ratio reports submitted by MA plans and Part D plans.

The PFS Addenda along with other supporting documents and tables referenced are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFSFederal-Regulation-Notices.html. Click on the link on the left side of the screen titled, "PFS Federal Regulations Notices" for a chronological list of PFS *Federal Register* and other related documents. For the final CY 2017 PFS Rule, refer to item CMS-1654-F.

As in the proposed rule, CMS' table of contents basically divides the subject matter into two major categories – provisions for the physician fee schedule and other items.

The PFS material encompass the following:

- Determination of Practice Expense Relative Value Units
- Determination of Malpractice Relative Value Units
- Medicare Telehealth Services
- Potentially Misvalued Services Under the Physician Fee Schedule
- Improving Payment Accuracy for Primary Care, Care Management Services, and Patient-Centered Services
- Improving Payment Accuracy for Preventive Services: Diabetes Self-Management Training
- Target for Relative Value Adjustments for Misvalued Services

continued

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MISSOURI HOSPITAL ASSOCIATION

- Phase-In of Significant RVU Reductions
- Geographic Practice Cost Indices
- Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services
- Procedures Subject to the Multiple Procedure Payment Reduction (MPPR) and the OPPS Cap
- Valuation of Specific Codes
- Therapy Caps

The remaining subject areas for the Other Items are:

- Chronic Care Management and Transitional Care Management Health Centers
- FQHC-Specific Marketbasket
- Appropriate Use Criteria for Advanced Diagnostic Imaging Services
- Reports of Payments or Other Transfers of Value to Covered Recipients: Solicitation of Public Comments
- Release of Part C Medicare Advantage Bid Pricing Data and Part C and Part D Medical Loss Ratio Data
- Prohibition on Billing Qualified Medicare Beneficiary Individuals for Medicare Cost-Sharing
- Recoupment or Offset of Payments to Providers Sharing the Same Taxpayer Identification Number
- Accountable Care Organization Participants Who Report Physician Quality Reporting System Quality Measures Separately
- Medicare Advantage Provider Enrollment
- Proposed Expansion of the Diabetes Prevention Program Model
- Medicare Shared Savings Program
- Value-Based Payment Modifier and Physician Feedback Program
- Physician Self-Referral Updates
- Designated Health Services

COMMENT

As always, the PFS rule is a long, complex and detailed document. This version is 1,401 versus the proposed rule at 856 pages. Again, there is much history, perhaps much, too much, history, being repeated in numerous sections.

While the statute mandates a 0.5 percent increase in physician payments, other items are offsetting the increase. Further, there are numerous changes to the Resource Based Relative Values (RVUs) that have an impact on specific services and specialty groups.

Most material does not easily identify the changes being made.

This and most CMS rulemaking need a major overhaul in presentation format. In this rule, for example, there is much discussions about items that CMS is not acting or making changes. Such information just detracts and clouds the issues being changed. Focus needs to be on changes being made within clearly identified sections.

CONVERSION FACTORS

To calculate the conversion factor for this year, CMS says it multiplies the product of the current year (CY 2016) conversion factor and updates as noted in the table below.

continued

Conversion Factor in Effect in CY 2016		35.8043
Update Factor	0.50 percent (1.0050)	
CY 2017 RVU Budget Neutrality Adjustment	-0.013 percent (0.99987)	
CY 2017 Target Recapture Amount	-0.18 percent (0.9982)	
CY 2017 Imaging MPPR Adjustment	-0.07 percent (0.9993)	
CY 2017 Conversion Factor		35.8887

The CY 2017 anesthesia conversion factor is as follows:

CY 2016 National Average Anesthesia Conversion Factor		21.9935
Update Factor	0.50 percent (1.0050)	
CY 2017 RVU Budget Neutrality Adjustment	-0.013 percent (0.99987)	
CY 2017 Target Recapture Amount	-0.18 percent (0.9982)	
CY 2017 Imaging MPPR Adjustment	-0.07 percent (0.9993)	
CY 2017 Conversion Factor		22.0454

I. PROVISIONS OF THE RULE

Determination of Practice Expense Relative Value Units

Practice expense is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding malpractice expenses.

This is an area that appears under constant updating and change. The following are some of the items CMS is adding to the overall PE cost base.

(1) PE Inputs for Digital Imaging Services

CMS will finalize its proposal to add a professional PACS workstation (ED053) to the equipment database and price it at the proposed rate of $14,616.93

The rule's Table 4 contains the full list of affected codes.

(2) Standardization of Clinical Labor Tasks

CMS is finalizing a range of appropriate standard minutes for the clinical labor activity, "Technologist QCs images in PACS, checking for all images, reformats, and dose page" as follows: simple (2 min); intermediate (3 min), complex (4 min) and highly complex (5 min). CMS is also finalizing its criteria for determining the simple and intermediate categories as proposed.

(3) Equipment Recommendations for Scope Systems

CMS is averaging the price of the digital capture device at $18,346.00. CMS will add this into the overall cost of the endoscopy video system. CMS is finalizing the price of the

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endoscopy video system at $33,391.00, based on component prices of $9,000.00 for the processor, $18,346.00 for the digital capture device, $2,000.00 for the monitor, $2,295.00 for the printer, and $1,750.00 for the cart.

(4) Restoration of Inputs

CMS is finalizing its proposal to add the fiberoptic headlight (EQ170) to CPT codes 30300, 31295, 31296, 31297, and 92511 at the same number of equipment minutes as the xenon light (EQ167).

The PE RVUs are displayed in Addendum B on the CMS website.

B. Determination of Malpractice Relative Value Units

CMS is not proposing any changes with respect to the malpractice inputs.

C. Medicare Telehealth Services

For the list of telehealth services, see the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

CMS proposed to add the following services to the telehealth list on a category 1 basis for CY 2017:

CPT codes:

- 90967 (End-stage renal disease related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age;
- 90968 (End-stage renal disease related services for dialysis less than a full month of service, per day; for patients 2-11 years of age;
- 90969 (End-stage renal disease related services for dialysis less than a full month of service, per day; for patients 12-19 years of age); and
- 90970 (End-stage renal disease related services for dialysis less than a full month of service, per day; for patients 20 years of age and older).

Two advance care planning service codes:

- CPT code 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), or surrogate); and
- CPT code 99498 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)).

Critical care consultation codes:

- Telehealth Consultations for a Patient Requiring Critical Care Services (G0508 and G0509)

CMS is finalizing its proposal to add these services to the list of Medicare telehealth services for CY 2017 on a category 1 basis.

CMS is also finalizing its proposal to use the place of service code for telehealth and to use the facility PE RVUs to pay for telehealth service reported by physicians or practitioners with the telehealth POS code for CY 2017. CMS says it has updated the POS code list at

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https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html to include POS 02: Telehealth (Descriptor: The location where health services and health related services are provided or received, through telecommunication technology). The new code will be used for services furnished on or after January 1, 2017.

COMMENT

In today's ever growing electronics' world, the use of telehealth seems to be a fascinating and a positive means of helping beneficiaries. Yet, CMS appears very reluctant to expand this delivery vehicle. Instead, CMS spend most of the discussion – some 35 pages as to items it has rejected that could be beneficial. Some of the material presented goes back to 2002.

D. Potentially Misvalued Services Under the Physician Fee Schedule

Section 1848(c)(2)(K) of the Act 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.

CMS says it is finalizing the data collection strategy that significantly reduces the burden on practitioners compared to the proposed rule by:

- Requiring reporting of post-operative visits only for high-volume/high-cost procedures
- Using existing CPT code 99024 instead of the proposed G-codes.
- Requiring reporting only from a sample of practitioners consisting of those in larger practices (10 or more practitioners) in specified states, and
- Allowing all others to report voluntarily.

While practitioners are encouraged to begin reporting post-operative visits for procedures furnished on or after January 1, 2017, the requirement to report will be effective for services related to global procedures furnished on or after July 1, 2017. To the extent that these data result in proposals to revalue any global packages, that revaluation will be done through notice and comment rulemaking at a future time.

CMS will require data for procedures furnished on or after July 1, 2017, from practitioners, who practice in practices that includes of 10 or more practitioners, in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island.

CMS has noted that several high volume procedure codes currently valued with routine visits as part of the global package are typically reported with a modifier (Modifier 25) that allows separate payment for visits, even though the modifier should only be used for reporting services beyond those usually provided. Therefore, CMS believes the services may be misvalued. As a result, CMS is prioritizing 19 services for review as potentially misvalued and intends to investigate this policy concern in future rulemaking.

Valuation of Moderate Sedation Services

CMS is finalizing values for the new CPT moderate sedation codes and adopting a uniform methodology for valuation of the procedural codes that currently include moderate sedation as an inherent part of the procedure. CMS is also augmenting the new moderate sedation CPT codes with an endoscopy-specific moderate sedation code, and finalizing valuations reflecting the differences in physician survey data between gastroenterology and other specialties.

continued

COMMENT

This section is nearly 100 pages. It contains much redundancy making it more complex than it needed to be. Simply said, CMS could have said that its efforts to determine misvalued services regarding global it is going to collect CPT 99024 information from certain practitioners in nine states.

E. Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services

CMS notes that historically, care management and cognitive work has been "bundled" into the evaluation and management visit codes used by all specialties. This has meant that payment for these services has been distributed equally among all specialties that report the visit codes, instead of being targeted toward practitioners who manage care and/or primarily provide cognitive services.

CMS is finalizing a number of coding and payment changes to better identify and value primary care, care management, and cognitive services as follows:

- Make separate payments for certain existing Current Procedural Terminology codes describing non-face-to-face prolonged evaluation and management services.
- Revalue existing CPT codes describing face-to-face prolonged services.
- Make separate payments using a new code to describe the comprehensive assessment and care planning for patients with cognitive impairment (e.g., dementia).
- Make separate payments using new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions. Several of these codes describe services within behavioral health integration models of care, including the Psychiatric Collaborative Care Model that involves care coordination between a psychiatric consultant or behavioral health specialist, behavioral health care manager, and the primary care clinician, which has been shown to improve quality of care.
- Make separate payments for codes describing chronic care management for patients with greater complexity.
- Make several changes to reduce administrative burden associated with the chronic care management codes to remove potential barriers to furnishing and billing for these important services.

COMMENT

This section encompasses more than 120 pages. The material is not very clear and nor concise. Many issues address items from years past. While there are many new codes, there is simply too much detailed information to convey in this limited space.

F. Improving Payment Accuracy for Services: Diabetes Self-Management Training

DSMT includes, as applicable, instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the new skills for self-management (see §410.144(a)(5)). DSMT services are reported under HCPCS codes G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) and G0109 (Diabetes outpatient self- management training services, group session (2 or more), per 30 minutes).

While CMS addresses the issue, it appears that CMS is not making any changes regarding accuracy.

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G. Target for Relative Value Adjustments for Misvalued Services

Section 1848(c)(2)(O) of the Act establishes an annual target for reductions in PFS expenditures resulting from adjustments to relative values of misvalued codes. The target that applies to calendar years (CYs) 2017 and 2018 is calculated as 0.5 percent of the estimated amount of expenditures under the PFS for the year.

CMS estimates the CY 2017 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.32 percent. Since this amount does not meet the 0.5 percent target established by the Achieving a Better Life Experience Act of 2014, payments under the fee schedule must be reduced by the difference between the target for the year and the estimated net reduction in expenditures, known as the target recapture amount. As a result, CMS estimates that the CY 2017 target recapture amount will produce a reduction to the conversion factor of -0.18 percent. This amount is reflected in the conversion factors as shown above.

COMMENT

For a relatively short section, the material is confusing to say the least. The real impact and adjustment amounts is found in the regulatory analysis section.

H. Phase-in of Significant RVU Reductions

Section 1848(c)(7) of the Act specifies that for services that are not new or revised codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year, the applicable adjustments in work, PE, and MP RVUs shall be phased in over a 2-year period.

CMS proposed, and is adopting, a policy that it would make a maximum reduction of 19 percent in total one-year reduction for all codes (except those considered new and revised), including those codes with phase-in values in the previous year. In other words, for purposes of the 20 percent threshold, every service is evaluated anew each year, and any applicable phase-in is limited to a decrease of 19 percent. For example, if CMS were to adopt a 50 percent reduction in total RVUs for an individual service, the reduction in any particular year would be limited to a decrease of 19 percent in total RVUs.

I. Geographic Practice Cost Indices

Section 1848(e)(1)(A) of the Act requires CMS to develop separate Geographic Practice Cost Indices to measure relative cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, PE, and malpractice).

CMS has completed a review of the GPCIs. CMS will continue to use the current cost share weights for determining the PE GPCI values and locality GAFs for CY 2017.

continued

Expense Category	Current Cost Share Weight	CY 2017 Cost Share Weight
Work	50.866%	50.866%
Practice Expense	44.839%	44.839%
-- Employee Compensation	*16.553%*	*16.553%*
-- Office Rent	*10.223%*	*10.223%*
-- Purchased Services	*8.095%*	*8.095%*
-- Equipment, Supplies, Other	*9.968%*	*9.968%*
Malpractice Insurance	4.295%	4.295%
Total	100.000%	100.000%

There will be no changes in the states identified as Frontier States for CY 2017. The qualifying states are: Montana, Wyoming, North Dakota, South Dakota, and Nevada. In accordance with statute, CMS will apply a 1.0 PE GPCI floor for these states in CY 2017.

The final CY 2017 updated GPCIs are displayed in Addenda D and E at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

There are currently 89 total PFS localities; 34 localities are statewide areas (that is, only one locality for the entire state).

Beginning in CY 2017, section 1848(e)(6)(A)(i) of the Act requires that the fee schedule areas used for payment in California must be Metropolitan Statistical Areas as defined by the Office of Management and Budget as of December 31 of the previous year; and section 1848(e)(6)(A)(ii) of the Act requires that all areas not located in an MSA must be treated as a single rest-of-state fee schedule area. The resulting modifications to California's locality structure will increase its number of localities from nine to 27.

Section 1848(e)(6)(B) specifies that the GPCI values used for payment in a transition area are to be phased in over 6 years, from 2017 through 2021. There are a total of 58 counties in California, 50 of which are in transition areas as defined in section 1848(e)(6)(D) of the Act. Therefore, the GPCIs for the eight counties under the MSA-based locality structure may be less than they would have been under the current GPCI structure. The eight counties that are not within transition areas are: Orange; Los Angeles; Alameda; Contra Costa; San Francisco; San Mateo; Santa Clara; and Ventura counties.

J. Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services

Effective for services furnished beginning January 1, 2017, section 1848(b)(9)(A) of the Act reduces by 20 percent the payment amounts under the PFS for the technical component (including the TC portion of a global service) of imaging services that are X-rays taken using film.

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CMS is establishing a new modifier (modifier "FX"). The use of this modifier to indicate an X-ray taken using film will result in a 20-percent reduction of the X-ray service.

K. Procedures Subject to the Multiple Procedure Payment Reduction and the OPPS Cap

Effective January 1, 2012, CMS implemented an MPPR of 25 percent on the professional component of advanced imaging services.

Section 502(a)(2)(A) of the Consolidated Appropriations Act of 2016 added a new section 1848(b)(10) of the Act which revises the payment reduction from 25 percent to 5 percent, effective January 1, 2017.

L. Valuation of Specific Codes

CMS notes that establishing valuations for newly created and revised CPT codes is a routine part of maintaining the PFS.

COMMENT

This is a long section comprising nearly 400 pages. CMS discusses its valuation changes to specific codes as shown below.

[Note the page numbers provided below are from the display copy of the rule. Each is the staring page of the subject matter. Page numbers will change upon publication in the Federal Register]

Valuation of Specific Codes		
1	Anesthesia Services Furnished in Conjunction with Lower Gastrointestinal (GI) Procedures (CPT codes 00740 and 00810)	417
2	Soft Tissue Localization (CPT codes 10035 and 10036)	418
3	Removal of Nail Plate (CPT code 11730)	419
4	Bone Biopsy Excisional (CPT code 20245)	422
5	Insertion of Spinal Stability Distractive Device (CPT codes 228X1, 228X2, 228X4, and 228X5)	423
6	Biomechanical Device Insertion (CPT codes 22853, 22854, and 22859)	425
7	Repair Flexor Tendon (CPT codes 26356, 26357, and 26358)	428
8	Closed Treatment of Pelvic Ring Fracture (CPT codes 27197 and 27198)	431
9	Bunionectomy (CPT codes 28289, 28291, 28292, 28295, 28296, 28297, 28298, and 28299)	434
10	Endotracheal Intubation (CPT code 31500)	436
11	Flexible Laryngoscopy (CPT codes 31572, 31573, 31574, 31575, 31576, 31577, 31578, and 31579)	437
12	Laryngoplasty (CPT codes 31580, 31584, 31587, 31551-31554, 31591, and 31592)	444
13	Closure of Left Atrial Appendage with Endocardial Implant (CPT code 33340)	447
14	Valvuloplasty (CPT codes 33390 and 33391)	448
15	Mechanochemical Vein Ablation (MOCA) (CPT codes 36473 and 36474)	450
16	Dialysis Circuit (CPT codes 36901, 36902, 36903, 36904, 36905, 36906, 36907, 36908, 36909)	452
17	Open and Percutaneous Transluminal Angioplasty (CPT codes 37246, 37247, 37248, and 37249)	476

Valuation of Specific Codes		
18	Esophagogastric Fundoplasty Trans-Oral Approach (CPT code 43210)	480
19	Esophageal Sphincter Augmentation (CPT codes 43284 and 43285)	482
20	Percutaneous Biliary Procedures Bundling (CPT codes 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540, 47541, 47542, 47543, and 47544)	484
21	Percutaneous Image Guided Sclerotherapy (CPT code 49185)	490
22	Genitourinary Procedures (CPT codes 50606, 50705, and 50706)	493
23	Electromyography Studies (CPT code 51784)	498
24	Cystourethroscopy (CPT code 52000)	500
25	Biopsy of Prostate (CPT code 55700)	501
26	Laparoscopic Radical Prostatectomy (CPT code 55866)	502
27	Hysteroscopy (CPT codes 58555, 58558, 58559, 58560, 58561, 58562, and 58563)	507
28	Intracranial Endovascular Intervention (CPT codes 61645, 61650, and 61651)	512
29	Epidural Injections (CPT codes 62320, 62321, 62322, 62323, 62324, 62325, 62326, and 62327)	516
30	Endoscopic Decompression of Spinal Cord (CPT code 62380)	517
31	Paravertebral Block Injection (CPT codes 64461, 64462, and 64463)	520
32	Implantation of Neuroelectrodes (CPT codes 64553 and 64555)	521
33	Ocular Reconstruction Transplant (CPT Code 65780)	523
34	Trabeculoplasty by Laser Surgery (CPT Code 65855)	524
35	Glaucoma Surgery (CPT codes 66170 and 66172)	526
36	Retinal Detachment Repair (CPT codes 67101, 67105, 67107, 67108, 67110, and 67113)	528
37	Fetal MRI (74712 and 74713)	532
38	Abdominal Aortic Ultrasound Screening (CPT code 76706)	532
39	Fluoroscopic Guidance (CPT codes 77001, 77002, and 77003)	534
40	Mammography - Computer Aided Detection Bundling (CPT codes 77065, 77066 and 77067)	536
41	Radiation Treatment Devices (CPT codes 77332, 77333, and 77334)	545
42	Special Radiation Treatment (CPT code 77470)	548
43	Interstitial Radiation Source Codes (CPT codes 77778 and 77790)	550
44	Interstitial Radiation Source Codes (CPT codes 77778 and 77790)	553
45	Cytopathology Fluids, Washings or Brushings and Cytopathology Smears, Screening, and Interpretation (CPT codes 88104, 88106, 88108, 88112, 88160, 88161, and 88162)	554
46	Flow Cytometry Interpretation (CPT codes 88184, 88185, 88187, 88188, and 88189)	557
47	Microslide Consultation (CPT codes 88321, 88323, and 88325)	575
48	Immunohistochemistry (CPT Codes 88341, 88342, 88344, and 88350)	579
49	Morphometric Analysis (CPT Codes 88364, 88365, 88367, 88368, 88369 and 88373)	583
50	Liver Elastography (CPT code 91200)	587
51	Closure of Paravalvular Leak (CPT codes 93590, 93591, and 93592)	590
52	Electroencephalogram (EEG) (CPT codes 95812, 95813, and 95957)	592
53	Analysis of Neurostimulator Pulse Generator System (CPT codes 95971, 95972)	593
54	Patient, Caregiver-focused Health Risk Assessment (CPT codes 96160 and 96161)	593
55	Reflectance Confocal Microscopy (CPT codes 96931, 96932, 96933, 96934, 96935, and 96936)	595
56	Evaluative Procedures for Physical Therapy and Occupational Therapy (CPT codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168)	598

continued

Valuation of Specific Codes		
57	Valuation of Services Where Moderate Sedation is an Inherent Part of the Procedure and Valuation of Moderate Sedation Services (CPT codes 99151, 99152, 99153, 99155, 99156, and 99157; and HCPCS code G0500)	620
58	Prolonged Evaluation and Management Services (CPT codes 99354, 99358, and 99359)	640
59	Complex Chronic Care Management Services (CPT codes 99487 and 99489)	640
60	Prostate Biopsy, Any Method (HCPCS code G0416)	641
61	Resource-Intensive Services (HCPCS Code G0501)	643
62	Behavioral Health Integration: Psychiatric Collaborative Care Model (HCPCS codes G0502, G0503, and G0504) and General Behavioral Health Integration (HCPCS code G0507)	644
63	Comprehensive Assessment and Care Planning for Patients with Cognitive Impairment (HCPCS code G0505)	649
64	Comprehensive Assessment and Care Planning for Patients Requiring Chronic Care Management (HCPCS code G0506)	651
65	65) Telehealth Consultation for a Patient Requiring Critical Care Services (HCPCS codes G0508 and G0509)	651

The rule's table 27 (display copy page 654) contains a list of codes for which CMS is finalizing work RVUs; this includes all RUC recommendations received by February 10, 2016, and codes for which CMS established interim final values in the CY 2016 PFS final rule.

The rule's table 28 (display copy page 673) details CMS' finalized refinements of the RUC's direct PE recommendations at the code-specific level.

M. Therapy Caps

Increasing the CY 2016 therapy cap of $1,960 by the CY 2017 MEI of 1.2 percent and rounding to the nearest $10.00 results in a CY 2017 therapy cap amount of $1,980.

II. OTHER PROVISIONS OF THE FINAL PFS REGULATIONS

A. Chronic Care Management and Transitional Care Management Supervision Requirements in Rural Health Clinics and Federally Qualified Health Centers

CMS is revising §405.2413(a)(5) and §405.2415(a)(5) to state that services and supplies furnished incident to TCM and CCM services can be furnished under general supervision of a RHC or FQHC practitioner. The exception to the direct supervision requirement will apply only to auxiliary personnel furnishing TCM or CCM incident to services, and will not apply to any other RHC or FQHC services.

B. FQHC-Specific Marketbasket

For CY 2017, CMS proposed to create a 2013-based FQHC marketbasket. The proposed marketbasket uses Medicare cost report (MCR) data submitted by freestanding FQHCs.

Based on IHS Global Insight's (IGI) third quarter 2016 forecast with historical data through the second quarter of 2016, the final FQHC marketbasket increase factor for CY 2017 is 1.8 percent. This reflects a 2.2 percent increase of FQHC input prices and a 0.4-percent adjustment for productivity.

continued

Comment

This section took some 30 pages to tell us that CMS has adopted a FQHC marketbasket and the CY rate is 1.8 percent. Again, why so much detail?

C. Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Section 218(b) of the ***Patient Access and Medicare Protection Act*** (PAMA) amended Title XVIII of the Act to add section 1834(q) of the Act directing CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. For purposes of this program, AUC are a set or library of individual appropriate use criteria.

There are four major components of the AUC program each with its own implementation date: (1) establishment of AUC by November 15, 2015 (section 1834(q)(2)); (2) identification of mechanisms for consultation with AUC by April 1, 2016 (section 1834(q)(3)); (3) AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals by January 1, 2017 (section 1834(q)(4)); and (4) annual identification of outlier ordering professionals for services furnished after January 1, 2017 (section 1834(q)(5)).

CMS established a new §414.94(e)(5) to set forth the initial list of priority clinical areas. CMS is removing chest pain as a priority clinical area and finalizing suspected pulmonary embolism and coronary artery disease as two distinct areas. CMS is finalizing the proposed areas of low back pain and headache, as well as cancer of the lung (primary or metastatic, suspected or diagnosed). CMS is removing suspected stroke and retaining headache in the final list of priority clinical areas.

The final list of priority clinical areas is as follows:

- Coronary artery disease (suspected or diagnosed).
- Suspected pulmonary embolism.
- Headache (traumatic and non-traumatic).
- Hip pain.
- Low back pain.
- Shoulder pain (to include suspected rotator cuff injury).
- Cancer of the lung (primary or metastatic, suspected or diagnosed).
- Cervical or neck pain.

CMS is finalizing the following requirements at §414.94(g)(1):

- Make available specified applicable AUC and its related supporting documentation.
- Identify the appropriate use criterion consulted if the clinical decision support mechanisms (CDSM) makes available more than one criterion relevant to a consultation for a patient's specific clinical scenario.
- Make available, at a minimum, specified applicable AUC that reasonably address common and important clinical scenarios within all priority clinical areas.
- Incorporate specified applicable AUC from more than one qualified PLE.
- Generate and provide a certification or documentation at the time of order that documents which qualified CDSM was consulted; the name and national provider identifier (NPI) of the ordering professional that consulted the CDSM; whether the service ordered would adhere to specified applicable AUC; whether the service ordered would not adhere to specified applicable AUC; or whether the

continued

specified applicable AUC consulted was not applicable to the service ordered. Certification or documentation must be generated each time an ordering professional consults a qualified CDSM and include a unique consultation identifier generated by the CDSM.

- Modifications to AUC within the CDSM must comply with the following timeline requirements: make available updated AUC content within 12 months from the date the qualified PLE updates AUC; and have a protocol in place to expeditiously remove AUC determined by the qualified PLE to be potentially dangerous to patients and/or harmful if followed; and make available for consultation within 12 months of a priority clinical area being finalized by CMS specified applicable AUC that reasonably address common and important clinical scenarios within any new priority clinical area.
- Meet privacy and security standards under applicable provisions of law.
- Provide to the ordering professional aggregate feedback regarding their consultations with specified applicable AUC in the form of an electronic report on at least an annual basis.
- Maintain electronic storage of clinical, administrative, and demographic information of each unique consultation for a minimum of 6 years.
- Comply with modification(s) to any requirements under paragraph (g)(1) of this section made through rulemaking within 12 months of the effective date of the modification.
- Notify ordering professionals upon de-qualification.

Comment

The material presented in this section extends for more than 100 pages. CMS states that, "Section 1834(q) of the Act includes rapid timelines for establishing a Medicare AUC program for advanced diagnostic imaging services. The number of clinicians impacted by the scope of this program is massive as it will apply to every physician or other practitioner who orders or furnishes applicable imaging services. This crosses almost every medical specialty and could have a particular impact on primary care physicians since their scope of practice can be quite broad."

One must question the time, energy, cost and burden in adopting and complying with this mandate. In the name of quality, is this overkill – using an elephant gun on a mouse. We may spend more time complying with paperwork than with providing patient care.

D. Reports of Payments or Other Transfers of Value to Covered Recipients: Solicitation of Public Comments

CMS says it does not intend to finalize any requirements related to Open Payments directly in this final rule; rather, CMS expects to conduct such in future rulemaking.

E. Release of Part C Medicare Advantage Bid Pricing Data and Part C and Part D Medical Loss Ratio Data

CMS proposed to release to the public MA bid pricing data and Part C and Part D MLR data on a specific schedule and subject to specified exclusions. CMS proposed to add contract terms and expand the basis and scope of its regulations on MA bidding and Part C and Part D MLR submission to incorporate section 1106(a) of the Act (42 U.S.C. 1306(a)), which authorizes disclosure of information filed with CMS in accordance with regulations adopted by the agency.

In general, CMS proposed to release the data submitted by MA organizations in the Medicare Advantage Bid Pricing Tool, subject to a 5-year delay;

continued

and to release data submitted by MAOs and Part D sponsors in accordance with MLR requirements, subject to an 18-month delay.

CMS is finalizing its proposal to release MA bid pricing data after a 5-year delay, subject to certain specified exclusions.

F. Prohibition on Billing Qualified Medicare Beneficiary Individuals for Medicare Cost-Sharing

CMS reminds all Medicare providers (including providers of services defined in section 1861 of the Act and physicians) that federal law prohibits them from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments, from beneficiaries enrolled in the Qualified Medicare Beneficiaries program (a Medicaid program which helps certain low-income individuals with Medicare cost-sharing liability).

G. Recoupment or Offset of Payments to Providers Sharing the Same Taxpayer Identification Number

Medicare payments to providers and suppliers may be offset or recouped, in whole or in part, by a Medicare Administrator Contractor if the MAC or CMS has determined that a provider or supplier has been overpaid.

CMS will, as proposed, create a new paragraph (f) in §405.373 to state that §405.373(a) does not apply in instances where the Medicare Administrative Contractor intends to offset or recoup payments to the applicable provider of services or supplier to satisfy an amount due from an obligated provider of services or supplier when the applicable and obligated provider of services or supplier share the same Taxpayer Identification Number.

H. Accountable Care Organization Participants Who Report Physician Quality Reporting System Quality Measures Separately

Current Shared Savings Program regulations at §425.504(c) do not allow eligible professionals billing through the Taxpayer Identification Number of an Accountable Care Organization participant to participate in PQRS outside of the Shared Savings Program, and these EPs and the ACO participants through which they bill may not independently report for purposes of the PQRS apart from the ACO.

CMS is amending the regulation at §425.504 to permit EPs that bill under the TIN of an ACO participant to report separately for purposes of the 2018 PQRS payment adjustment when the ACO fails to report on behalf of the EPs who bill under the TIN of an ACO participant.

I. Medicare Advantage Provider Enrollment

The Medicare program is the primary payer of health care for approximately 54 million beneficiaries and enrollees.

This final rule will require providers and suppliers in MA organization networks and other designated plans (hereafter including MA-PD plans, FDRs, PACE, Cost HMOs or CMPs, demonstration programs, pilot programs, locum tenens suppliers, and incident-to suppliers) to be enrolled in Medicare in an approved status.

Health care providers or suppliers – either as individuals or entities – can enroll if they are eligible in accordance with the requirements of the Social Security Act.

As part of these changes, the enrollment provisions would be included in CMS contracts with the designated plans and

continued

programs. Plans that do not meet these requirements may be subject to contract actions ranging from intermediate sanctions to contract termination. These provisions will begin two years after publication of this final rule and will be effective on the first day of the plan year.

J. Expansion of the Diabetes Prevention Program (DPP) Model

CMS is expanding the duration and scope of the DPP model test by expanding DPP under section 1115A(c) of the Act, and refers to this expanded model as the Medicare Diabetes Prevention Program (MDPP). The MDPP expanded model will become effective nationwide beginning on January 1, 2018.

CMS is finalizing its proposal that the MDPP core benefit is a 12 consecutive month program that consists of at least 16 weekly core sessions over months 1-6 and at least six monthly core maintenance sessions over months 6-12, furnished regardless of weight loss. CMS is also finalizing its proposal that beneficiaries have access to ongoing maintenance sessions after the 12-month core benefit if they achieve and maintain the required minimum weight loss of 5 percent.

CMS will limit coverage of MDPP as proposed. The MDPP core benefit is available only once per lifetime per MDPP eligible beneficiary, and ongoing maintenance sessions are available only if the MDPP eligible beneficiary has achieved maintenance of weight loss. These limitations are specified in §410.79.

CMS is deferring finalizing the proposed reimbursement structure to future rulemaking.

Comment

It is obvious that this section was written by different staff. The material is more organized and there are clearly identified "final decision" sections making it easier to comprehend and digest the information being presented.

K. Medicare Shared Savings Program

The Medicare Shared Savings Program was established to promote accountability for a patient population, coordinate items and services under parts A and B, and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery through provider and supplier participation in an Accountable Care Organization.

The CY 2017 PFS final rule includes the following several finalized policies specific to certain sections of the Shared Savings Program regulations such as:

- Updates the ACO quality reporting requirements, including changes to the quality measure set and the procedures for quality validation audits, revisions to terminology used in quality assessment, revisions that would permit eligible professionals in ACOs to report quality separately from the ACO, and updates to align with the Physician Quality Reporting System and the final Quality Payment Program;
- Modifies the assignment algorithm to align beneficiaries to an ACO when a beneficiary has designated an ACO professional as responsible for their overall care;
- Establishes beneficiary protection policies related to use of the Skilled Nursing Facility 3-day waiver; and,
- Makes technical changes to certain rules related to merged and acquired

continued

TINs and for reconciliation of ACOs that fall below 5,000 beneficiaries, and other program refinements.

Table 42 lists the Shared Savings Program quality measure set that will be used to assess quality performance starting with the 2017 performance year including the new measures adopted in this final rule. Each measure that is indicated as a new measure will be assessed as a pay for reporting measure for the 2017 and 2018 performance years. After that, the measure will be assessed based on the phase-in schedule noted in the table.

Table 43 provides a summary of the number of measures by domain and the total points and domain weights that will be used for scoring purposes under the changes to the quality measure set adopted in this final rule.

CMS is modifying the SNF 3-day rule waiver under §425.612(a)(1) to include a 90-day grace period that will permit payment for SNF services provided to beneficiaries without a qualifying inpatient stay who were initially on the ACO's prospective assignment list for a performance year but were subsequently excluded during the performance year, if such services would otherwise be covered under the SNF 3-day rule waiver.

In addition, in the event that a SNF that is a SNF affiliate of a Track 3 ACO that has been approved for the SNF 3-day rule waiver admits a FFS beneficiary who was never prospectively assigned to the ACO (or was assigned but later excluded and the 90-day grace period has lapsed), and the claim is rejected only for lack of a qualifying inpatient hospital stay, CMS will make no payment to the SNF, and the SNF may not charge the beneficiary for the non-covered SNF services.

Comment

The Medicare Shared Savings section contains numerous items, too many to simply report in this analysis. The material covers nearly 110 pages. The material requires in-depth review by those being impacted. Again, this section has been written by different staff. It contains helpful "final decision" sections.

L. Value-Based Payment Modifier and Physician Feedback Program

Section 1848(p) of the Act requires the Secretary to establish a value-based payment modifier and apply it to specific physicians and groups of physicians the Secretary determines appropriate starting January 1, 2015, and to all physicians and groups of physicians by January 1, 2017.

Under section 1848(p)(4)(B)(iii) of the Act, as amended by section 101(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015, the VM shall not be applied to payments for items and services furnished on or after January 1, 2019. Section 1848(q) of the Act, as added by section 101(c) of MACRA, establishes the Merit-based Incentive Payment System that shall apply to payments for items and services furnished on or after January 1, 2019.

CMS is updating the VM informal review policies and establishing how the quality and cost composites under the VM will be affected for the CY 2017 and CY 2018 payment adjustment periods in the event that unanticipated program issues arise.

M. Physician Self-Referral Updates

CMS is "re-proposing certain requirements for arrangements involving the rental of office space or equipment."

continued

CMS is finalizing without modification its proposal to include at §411.357(a)(5)(ii)(B), (b)(4)(ii)(B), (l)(3)(ii), and (p)(1)(ii)(B) a requirement that the rental charges for the lease of office space or equipment are not determined using a formula based on per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee.

Comment

The issue of physician referrals has been somewhat contentious since the law was enacted. CMS spends considerable effort rehashing past rules and regulations in this section.

N. Physician Self-Referral Law: Annual Update to the List of CPT/HCPCS Codes

The updated, comprehensive Code List effective January 1, 2017, is available on CMS' website at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/List_of_Codes.html.

Final Thoughts

After reading CMS' latest series of rules on updates to the CY PPS programs, it is very apparent that these rules grow longer and longer each year. One must question why. Is it the continuous and redundant repetition of history long gone, is it the manner in which CMS responds to every comment, is it the voluminous "thank you" and "we appreciate" citations?

Bottom line, without some major changes in the formatting of these rules, they will grow exponentially in the years ahead. It's time for CMS to revamp its format.

First and foremost is the need to (1) clearly state the issue and (2) provide a clear, concise final action/decision section.

Second, is the need to provide more section references. In the PFS, the table of contents is short – only 3 pages. Nonetheless, the identified sections in the table of contents have many subsections. For example, on page 25 of the display copy, the following head is presented –

II. Provisions of the Final Rule for PFS

A. Determination of Practice Expense Relative Value Units

1. Overview

If I try and find 2, many reference "2s" will show. If I try to find II.2, nothing is found. CMS needs to include more comprehensive numbering of its sections.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting