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**Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements
[CMS-1654-F]**

Summary of Final Rule

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I. Introduction and Background

On November 2, 2016, the Centers for Medicare & Medicaid Services (CMS) placed on public display a final rule relating to the Medicare physician fee schedule (PFS) for CY 2017¹ and other revisions to Medicare Part B policies. The final rule is slated for publication in the November 15, 2016 issue of the *Federal Register*. Finalized policies in the final rule generally will take effect on January 1, 2017.

The final rule updates the PFS payment policies that apply to services furnished by physicians and other practitioners in all sites of services. In addition to physicians, the PFS pays a variety of practitioners and entities, including nurse practitioners, physician assistants, physical therapists, radiation therapy centers, and independent diagnostic testing facilities. The final rule includes new payment policies for services provided to patients with multiple chronic conditions, mental and behavioral health issues, and cognitive impairment. The final rule also includes policies related to the Medicare Shared Savings Program.

The **CF for 2017 is \$35.8887**, which reflects the 0.5 percent update adjustment factor specified under MACRA, a budget neutrality adjustment of -0.50 percent, a target recapture amount of -0.18 percent, and an imaging MPPR adjustment of -0.07. Table 50 from the final rule details the calculation.

¹ Henceforth in this document, a year is a calendar year unless otherwise indicated.

TABLE 50: Calculation of the Final 2017 PFS Conversion Factor

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

The 2017 anesthesia CF is \$22.0454, which reflects the same adjustments to the 2016 anesthesia CF, which was \$21.9935.

On a specialty-specific basis, CMS estimates that the combined impact of the final rule will have the greatest positive effect on allergy/immunology (+1 percent), family practice (+1 percent), geriatrics (+1 percent), internal medicine (+1 percent), multispecialty clinic (+1 percent), and physical/occupational therapy (+1 percent); and the greatest negative effect on independent laboratories (-5 percent), ophthalmology (-2 percent), and urology (-2 percent). Table 52 (included at the end of this summary) shows the estimated payment impact on PFS services for all specialties.

The addenda to the final rule along with other supporting documents are again only available through the Internet at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>.

II. Provisions of the Final Rule for PFS

A. Medicare Telehealth Services

1. Billing and Payment for Telehealth Services

CMS finalizes, as proposed, to add the following CPT codes to the telehealth list on a category 1 basis: ESRD-related services (CPT codes 90967-90970)² and Advanced Care Planning services (CPT codes 99497-99498). CMS also finalizes, as proposed, the creation and addition of Telehealth Consultations for a Patient Requiring Critical Care Services (HCPCS codes G0508 and G0509) on a category 2 basis³.

CMS finalizes, as proposed, decisions not to add the services below to the telehealth list.

- Observation care (CPT codes 99217-20; 99224-26; 99234-36); CMS disagrees that these services qualify under category 1 and commenters did not provide any information supporting category 2 status.

² The required clinical examination of the catheter access site must be furnished face-to-face “hands on”.

³ CMS inconsistently refers to addition of G0508 and G0509 as qualifying by category 1 or 2. Since these are newly created code descriptors and the closest existing CPT codes (critical care E/M 99291-2) are not on the existing telehealth services list, G0508 and G0509 appear to qualify for the telehealth list on a category 2 basis.

- Emergency Department (ED) Visits (CPT codes 99281-99285). CMS disagrees that these services qualify under category 1 and commenters did not provide any information supporting category 2 status.
- Psychological Testing (CPT codes 96101-2, 96118-9). CMS disagrees that these services qualify under category 1 and commenters did not provide any information supporting category 2 status.
- Physical and Occupational Therapy and Speech-Language Pathology Services (CPT codes 95207-08; 92521-24; 92526; 92610; 97001-04; 97110, 97112, 97116; 97532, 97533, 97535, 97537; 97542; 97550; 97555; 97660-02). The statutory definition of authorized telehealth practitioners does not include physical therapists, occupational therapists, or speech-language pathologists.

2. Place of Service (POS) Code for Telehealth Services

CMS had proposed several payment rules for use with the telehealth POS code and associated regulatory changes to §414.22(b)(5)(i)(A). The telehealth POS code would be reported by the practitioner providing services (who is located at the distant site), not by the originating site⁴. Payment to the distant site practitioner would be made under the PFS at the facility rate associated with the CPT or HCPCS code being billed, subject to related proposed provisions of the OPFS concerning provider-based departments. CMS also proposed to delete §414.32 which applies to certain payments calculations made prior to 2002.

Commenters generally supported establishment of the telehealth POS code. Commenters were divided between support for and opposition to the use of facility, rather than non-facility, PFS payment rates. Highlights from the discussion include:

- CMS does not believe that the telehealth POS code can be replaced by a recently-adopted CPT telehealth modifier, as the POS code was requested by other payers and prior HCPCS telehealth modifiers have been used inconsistently.
- For 2017, the GT and GQ modifiers (certifying that services meet telehealth requirements) still will be required, but CMS will consider future rulemaking to eliminate their use.
- The telehealth POS code has no relationship to state licensure requirements for practitioners furnishing telehealth services.
- Regarding potential payment reductions related to facility versus non-facility payment rates, CMS cites utilization data for 56 telehealth codes (of 81 codes on the list), showing that the payment differential is ≥ 1.0 PE RVU for only three of 56 codes.
- For HCPCS codes on the telehealth list for which facility PE RVUs have not been established, CMS notes that non-facility PE RVUs would serve as proxies.

CMS notes the creation by the CMS POS Workgroup of code POS 02: Telehealth⁵ and states that this new code will apply to telehealth services provided beginning January 1, 2017⁶. CMS then finalizes the proposal to use the telehealth POS code for reporting, the proposal to use the PFS facility PE RVUs in making payments to telehealth practitioners, and the deletion of §414.32. CMS

⁴ The originating site POS would continue to be that of the facility type at which the patient is located.

⁵ POS 02: Telehealth Descriptor: the location where health services and health related services are provided or received, through telecommunication technology.

⁶ As of 11/07/16, the provided hyperlink connects to the 8/6/2015 POS code list without the new Telehealth POS.

notes that requests for addition of telehealth services for 2018 must be received by December 31, 2016⁷.

B. Potentially Misvalued Services Under the Physician Fee Schedule

1. CY 2017 Identification and Review of Potentially Misvalued Services

a. 0-day Global Services that are Typically Billed with an Evaluation and Management (E/M) Service with Modifier 25

As discussed in the proposed rule, CMS' review of Medicare claims data for 2015 showed that 19 percent of the codes that describe 0-day global services were billed over 50 percent of the time with an E/M service with Modifier 25. Since a routine E/M service is included in the RVU valuation of 0-day global services, CMS believed this billing pattern may indicate a possible problem with the valuation of the 0-day global services, which includes all the routine care associated with the service.

To develop a proposed list of potentially misvalued services that are 0-day global codes, CMS identified 0-day global codes billed with an E/M service 50 percent of the time or more, on the same day of the service, with the same physician and the same beneficiary. CMS identified 83 codes that had not been reviewed in the last 5 years and had greater than 200,000 services. For 2017, CMS proposed these 83 codes as potentially misvalued (see Table 7).

After consideration of comments and removing from the proposed list codes that had been reviewed in the past 5 years, CMS finalizes a list of 19 codes that it identifies as potentially misvalued.

TABLE 8: List of Potentially Misvalued Services Identified through the Screen for 0-day Global Services that are Typically Billed with an Evaluation and Management (E/M) Service with Modifier 25

HCPCS	Long Descriptor
11755	Biopsy of finger or toe nail
20526	Injection of carpal tunnel
20551	Injections of tendon attachment to bone
20612	Aspiration and/or injection of cysts
29105	Application of long arm splint (shoulder to hand)
29540	Strapping of ankle and/or foot
29550	Strapping of toes
43760	Change of stomach feeding, accessed through the skin
45300	Diagnostic examination of rectum and large bowel using an endoscope
57150	Irrigation of vagina and/or application of drug to treat infection
57160	Fitting and insertion of vaginal support device
58100	Biopsy of uterine lining
64405	Injection of anesthetic agent, greater occipital nerve
64455	Injections of anesthetic and/or steroid drug into nerve of foot
65205	Removal of foreign body in external eye, conjunctiva
65210	Removal of foreign body in external eye, conjunctiva or sclera
67515	Injection of medication or substance into membrane covering eyeball
G0168	Wound closure utilizing tissue adhesive(s) only

⁷ For instructions, see <https://www.cms.gov/Medicare/Medicare-General-Information/telehealth/index.html>.

G0268	Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing
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b. End-Stage Renal Disease (ESRD) Home Dialysis Services (CPT codes 90963-90970)

A 2015 GAO report⁸ examined utilization of home dialysis and concluded that based on information from experts and stakeholders a realistic target for utilization of home dialysis would be 25 percent of dialysis patients. The GAO recommended that CMS examine Medicare policies for monthly payments to physicians managing the care of home dialysis patients and revise them if necessary to ensure the policies are consistent with encouraging appropriate use of home dialysis.

CMS agrees with the GAO recommendation and finalizes its proposal to identify CPT codes 90963 through 90970 as potentially misvalued codes.

c. Direct PE Input Discrepancies

1. Appropriate Direct PE Inputs Involved in Procedures Involving Endoscopes

In response to stakeholders concerns about potential inconsistencies with the inputs and the prices related to endoscopic procedures in the direct PE database, in the proposed rule CMS reviewed this issue and identified 45 different pieces of endoscopic related-equipment and 25 different pieces of endoscopic related-supplies associated with endoscopies that could have inconsistencies in the direct PE inputs. As compared to other kinds of equipment items in the direct PE input database, CMS stated this unusual degree of variation is likely to result in code misevaluation.

CMS requested that stakeholders, such as the RUC, review and make recommendations on the appropriate endoscopic equipment and supplies typically provided in all endoscopic procedures for each anatomical region, along with their appropriate prices. In response, the RUC stated that due to the complexity of this issue and the need to incorporate input from various specialty societies it plans to form a workgroup of the PE subcommittee to review this issue. CMS will review any recommendations provided by the RUC for future rulemaking.

2. Appropriate Direct PE Inputs in the Facility Post-Service Period When Post-Operative Visits are Excluded

In the proposed rule, CMS identified a potential inconsistency for 13 codes that have direct PE inputs included in the facility post service period even though the post-operative visits are not included in the service (see Table 8 in the proposed rule, 81 FR 46190). CMS noted that it does not know if this discrepancy is caused by inaccurate direct PE inputs or inaccurate post-operative data in the work time file.

CMS requested that stakeholders, including the RUC, review these discrepancies and provide their recommendations on the appropriate direct PE inputs for these codes. The RUC and other commenters provided recommendations and CMS will consider these for future rulemaking.

⁸ *End-Stage Renal Disease Medicare: Payment Refinements Could Promote Increased Use of Home Dialysis.* (GAO-16-125). Washington DC: US Government Accountability Office, 2015. <http://www.gao.gov/products/GAO-16-125>.

d. Insertion and Removal of Drug Delivery Implants (CPT codes 11981 and 11983)

In response to stakeholders request for CMS to create new codes for the insertion and removal of drug delivery implants for buprenorphine hydrochloride (a long acting subdermal drug implant for the treatment of opioid addiction), in the proposed rule, CMS identified existing drug delivery implant CPT codes 11981 and 11982 as potentially misvalued.

CMS requested information regarding whether the current resource inputs for work and practice expense for these codes appropriately account for the variation in the service relative to which devices and related drugs are inserted and removed. CMS appreciates the comments received and will review new coding and recommended valuations for future rulemaking.

2. Valuing Services that Include Moderate Sedation as an Inherent Part of Furnishing the Procedure

The CPT manual identifies more than 400 diagnostic and therapeutic procedures (listed in Appendix G) that have moderate sedation as an inherent part of providing the procedure. CMS has raised concerns that for many endoscopic procedures, anesthesia was increasingly being separately reported and that the resources associated with sedation were no longer an inherent part of the procedure and solicited recommendations on this issue. In response, for the 2017 CPT Manual, the CPT Editorial panel created CPT codes for separately reporting moderate sedation services in association with the elimination of Appendix G codes. The RUC also provided a recommended methodology to remove work RVUs for moderate sedation from the Appendix G codes and also recommended values for separately provided moderate sedation (not provided by the physician providing the procedure).

In the proposed rule, CMS discussed its concerns that based on the RUC recommendations, the overall resource costs for the procedure with sedation were higher when moderate sedation was not included in the payment for the procedure. CMS stated that the overall resource costs of these services should be the same as the current resource assumptions for these procedures when the same provider or a different provider furnishes moderate sedation and that the current resources should be redistributed instead of increased. Section II.L of this summary discusses CMS' establishment of an endoscopy-specific moderate sedation code that augments the new CPT codes for moderate sedation, the public comments, and finalized values.

3. Collecting Data on Resources Used in Furnishing Global Services

a. Data Collection Required to Accurately Value Global Packages

CMS adopts a three-pronged approach to collect timely, accurate and comprehensive data on the frequency of, and the inputs involved in furnishing global services including the procedure and the pre-operative visits, the post-operative visits, and other services for which payment is included in the global surgical payment. The approach would include:

- Comprehensive claims-based reporting of post-operative visits for 10- and 90-day global services.
- A survey of a representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time.

- A more in-depth study, including direct observation of the pre-and post-operative care delivered in a small number of sites, including some ACOs.

1. Claims-based Data Collection

CMS finalizes a claims-based data collection policy with the following requirements:

- CPT code 99024 will be used for reporting post-operative services during the global period of a specified procedure (CPT code 99024: Postoperative follow-up visit, normally included in the surgical package, to indicate that an E/M service was performed during a postoperative period for a reason(s) related to the original procedure).
- Reporting will only be required for services related to codes reported annually by more than 100 practitioners and are either reported more than 10,000 times annually or have more than \$10 million in annual allowed charges. The final list will be available on the CMS web site.
- Only practitioners who practice in groups with 10 or more practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island will be required to report.
- Reporting will be required for procedures furnished on or after July 1, 2017.

CMS encourages all practitioners to report for procedures furnished on or after January 1, 2017. It also encourages practices with fewer than 10 practitioners to report data.

a. Information to be Reported. CMS finalizes that CPT code 99024 will be used for reporting post-operative services during the global period of a specified procedure.

b. Special Provisions for Teaching Physicians. CMS finalizes that teaching physicians will be subject to the same requirements as other physicians. Teaching physicians should report CPT code 99024 only when the services furnished would meet the general requirements for reporting services and should use the GC or GE modifier, as appropriate, to identify those services in which surgical residents are involved.

c. Who Reports.

CMS defines practices as a group of practitioners whose business or financial operations, clinical facilities, records or personnel are shared by two or more practitioners. CMS notes that it is not necessary for practices to share the same address. CMS also clarifies that the exception for reporting post-operative visit applies only to practices with fewer than 10 physicians and qualified non-physician practitioners regardless of specialty. CMS states that all practitioners should be included regardless of whether they are furnishing services under an employment model, a partnership model, or an independent contractor model under which they practice as a group and share facility and other resources but continue to bill Medicare independently instead of reassigning benefits.

CMS also recognizes that practice size can fluctuate over the year and anticipates that practices will determine their eligibility based on their expected staffing. CMS notes that practitioners in short term locum tenens arrangements would generally not be included in the count of practitioners. In addition, when practitioners are also provided services in multiple settings, the count may be adjusted to reflect the estimated proportion of time spent in the group practice and other settings.

2. Survey of Participants

In addition to the claims-based reporting, CMS finalizes its proposal to survey a large, representative sample of practitioners and their clinical staff to obtain information about approximately 20 discrete pre-operative and post-operative visits and other global services such as care coordination and patient training.

3. Required Participation in Data Collection

Section 1848(a)(9) of the Act authorizes the Secretary to withhold payment of up to 5 percent of the payment for services on which the practitioner is required to report until the practitioner has completed the required reporting. CMS is not implementing this option but if compliance with required claims-based reporting is not acceptable, CMS states it will consider in future rulemaking imposing up to a 5 percent payment withhold.

4. Data Collection from Accountable Care Organizations (ACOs)

CMS finalizes its proposal to collect primary data on the activities and resources involved in delivering services by surveying a small number of ACOs (Pioneer and Next Generation ACOs). CMS plans to begin with an initial phase of primary data collection to develop, pilot and validate an additional survey module specific to ACOs and then survey practitioners participating in approximately 4 to 6 ACOs.

5. Revaluation Based Upon Collected Data

CMS is not finalizing any proposals regarding valuation of global services and that it would include any revaluation proposals based on the data it collects in future rulemaking.

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

CMS is finalizing the following proposed changes to coding and payment policies:

- Improve payment for care management services for beneficiaries with behavioral health conditions (G0502, G0503, G0504, G0507).
- Improve payment for cognition and functional assessment, and care planning for beneficiaries with cognitive impairment (G0505).
- Recognize for Medicare payments the CPT codes for complex CCM services (CPT codes 99487 and 99489) and adjust payments for the visit during which CCM services are initiated (the initiating CCM visit, G0506).
- Recognize for Medicare payments the CPT codes for non-face-to-face prolonged E/M services (CPT codes 99358 and 99359).

For 2017, CMS is not finalizing its proposal related to providing separate payment for care visits furnished to beneficiaries whose care requires additional resources due to their mobility-related disabilities.

These policies are summarized below; readers are advised to review the final rule for more detailed information.

1. Non-Face-to-Face Prolonged E/M Services (CPT codes 99358 and 99359)

CMS finalizes its proposal to recognize the two CPT codes for non-face-to-face prolonged E/M services (CPT codes 99358, first hour and 99359, each additional 30 minutes) for separate payment under the PFS. CMS also adopts the CPT code descriptors and prefatory language for reporting these services. CMS emphasizes that the time spent reported under a non-face-to-face prolonged service code does not include the time spent in relevant services.

CMS does not finalize its proposal to require the services to be furnished on the same day by the same physician or other billing practitioner as the companion E/M code. CMS finalizes that non-face-to-face prolonged services may be reported with a companion E/M code, whether furnished on the same day or a different day. Non-face-to-face prolonged services can also be reported with G0505 (cognition and functional assessment); CMS considers G0505 as a face-to-face E/M service.

CMS finalizes that non-face-to-face prolonged services can be reported with non-complex CCM and the behavior health integration (BHI) services (G0502, G0503, G0504, and G0507).

CMS finalizes that non-face-to-face prolonged services cannot be reported:

- During the same month as complex CCM (CPT codes 99487 and 99489) when reported by the same practitioner and
- During the service time of transitional care management (TCM) (CPT codes 99495 and 99496) when reported by the same practitioner

CMS notes that these restrictions are based on CPT provisions.

For 2017, CMS finalizes that a prolonged service code (whether face-to-face or non-face-to-face) cannot be reported in addition to G0506. CMS states the billing practitioner may choose to report either prolonged services or G0506 (if requirements to bill these services are met), but cannot report both services in association with the companion E/M code that qualifies as the CCM initiating visit.

2. Establishing Separate Payment for Behavioral Health Integration (BHI)

CMS finalizes four G-codes for care management for Medicare beneficiaries with behavioral health conditions, a practice known as BHI. CMS finalizes three codes for the psychiatric Collaborative Care Model (CoCM) (G0502, G0503, and G0504) and one code describing related models of BHI services (G0507).

CMS states that the time spent by the treating physician or other qualified health care professional on activities for services reported separately may not be included in BHI services. Similarly, time spent by the behavioral health care manager on activities reported separately may not be included in these services. The services provided by the psychiatric consultant may be reported separately but the time cannot be included in these codes.

For payment purposes, CMS assigns a general supervision to all of the BHI service codes. CMS notes that general supervision⁹, does not by itself, comprise a qualifying relationship between the treating practitioner and other individuals providing BHI services under the incident to relationship. CMS allows BHI services in any setting of care. CMS also states that a single practitioner must choose whether to report psychiatric CoCM code(s) or the general BHI code for a given month for a given beneficiary.

a. Psychiatric Collaborative Care Management (G0502, G0503, and G0504)

CMS finalizes its proposal to provide payment for psychiatric CoCM services under the following codes:

- G0502: Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health professional with described required elements.
- G0503: Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health professional with described required elements.
- G0504: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health professional (List separately in addition to code for primary procedure) (Use G0504 in conjunction with G0502 and G0503).

The final rule lists the required services provided in each G-code.

CMS discusses these services are reported by the treating physician or other qualified health care professional for services furnished during a calendar month service period. These services may be furnished when a beneficiary has a psychiatric or behavioral health condition(s), including substance use disorder, that in the treating physician or other qualified professional's clinical judgment requires a behavioral health care assessment; establishing, implementing, revising or monitoring a care plan; and provision of brief interventions. The diagnosis may be pre-existing or made by the treating health care provider. The treating physician or other qualified health care professional must remain involved in ongoing oversight, management, collaboration and reassessment as appropriate to bill these services.

Psychiatric CoCM services include the services of the treating physician or other qualified health care professional, the behavioral health care manager and the psychiatric consultant. Time spent by administrative or clerical staff cannot be counted towards the time required to bill these services.

⁹ General supervision means the service is furnished under the overall direction and control of the practitioner billing the service, but without the presence of the practitioner being required during the performance of the service.

CMS defines the episode of care for beneficiaries as beginning when the behavioral health care manager engages in care of the beneficiary under the appropriate supervision of the billing practitioner and ending with:

- The attainment of targeted treatment goals, which typically results in the discontinuation of care management services and continuation of usual follow-up care; or
- Failure to attain targeted treatment goals culminating in a referral to a psychiatric care provider for ongoing treatment; or
- Lack of continued engagement with no psychiatric collaborative care management services provided over a consecutive 6-month calendar period (break in episode).

CMS states a new episode of care will start after a break in an episode of 6 calendar months or more.

CMS states the behavioral health care manager has formal education or specialized training in behavioral health, which could include a range of disciplines (e.g. social work, nursing, and psychology). In the final rule, CMS delineates the services provided by the behavioral health care manager that are done all in consultation with the psychiatric consultant. The behavioral health care manager needs to be available to provide all the services face-to-face and non-face-to-face, and consults with the psychiatric consultant minimally on a weekly basis. The behavioral health care manager is subject to the incident to rules and regulations and applicable state law, licensure and scope of practice (42 CFR 410.26).

CMS states the psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications. In the final rule, CMS delineates the services provided by the psychiatric consultant. The psychiatric consultant does not typically see the beneficiary or prescribe medications, except in rare circumstances, but can facilitate referrals for direct provision of psychiatric care when clinically indicated. The psychiatric consultant is also subject to the incident to rules and regulations and applicable state law, licensure and scope of practice (42 CFR 410.26).

CMS notes that it is not limiting the code to reporting by specific physician specialties. It believes primary care practitioners will most frequently perform the services described but if other specialists perform these services and meet all of the requirements they may report these codes. CMS does not expect psychiatrists to bill the psychiatric CoCM codes, because psychiatric work is defined as a sub-component of these codes. CMS also indicates these services can be provided in any setting, whether inpatient or outpatient. Nurse practitioners may bill for psychiatric CoCM codes and depending on their qualifications could serve as the behavioral health care manager and provide the psychiatric consultant services.

CMS clarifies that the care plan requirements for psychiatric CoCM services should take into account the whole patient but it should focus on behavior health or psychiatric issues. CMS believes the format of the care plan is less important than having a process whereby feedback and expertise from all relevant providers are integrated into the treatment plan and goals, and is regularly assessed by the practitioner assuming overall care management responsibility.

E/M visits (face-to-face E/M visits) may be separately billed during the service period or on the same day as the psychiatric CoCM services, provided time is not counted twice towards the same code.

b. General Behavioral Health Integration (BHI) (G0507)

CMS finalizes its proposal to make payment for care management for beneficiaries diagnosed with behavioral health conditions for the broadly defined application of integration in the primary care setting. The finalized code is:

- G0507: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month.

The final rule lists the required services provided in this code. G0507 does not include a specific individual designated as a behavioral health care manager and does not require a psychiatric consultant.

This service is reported by the treating physician or other qualified health care professional for services furnished during a calendar month service period. Similar to the psychiatric CoCM model, the services may be furnished when the beneficiary has a psychiatric or behavioral health condition(s) that the treating professional's clinical judgment, requires a behavioral health care assessment, behavioral health care planning, and provision of interventions. The presenting condition(s) may be pre-existing or newly diagnosis and include any psychiatric or behavioral health condition, including substance use disorders.

CMS requires that G0507 is provided directly by the treating physician or other qualified health care professional, or provided by clinical staff under the direction of the treating provider. For G0507, CMS notes the term "clinical staff" means the CPT definition of this term, subject to the incident to rules and regulations and applicable state law, licensure and scope of practice (42CFR 410.26). "Clinical staff" includes any psychiatric or other behavioral health specialist consultant that may provide consultative services. Clinical staff is not required to be employed by the treating provider or located on site, and these individuals may or may not be a professional permitted to independently furnish and report services to Medicare.

CMS states that E/M visits (face-to-face E/M visits) may be separately billed during the service period or on the same day as the BHI services, provided time is not counted twice towards the same code.

c. BHI Initiating Visit

CMS finalizes its proposal to require an initiating visit that is billable separate from the BHI services. Specifically, the same services that qualify as initiating visits for CCM services can serve as the initiating visits for BHI services. CMS requires that CCM must be initiated by the billing practitioner during a "comprehensive" E/M visit, annual wellness visit (AWV) or initial physical exam (IPPE). Levels 2 through 5 E/M visits (CPT codes 99212 through 99215) and the face-to-face visit included in TCM services (CPT codes 99495 and 99496) qualify as the "comprehensive" visits for CCM initiation.

CMS notes the initiating visit establishes the beneficiary's relationship with the treating practitioner and ensures that the treating practitioner assesses the beneficiary prior to initiating care management. In response to comments, CMS states that an initiating visit for BHI services is only required for new patients or beneficiaries not seen within a year of commencement of BHI services.

d. Beneficiary Consent

CMS finalizes its proposal to require beneficiary consent prior to initiating BHI services. CMS finalizes a requirement for a *general beneficiary consent* to allow consultation with relevant specialists prior to initiating these services, recognizing that applicable rules regarding privacy continue to apply. The general consent would encompass conferring with a psychiatric consultant. CMS finalizes that the billing practitioner must document in the medial record that the beneficiary's consent was obtained to consult with a relevant specialist, including a psychiatric consultant, and that the beneficiary is informed there is beneficiary cost-sharing, including potential deductible and coinsurance, for both in-person and non-face-to-face services that are provided. CMS is maintaining the requirement to maintain separate consents for CCM and BHI.

3. Reducing Administrative Burdens and Improving Payment Accuracy for Chronic Care Management (CCM) Services

CMS is finalizing its proposal to recognize and reimburse for additional CPT codes for complex CCM:

- CPT code 99487: Complex care management services, with described required elements, including 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month and
- CPT code 99489: Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Consistent with the complete definitions of these codes, less than 60 minutes of clinical staff time cannot be reported with CPT code 99487 and similarly, less than 30 minutes in addition to the first 60 minutes of complex CCM in a service period cannot be reported.

CMS finalizes that CPT codes 99487, 99489, and 99490 (CCM service) may only be reported once per service period (calendar month). A beneficiary can receive either a complex or non-complex CCM service during a given calendar month and only one practitioner can be reimbursed for CCM services for a given calendar month. Table 11 in the final rule and included at the end of this section in this summary lists the service elements and billing requirements (discussed below).

a. Initial Visit

CMS requires that CCM must be initiated by the billing practitioner during a “comprehensive” E/M visit, annual wellness visit (AWV) or initial physical exam (IPPE). Level 2 through 5 E/M visits (CPT codes 99212 through 99215) and the face-to-face visit included in TCM services (CPT codes 99495 and 99496) qualify as the “comprehensive” visits for CCM initiation.

CMS finalizes its proposal to require the initiating visit only for new patients or patients not seen within one year instead of requiring the initiating visit for all beneficiaries receiving CCM services. CMS states this will allow practitioners with existing relationships with patients to initiate CCM services without furnishing a potentially unnecessary E/M visit.

CMS also finalizes its proposal to create a new add-on G code, G0506, for beneficiaries who require extensive face-to-face assessment for care planning by the billing practitioner (as opposed to the clinical staff):

- G0506: Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring CCM services (billed separately from monthly management services) (Add-on code, list separately in addition to primary service).

CMS finalizes that when the billing practitioner initiating CCM *personally* performs extensive assessment and care planning outside of the usual effort described by the billed E/M code (or AWW or IPPE), the practitioner can bill G0506.

CMS reiterates it will not allow G0506 and G0505 (cognitive function assessment) to be billed on the same day by a single practitioner. G0506 will not be an add-on code for the BHI initiating visit or BHI services. CMS states that G0506 will be a one-time service code for CCM initiation and the billing practitioner must choose whether to report either G0506 or prolonged services in association with CCM initiation (if requirements to bill both are met). CMS also notes it is not precluding use of the CCM codes to report or count, behavioral health management if it is provided as part of a broader CCM service. However, such behavioral care management services could not also be counted towards reporting a BHI service. CCM and BHI services can only be billed the same month for the same beneficiary if all the requirements to bill each service are separately met.

b. 24/7 Access to Care and Continuity of Care

CMS finalizes its proposal to adopt the CPT language to describe the service elements for 24/7 Access to Care and Continuity of Care. For 24/7 Access to Care, the scope of the service will be to provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of the week. CMS also finalizes removing the requirement that individuals providing CCM after hours must have access to the electronic health plan.

For Continuity of Care, the CPT language references successive routine appointments “with a designated member of the care team” and does not make specific reference to requiring the appointment with the billing practitioner. As the billing practitioner is a member of the CCM care team, CMS adopts the CPT language.

c. Electronic Care Plan

CMS finalizes its proposal to change the CCM service element to require timely electronic sharing of care plan information within and outside the billing practice, but not necessarily on a 24/7 basis, and to allow transmission of the care plan by fax. CMS states this will still allow timely availability of health information, will simplify the provision of this service, and improve access to CCM.

d. Clinical Summaries

CMS finalizes its proposal to require the billing practitioner to create and exchange/transmit continuity of care document(s) timely with other practitioners. CMS states it will no longer specify

how the billing practitioner must transport or exchange these documents, as long as it is done timely and consistent with the Management of Care Transitions scope of service element. Instead of referring to these documents as “clinical summaries,” CMS will refer to them as “continuity of care documents” which is similar to the CPT prefatory language for TCM services.

e. Beneficiary Receipt of Care Plan

CMS finalizes its proposal to simplify the requirement to provide the beneficiary with a written or electronic care plan and adopts the CPT language, which requires that a copy of the care plan must be given to the patient or the caregiver. CMS does not believe it is necessary to specify the format of the care plan and recognizes that there may be times that sharing the care plan with a caregiver may be appropriate.

f. Beneficiary Consent

CMS finalizes its proposal to continue to require billing practitioners to inform the beneficiary of the currently required information. However, instead of requiring a written agreement, CMS finalizes that the practitioner will be allowed to document in the medical record that the information was explained and note whether the beneficiary accepted or declined CCM services.

CMS also removes the language requiring beneficiary authorization for the electronic communication of their medical information as a condition of payment for CCM services.

g. Documentation

CMS finalizes its proposal to no longer require the use of a qualifying certified EHR to document communication to and from home- and community-based providers regarding the patient’s psychosocial needs and functional deficits. CMS will continue to require documentation in the medical record that the communication occurred.

4. Assessment and Care Planning for Patients with Cognitive Impairment

CMS finalizes its proposal for a G-code that provides separate payment to recognize the work of a physician (or other appropriate billing practitioner) in assessing and creating a care plan for beneficiaries with cognitive impairment:

- G0505: Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office or other outpatient setting or home or domiciliary or rest home.

CMS acknowledges that CPT has approved a similar code, presumably for 2018, and it will consider whether to adopt and establish values for this new CPT code in future rulemaking.

CMS finalizes the following as required service elements of G0505:

- Cognition-focused evaluation including a pertinent history and examination.
- Medical decision making of moderate or high complexity (defined by the E/M guidelines).

- Functional assessment (for example, Basic and Instrumental Activities of Daily Living), including decision-making capacity.
- Use of standardized instruments to stage dementia.
- Medication reconciliation and review for high-risk medications, if applicable.
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized instrument(s).
- Evaluation of safety (for example, home), including motor vehicle operation, if applicable.
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks.
- Advance care planning and addressing palliative care needs, if applicable and consistent with beneficiary preference.
- Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed; care plan shared with the patient and/or caregiver with initial education and support.

CMS finalizes that G0505 cannot be billed on the same date of service as the following CPT codes: 90785, 90791, 90792, 96103, 96120, 96127, 99201- 99215, 99324-99337, 99431-99350, 99366-99368, 99497, and 99498. CMS states these codes all reflect face-to-face services provided by the physician or other billing practitioners for related services that are separately payable. In addition, CMS prohibits billing of G0505 with other care planning services.

CMS finalizes that non-face-to-face prolonged services may be reported with a companion E/M code, whether furnished on the same day or a different day. Non-face-to-face prolonged services can also be reported with G0505 (cognition and functional assessment); CMS considers G0505 as a face-to-face E/M service.

5. Improving Payment Accuracy for Care of People with Disabilities

CMS proposed a new add-on G-code to describe the additional services furnished in conjunction with E/M services to beneficiaries with disabilities that impair their mobility:

- G0501: Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lifts, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient E/M service visit (Add-on code, list separately in addition to primary procedure).

CMS does not finalize payment for G0501 but it is including the code in the 2017 code set. The HCPCS code G0501 will not be payable under the Medicare PFS for 2017. CMS notes that practitioners will be able to report the code if they want to. CMS plans to work with interested stakeholders and intends to discuss this issue again in future rulemaking.

6. Supervision for Requirements for Non-face-to-face Care Management Services

CMS adopts its proposal to amend §410.26(a)(3) and §410.26(b) to better define general supervision and to allow general supervision not only for CCM services (CPT code 99490) and the

non-face-to-face portion of TCM services (CPT codes 99495 and 99496), but also for the following codes:

- Chronic CCM services: CPT codes 99487 and 99489
- BHI services: G0502, G0503, G0504, G0507

CMS specifies at 410.32(b)(3)(i) that general supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service.

7. CCM Requirements for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Since January 1, 2016, RHC and FQHCs have been authorized to bill for CCM services. RHCs and FQHCs are paid based on the Medicare PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. The requirements for billing CCM services have generally followed the requirements for practitioners billing under the PFS.

CMS finalizes its proposed revisions for CCM services furnished by RHCs and FQHCs similar to the finalized policies discussed above (see Table 11 below in this summary). Specifically, CMS finalizes:

- Requiring CCM is initiated during an AWW, IPPE, or comprehensive E/M visit only for new patients or patients not seen within one year.
- Requiring 24/7 access to a RHC or FQHC practitioner or auxiliary staff with a means to make contact with a RHC or FQHC practitioner to address urgent health needs regardless of the time of day or day of week. This change no longer requires the health care practitioners in the RHC or FQHC to have 24/7 access to the patient's electronic care plan.
- Requiring timely electronic sharing of care plan information within and outside the RHC or FQHC, but not necessarily on a 24/7 basis and allow transmission of the care plan by fax.
- Requiring in managing care transmissions, the RHC or FQHC transmit continuity of care documents in a timely manner with other providers. This proposal will no longer require a standard format for the documentation and transmission of the information.
- Requiring a copy of the care plan is given to the patient or caregiver.
- Requiring the RHC or FQHC practitioner to document in the medical record that all elements of beneficiary consistent were provided, and whether the beneficiary accepted or declined CCM services.
- Requiring communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits is documented in the medical record.

CMS does not finalize an additional payment adjustment for patients who require extensive assessment and care planning as part of the initiating visit, because payments for RHC and FQHC services are not adjusted for length or complexity of the visit.

CMS clarifies that RHCs and FQHCs that bill for CCM services must develop a comprehensive care plan that includes all the required elements (see Table 11). When all the requirements are met,

including the development of a comprehensive care plan, the RHC or FQHC would submit a claim for CCM payment using CPT code 99490. There is no additional payment existing care plan and if a care plan that meets the CCM requirements was developed before initiating CCM, the time spent developing the existing care plan could not be counted towards the 20 minute minimum requirement for CPT code 99490.

TABLE 11: Summary of CY 2017 Chronic Care Management Service Elements and Billing Requirements

<p>Initiating Visit Initiation during an AWW, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of chronic care management (CCM) services.</p>
<p>Structured Recording of Patient Information Using Certified EHR Technology Structured recording of demographics, problems, medications and medication allergies using certified EHR technology. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.</p>
<p>24/7 Access & Continuity of Care</p> <ul style="list-style-type: none"> • Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week. • Continuity of care with a designated member of the care team with whom the beneficiary is able to schedule successive routine appointments.
<p>Comprehensive Care Management Care management for chronic conditions including systematic assessment of the beneficiary’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.</p>
<p>Comprehensive Care Plan</p> <ul style="list-style-type: none"> • Creation, revision and/or monitoring (as per code descriptors) of an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. • Must at least electronically capture care plan information, and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the beneficiary’s care. • A copy of the plan of care must be given to the patient and/or caregiver.
<p>Management of Care Transitions</p> <ul style="list-style-type: none"> • Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visits; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. • Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers.
<p>Home- and Community-Based Care Coordination</p> <ul style="list-style-type: none"> • Coordination with home and community based clinical service providers. • Communication to and from home- and community-based providers regarding the patient’s psychosocial needs and functional deficits must be documented in the patient’s medical record.
<p>Enhanced Communication Opportunities Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary’s care through not only telephone access, but also through the use of</p>

secure messaging, Internet, or other asynchronous non -face-to-face consultation methods.
<p>Beneficiary Consent</p> <ul style="list-style-type: none"> • Inform the beneficiary of the availability of CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM services at any time (effective at the end of the calendar month). • Document in the beneficiary’s medical record that the required information was explained and whether the beneficiary accepted or declined the services.
<p>Medical Decision-Making</p> <p>Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner</p>

D. Target for Relative Value Adjustments for Misvalued Services

CMS estimates the 2017 net reduction in expenditures resulting from proposed adjustments to relative values of misvalued codes to be 0.32 percent. Since this amount does not meet the 0.5 percent statutory target, CMS must reduce 2017 PFS payments by the difference between the target for the year (0.5%) and the estimated net reduction in expenditures, known as the target recapture amount. Thus, the 2017 target recapture amount will result in a reduction to the conversion factor of -0.18 percent. CMS also refers readers to the public use file that provides a comprehensive description of how the target is calculated as well as the estimated impact by code family (See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2017-PFS-FR-HCPCS-Misvalued.zip>)

E. Phase-in of Significant RVU Reductions

Section 1848(c)(7) of the Act, added by PAMA, also specifies that for services that are not new or revised codes, applicable adjustments in work, PE, and MP RVUs shall be phased-in over a 2-year period if the total RVUs for a service for a year decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year. The ABLE Act amended section 1848(c)(7) of the Act to require that the phase-in begin for 2016 rather than 2017, as specified by PAMA. In 2016, CMS proposed and finalized a methodology to implement this statutory provision.

CMS states that since 2016 was the first year in which it applied the phase-in transition, 2017 will be the first year in which a single code could be subject to RVU reductions greater than 20 percent for 2 consecutive years. CMS notes that the majority of codes with reductions in RVUs that are greater than 20 percent in year 1 would not likely meet the 20 percent threshold in a consecutive year. However, CMS acknowledges that in a few cases significant changes could produce reductions of 20 percent or greater in consecutive years.

CMS states its belief that a consistent methodology regarding the phase-in transition should be applied to these cases. Specifically, CMS proposed to reconsider in each year, for all codes that are not new or revised codes and including codes that were assigned a phase-in value in the previous year, whether the total RVUs for the service would decrease by an estimated 20 percent or more as compared to the total RVUs for the previous year. 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. CMS gives the example that if it 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. This phase-in transition continues to apply until the year-to-year reduction for a given code does not meet the 20 percent threshold.

Many commenters supported the proposal that a 19 percent reduction in total RVUs would continue to be the maximum one-year reduction for all codes that are not new or revised. One commenter believed that the proposal twisted a plain reading of the law to extend the phase-in period well beyond the 2 years prescribed by the statute. In response, CMS states it continues to believe that limiting reductions to 19 percent as the maximum 1-year decrease for all codes (except those new and revised) is the best and most fair way to apply the phase-in. CMS also clarifies that the technical component of certain imaging services subject to the OPSS cap are not subject to the phase-in on that basis.

CMS finalizes its policy as proposed.

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

Effective for services furnished beginning January 1, 2017, the payment amounts under the PFS for the technical component (TC) (including the TC of a global service) of imaging services that are X-rays taken using *film* are reduced by 20 percent. The reduction is made prior to any other adjustment under this section.

CMS finalizes its proposal to establish a new modifier (modifier FX) to be used on claims. Beginning January 1, 2017, this modifier will be required on claims for X-rays that are taken using film; the modifier will be required on claims for the technical component of the X-ray service, including when the service is billed globally. The use of this modifier will result in a 20-percent reduction for the technical component of the X-ray service. This reduction is exempt from budget neutrality.

In the proposed rule, CMS stated that the list of 2017 applicable HCPCS codes describing services that are X-ray services would be listed on the PFS website. CMS clarifies it did not intend this to indicate that it would be displaying an exhaustive list of applicable codes. Instead, CMS intends to refer to several lists of PFS imaging codes, including those that describe imaging services that are X-rays. In response to a comment, CMS states that it believes practitioners are in the best position to determine whether a particular imaging service is an X-ray taken using film.

Further, services made under the PFS that are X-rays (including the X-ray component of a packaged service) taken using *computed radiology* furnished during 2018 through 2022 are subject to a 7 percent reduction in payments and for a 10 percent reduction during 2023 or a subsequent year. Computed radiology technology is defined as cassette-based imaging, which utilizes an imaging plate to create the image involved. CMS states it will address implementation of this section in future rulemaking.

G. Procedures Subject to the Multiple Procedure Payment Reduction and the OPSS Cap

The Consolidated Appropriations Act of 2016 revises the Multiple Procedure Payment Reduction 25 percent to 5 percent, effective January 1, 2017. The reduction continues to apply when multiple imaging procedures are furnished by the same physician (or physician in the same group practice) to

the same patient, in the same session, on the same day. Full payment is made for the PC of the highest priced procedure and payment for the PCs of subsequent services is reduced by 25 percent. In addition, the statute exempts the reduced expenditures attributable to the revised 5 percent MPPR on the PC of imaging from the PFS budget neutrality provision.

The list of imaging services in 2017 that are subject to the MPPR and subject to the OPSS cap (under section 5102(b) of the DRA), are available on the CMS website. See <http://www.cms.gov/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFSFederal-Regulation-Notices.html>.

H. Valuation of Specific Codes

The final work RVUs plus work times and other payment information for all 2017 payable codes are available for download on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html>.

1. Methodology for Proposing the Direct PE Inputs to Develop PE RVUs

a. Background

The final 2017 direct PE inputs are shown in the 2017 direct PE input database, available for download at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html>.

2. Specialty-Mix Assumptions for Proposed Malpractice RVUs (MP RVUs)

The final 2017 malpractice crosswalk table is found with the public use files available for download at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html>. MP RVUs for all 2017 PFS services and the utilization crosswalk with source codes are reflected in Addendum B at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html>.

3. Rationales for Specific Code Valuations

Table 27 in the rule lists by CPT/HCPCS code number the work RVU changes made for 2017 and indicates whether total or intraservice work times were used by CMS in making work RVU adjustments to RUC recommended values. Readers with a particular interest in any of the codes from Section II.L.5 of the final rule should directly review the relevant portion of the rule for code-specific details. This summary provides highlights about changes within selected code categories affecting large code subsets, high volume codes, codes on which CMS specifically invited comment in the proposed rule, or codes for which CMS has potential beneficiary access concerns. (The code category numbering below follows the numbering in the final rule; since not all codes are discussed herein, the numbers are discontinuous.)

(1) Anesthesia Services Furnished in Conjunction with Lower Gastrointestinal (GI) Procedures
(CPT codes 00740 and 00810)

Given how often anesthesia codes are reported with colonoscopy services (over 50 percent of the time), CMS believed that the relative values of certain anesthesia services should be reexamined. CMS identified CPT codes 00740 and 00810, which are used to report anesthesia in conjunction with lower gastrointestinal (GI) procedures, as potentially misvalued.

The RUC recommended maintaining the existing base unit of 5 RVUs as an interim base value for both codes to allow the societies time to re-survey the codes with updated typical patient vignettes. CMS proposed and now finalizes agreement with maintaining the existing base values for 2017 but continues to regard these two services as potentially misvalued and seeks additional input for future rulemaking.

(2) Percutaneous Biliary Procedures Bundling
(CPT codes 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540, 47541, 47542, 47543, and 47544)

CMS restored the work RVUs for code 47541 to the RUC recommended 7.00. However, for this code (as well as for codes 47532, 47533, 47534, 47535, 47536, 47538, 47539, and 47540), CMS is establishing a final work value by removing 0.25 RVU related to the finalized moderate sedation work values (discussed later in this summary). Thus, the final 2017 work RVU for code 47541 is 6.75.

CMS also proposed several direct PE input changes in this family related to removing clinical labor time, supplies and equipment used for moderate sedation; replacing a PTA balloon catheter with a Dowd ureteral balloon catheter; and moving a supply item “stone basket” from one code and adding it to another to correct a PE database error. CMS finalized all the direct PE input changes in this code family as proposed.

(3) Laparoscopic Radical Prostatectomy
(CPT code 55866)

CMS set an interim final value of 21.36 RVUs in 2016 by crosswalk to code 55840 rather than the RUC recommended, survey-based 26.80. Commenters objected that the CPT descriptor for code 55866 includes robotic and non-robotic procedures, and that the latter approach takes significantly longer to perform. CMS, however, elected to maintain the interim value of 21.36 and to solicit additional input because of disparity between the clinical study and RUC survey operative times. During the current rulemaking cycle, additional study data supporting longer operating times were provided. Since data also support that the majority of procedures are now performed robotically, CMS is finalizing the RUC recommended value of 26.80 RVUs for 2017.

(4) Intracranial Endovascular Intervention
(CPT codes 61645, 61650, and 61651)

CMS established interim final work values of 15.00 for code 61645 (RUC recommended value 17.00), 10.00 for code 61650 (RUC recommended value 12.00), and 4.25 for code 61651 (RUC recommended value 5.50) which it finalized in this rule.

(5) Implantation of Neuroelectrodes
(CPT codes 64553 and 64555)

CMS maintained the interim work values and direct PE inputs while agreeing with the RUC's comment suggesting referral of the codes to the CPT Editorial Panel for possible revisions. For 2017, CMS finalizes the proposed time and direct PE input values for both codes. CMS also notes that time discrepancies in the 2016 work time file for these codes have been corrected in the 2017 file.

(6) Mammography – Computer-Aided Detection (CAD) Bundling
(CPT codes 77065, 77066, and 77067)

CMS pays per statute via G-codes for digital mammography. For 2017, the CPT Editorial Panel deleted five mammography codes and created three new codes describing mammography bundled with CAD with the objective of eliminating the use of the mammography G-codes. CMS notes that the RUC recommended work RVUs and direct PE inputs for the new codes could potentially markedly reduce payments for mammography services. To preserve beneficiary access to mammography while pursuing additional PE input data, CMS proposed to modify the G-codes to include the new CPT code descriptor language, to assign the RUC recommended work values to the revised G-codes, and to maintain the existing technical component PE RVUs of the G-codes. CMS is finalizing its proposed mammography work and PE RVUs for 2017. Finally, CMS adds that there will be no changes to the breast tomosynthesis codes for 2017¹⁰.

(7) Interstitial Radiation Source Codes
(CPT codes 77778 and 77790)

The RUC recommended work RVUs of 8.78 but CMS adopted the survey 25th percentile of 8.00 for an interim final value. CMS, the RUC, and commenters all agree that some of the time inconsistencies for these codes relate to the use of standard RUC pre-service packages that may in fact not be applicable to code 77778. CMS again proposed a work value of 8.00 for 2017 but is finalizing the RUC recommended value of 8.78 based upon comments about the work of supervision, handling, and loading of radiation seeds and about the bundling of code 77778 with code 77790.

(8) Immunohistochemistry
(CPT codes 88341, 88342, 88344, and 88350)

For CY 2017, CMS proposed work values incorporating a 20% discount from base to add-on code, using reference codes 37252 and 37253. Commenters objected that a “standard discount” of 20% for add-on codes based upon a clinically unrelated reference code pair does not produce valid work RVUs. CMS notes that add-on code discounts are not uniform throughout the PFS, which allows for tailoring to specific code groups. CMS finalizes the proposed work values of 0.56, 0.70, 0.70, and 0.59 for CPT codes 88341, 88342, 88344, and 88350, respectively.

¹⁰ Breast tomosynthesis HCPCS code G0279 will be reported with the new CPT codes 77065 or 77066 instead of G-codes G0204 and G0206 once CMS can process claims containing the new CPT codes.

(9) Liver Elastography
(CPT code 91200)

CMS finalizes for 2017 its proposed work RVUs and direct PE inputs, with the addition of the updated machine price. For 2017, CMS has also corrected an error in the work time file as published on the CMS website.

(10) Evaluative Procedures for Physical Therapy (PT) and Occupational Therapy (OT)
(CPT codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168)

For 2017, the CPT Editorial Panel deleted four and created eight codes for PT and OT evaluative services and the HCPAC forwarded to CMS work RVU and direct PE inputs for each code. Three new codes, stratified by complexity, replace the current single-level PT evaluation (CPT code 97001); three new codes, also stratified by complexity replace the current single-level OT evaluation (CPT code 97003); and two new single-level codes replace the current PT (97002) and OT (97004) re-evaluation codes. Table 23 of the final rule lists the long descriptors of the eight new codes and the required components of each code.

The HCPAC recommended work RVUs for the six new PT and OT evaluation codes, intended to be work neutral when compared to the current single-level PT and OT codes. Achieving work neutrality is dependent upon the accuracy of the projected relative frequency utilization of the new multi-level codes. The PT specialty society projected a 25-50-25% split and the OT specialty society projected a 50-40-10% distribution across their respective new 3-code series.

In the proposed rule CMS voiced considerable concern about the accuracy of the projected utilization profiles for both specialties as well as about incentivizing upcoding through the graded complexity code structures. CMS, therefore, proposed to adopt the new evaluation code sets, but to value each specialty code set as a group. This approach avoids G-code creation while maintaining work neutrality. CMS proposed a work RVU of 1.2 for both the PT and the OT evaluation code groups, based on the long-standing value for the existing evaluation codes, 97001 (PT) and 97003 (OT). CMS proposed direct PE inputs for each service code group based upon inputs for the respective moderate complexity new codes as recommended by the HCPAC, with minor refinements.

CMS finalizes its proposal to implement for 2017 the new CPT codes rather than creating alternative G-codes; to value the services in code groups; to maintain work neutrality by adopting the current single code-level work RVUs of 1.20 for the new code groups; and to adopt the proposed direct PE inputs for the new code groups. CMS adopted a one-year delay for implementing the multi-level code sets' documentation requirements.

CMS had proposed to maintain the existing work values (0.60) for the new (single-level) PT and OT re-evaluation codes rather than adopting the RUC recommended values (0.75 for PT and 0.80 for OT), citing work neutrality maintenance. Commenters objected, noting that these codes had not changed since 1997.

CMS reiterates that all eight new codes will be defined as “always therapy”, meaning that the services will always be considered therapy services regardless of the provider performing them and that the services will require the GP or GO modifier (for PT and OT respectively) to signify that

service delivery is under a PT or OT plan of care. The new codes will be subject to the therapy MPPR and to statutory therapy caps.

(11) Valuation of Services Where Moderate Sedation is an Inherent Part of the Procedure and Proposed Valuation of Moderate Sedation Services
(CPT codes 99151, 99152, 99153, 99155, 99156, and 99157; HCPCS code G0500)

In the final rule, CMS reprises elements of its proposal for valuing the six new CPT moderate sedation codes, created primarily to address the increasing use of anesthesia services during GI endoscopy:

- adopting the RUC recommended work RVUs for the new codes except code 991X4;
- valuing 991X4 through an incremental valuation approach;
- adopting the RUC recommended direct PE inputs for all six new codes, including 991X5, a zero-work, PE-only code;
- creating a G-code (GMMM1) for reporting the service otherwise described by 991X2 when moderate sedation is provided during GI endoscopy, reflecting the bimodal distribution of RUC survey values for GI endoscopists versus other practitioners; and,
- adopting a work value of 0.10 for GMMM1 based upon RUC survey data (versus 0.25 for 991X2, the code that will be used by practitioners other than GI endoscopists).

The final new code numbers and their finalized work values are shown in the table below. The RUC also provided CMS with work RVU recommendations for CPT Appendix G codes¹¹ from which moderate sedation has been removed. Believing that the RUC removed insufficient work RVUs, CMS proposed instead to remove 0.25 RVU for non-GI-endoscopy codes and 0.10 RVU for GI endoscopy codes. CMS finalizes the bimodal RVU removal proposal; changes the work decrease from 0.25 RVU to 0.10 for several gastrointestinal procedures¹²; and makes conforming changes in the G0500 descriptor (formerly GMMM1).

Table 26 in the final rule details the proposed and final work values for all codes affected by the moderate sedation changes, as well as identifies those codes with which the G0500 code is to be reported in lieu of the otherwise applicable new CPT conscious sedation codes. Table 26 is available for download at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html>.

Moderate Sedation Services Codes and Work Values: Proposed and Final

Service	Proposed Code	Finalized Code	Proposed Work Values	Final Work Values
same MD, pt < 5, first 15 min	991X1	99151	0.50	0.50
same MD, pt ≥ 5, first 15 min*	991X2	99152	0.25	0.25
another MD, pt < 5, first 15 min	991X3	99155	1.90	1.90
another MD, pt ≥ 5, first 15 min	991X4	99156	1.65	1.65
same MD, each additional 15 min	991X5	99153	0**	0**
another MD, each additional 15 min	991X6	99157	1.25	1.25

¹¹ Appendix G contains codes for which moderate sedation was considered inherent.

¹² Esophageal dilation, biliary endoscopy, and ERCP procedures

same MD, GI endo, ≥ 5 , first 15 min*	GMMM1	G0500	0.10	0.10
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*CPT code 99152 was subdivided for implementation by CMS; code 99152 is used for reporting to Medicare of moderate sedation not in support of gastrointestinal endoscopic services while code G0500 is reported when furnished with gastrointestinal endoscopic services.

**CPT code 99153 is a PE-only code so has a work value of zero.

(12) Expanded Primary Care Services and Behavioral Health Integration
(CPT codes 99358, 99359, 99487 and 99489; HCPCS codes G0501, G0502, G0503, G0504, G0505, G0506, and G0507)

CMS finalizes its proposals as follows for 2017:

- For non-face-to-face prolonged E/M services 99358 and 99359, CMS adopts the RUC recommended values and adopts the RUC recommended higher work value for the prolonged outpatient face-to-face service 99354.
- CMS unbundles complex chronic care management services 99487 and 99489 from other E/M services and finalizes the RUC recommended work values and direct PE inputs.
- CMS finalizes the creation of G-codes and payment for collaborative behavioral health services and finalizes total work RVUs that reflect an increase for the psychiatric consultant for codes G0502, G0503, and G0504. CMS finalizes adding behavioral health manager clinical labor type L057B to the direct PE input database and notes that code G0507 will include 20 minutes of behavioral health care manager time as a direct PE input.
- CMS finalizes creating G0505 for comprehensive assessment/care planning for cognitively-impaired patients and revises its proposed work value up to the RUC recommended RVU of 3.44. CMS is finalizing removal of 2 minutes of clinical labor but otherwise finalizes the proposed direct PE inputs for G0505.
- CMS finalizes creating G0506 for comprehensive assessment/care planning for chronic care management patients and finalizes the proposed work value and direct PE inputs.
- CMS does not finalize a value for new G-code G0501 to address extra resources needed to provide E/M services to mobility-impaired patients after receiving many comments supporting and opposing the code and its value. CMS notes that there are existing IRS tax credits and deductions to assist businesses in complying with the Americans with Disabilities Act.

(13) Telehealth Consultation for a Patient Requiring Critical Care Services
(HCPCS codes G0508 and G0509)

CMS finalizes work values for G0508 and G0509 (formerly codes GTTT1 and GTTT2, respectively). CMS also finalizes adding ESRD services (furnished for less than one month, CPT codes 90967-90970) and Advance Care Planning services (CPT codes 99497-99498) to the Medicare telehealth services list. CMS finalizes payment rules for the new telehealth place of service code (POS 02 Telehealth), required for reporting by the practitioner furnishing services at the distant site for 2017 and beyond.

I. Therapy Caps

CMS notes that the existing therapy caps are updated each year based on the MEI. Increasing the 2016 therapy cap of \$1,960 by the 2017 MEI of 1.2 percent and rounding to the nearest \$10.00 results in 2017 therapy cap of \$1,980.

CMS also notes that both the existing exceptions process for therapy caps and the manual medical review process for claims exceeding a threshold amount of \$3,700 expire on March 31, 2017 under current law.

III. Other Provisions of the Final Rule

A. Chronic Care Management (CCM) and Transitional Care Management (TCM) Supervision Requirements in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC)

To enable RHCs and FQHCs to contract with third parties to furnish aspects of CCM and TCM services, CMS finalizes its proposal to all that services and supplies furnished incident to TCM and CCM services can be furnished under general supervision of a RHC or FQHC practitioner. CMS notes that this exception to the direct supervision will only apply to auxiliary personnel furnishing TCM or CCM incident to services, and will not apply to other RHC or FQHC services.

B. FQHC-Specific Market Basket

Final 2017 FQHC Market Basket Update Compared to the MEI Update for 2017

Based on IGI's third quarter 2016 forecast with historical data through the second quarter of 2016, the final FQHC market basket increase factor for 2017 is 1.8 percent. This is based on a 2.2 percent increase of FQHC input prices and a 0.4 percent productivity adjustment. For comparison, the MEI increase factor for 2017 is 1.2 (a 1.6 percent MEI update and a 0.4 percent MFP adjustment). Table 39 in the final rule shows the final 2013-based FQHC market basket updates compared to the proposed 2013-based FQHC market basket updates for 2017.

CMS estimates that the cost of switching from a MEI-adjusted based payment to a FQHC PPS market basket-adjusted based payment rate will be approximately 210 million over 10 years from 2017-2026. CMS estimates that \$45 million will be paid through beneficiary premiums and the remaining \$165 million will be paid through Part B (Table 53).

C. Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Section 218(b) of the PAMA amended Title XVIII of the Act to add section 1834(q) directing CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. The 2016 PFS final rule addressed the first component of the AUC program – specifying applicable AUC. CMS established requirements for the development of AUC, defined provider-led entities (PLEs) and established the process by which PLEs may become qualified to develop, modify or endorse AUC.

This rule finalizes the requirements and process for specifications of qualified clinical decision support mechanisms (CDSMs) under the Medicare AUC program; the initial list of clinical priority

areas; and exceptions to the requirement that ordering professionals consult specified applicable AUC when ordering applicable imaging services. CMS plans to announce the first list of qualified CDSMs no later than June 30, 2017. CMS finalizes that starting January 1, 2018, ordering providers are required to consult with a qualified CDSM when ordering an applicable imaging service and the furnishing professional is required to include information about the ordering professional's consultation with a qualified CDSM on the Medicare claim.

1. Background

AUC are a set of individual criteria that present information in a manner that links a specific clinical condition or presentation, one or more services, and an assessment of the appropriateness of the service(s). Evidence-based AUC for imaging can assist clinicians in selecting the imaging study that is most likely to improve health outcomes for patients based on their individual context. AUC need to be integrated into the clinical workflow.

CDSMs are the electronic portals through which clinicians access AUC. Within Health IT applications, a CDSM is a functionality that provides persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care. PAMA requires information be reported on the claim form indicating whether the imaging service would or would not adhere to the specified AUC consulted through a CDSM, or whether the AUC was not applicable to the service.

2. Statutory Authority and Requirements

There are four major components of the AUC program under section 1834(q) of the Act, each with its own implementation date:

1. Establishment of AUC by November 15, 2015 (section 1834(q)(2));
2. 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 notes it did not identify mechanisms for consultation by April 1, 2016 and it will not have specified or published the list of qualified CDSMs by January 1, 2017; therefore ordering professionals will not be required to consult CDSMs and furnishing professionals will not be able to report information on the consultation by January 1, 2017.

3. Finalized Proposals for Implementation

CMS amends its regulations to add a new §414.94, "Appropriate Use Criteria for Certain Imaging Services."

a. Definitions

CMS finalizes its proposal to define CDSM as an interactive, electronic tool for use by clinicians that communicates AUC information to the user and assists them in making the most appropriate treatment decision for a patient's specific clinical condition. A CDSM will incorporate specified applicable AUC sets from which an ordering professional could select. A CDSM may be a module

within or available through certified EHR technology or private sector mechanisms independent from certified EHR technology. If within or available through certified EHR technology, a qualified CDSM will incorporate patient-specific information into the assessment of the appropriateness of an applicable imaging service.

b. Priority Clinical Areas

After consideration of comments, CMS modifies its proposed list of priority clinical areas and finalizes the following:

- Coronary artery disease (suspected or diagnosed),
- Suspected pulmonary emboli,
- Headache (traumatic and non-traumatic),
- Hip pain,
- Low back pain,
- Shoulder pain (including suspected rotator cuff injury),
- Cancer of the lung (primary or metastatic, suspected or diagnosed), and
- Cervical or neck pain without change.

CMS did not finalize its proposal to include chest pain, abdominal pain (any locations and flank pain), suspected stroke, and altered mental status as priority clinical areas. After consideration of comments, CMS added coronary artery disease, suspected pulmonary emboli, hip pain, and shoulder pain to the final list of priority clinical areas.

In response to commenters' concerns about the difficulty ordering professionals may have in identifying which clinical scenarios pertain to a priority clinical area, CMS reiterates that ordering professionals will be required to consult specified applicable AUC through a qualified CDSM for all applicable imaging services and will not be required to determine which applicable imaging services fall within priority clinical areas. The applicable imaging services are not limited under the statute to any particular area. For the purpose of the AUC program, priority clinical areas will be used as part of the input to identify ordering professionals that are outliers. CMS intends to use rulemaking for the 2018 PFS to develop policies for the annual identification of outlier ordering professionals.

In response to commenters requesting clarification regarding the role of local coverage determinations (LCDs) and national coverage determinations (NCDs) and the AUC program, CMS notes it considers LCDs and NCDs to be active and binding policies detailing the criteria upon which Medicare coverage or non-coverage is based. CMS states that consulting with AUC is not a replacement for a determination of medical necessity and that specified applicable AUC do not override LCDs or NCDs.

c. CDSM Qualifications and Requirements

CMS finalizes with modifications its proposed requirements:

1. Make available specified applicable AUC and its related supporting documentation.
2. Identify the appropriate use criterion consulted if the CDSM makes available more than one criterion relevant to a consultation for a patient's specific clinical scenario.
3. Make available, at a minimum, specified applicable AUC that reasonably address common and important clinical scenarios within all finalized priority clinical areas.

4. Be able to incorporate specified applicable AUC from more than one qualified PLE.
5. Determine, for each consultation, the extent to which the applicable imaging service is consistent with specified applicable AUC.
6. 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 adhered to or did not adhere to specified applicable AUC; or whether the specified applicable AUC consulted was not applicable to the service ordered; and
 - Include a unique consultation identifier generated by the CDSM.
7. Modifications to AUC within the CDSM must comply with the following requirements:
 - Make available updated AUC content within 12 months from the date the qualified PLE updates AUC;
 - 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 areas.
8. Meet privacy and security standards under applicable provisions of law.
9. 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.
10. Maintain electronic storage of clinical, administrative, and demographic information of each unique consultation for a minimum of 6 years.
11. Comply with modification(s) to any requirements made through rulemaking within 12 months of the effective date of the modification.
12. Notify ordering professionals upon de-qualification.

Some commenters requested CMS clarify that radiology benefit management (RBM) companies cannot be involved in any way with qualified PLEs and in the development of specified applicable AUC. In response CMS clarifies that qualified PLEs may collaborate with third parties that they believe add value to their development of AUC, provided such collaboration is transparent. In addition, CMS reminds commenters that qualified PLEs must disclose the parties external to the organization when such parties have involvement in the AUC development process.

d. Consultation by Ordering Professional and Reporting by Furnishing Professional

CMS states that at the earliest, the first qualified CDSM(s) will be specified on June 30, 2017 and it expects that furnishing professionals will be required to begin reporting January 1, 2018. CMS expects physicians and other stakeholders/regulated parties to begin preparing to report on January 1, 2018. CMS states it will adopt procedures for capturing this information on claim forms and the timing of the reporting requirements through 2018 PFS rulemaking

CMS intends to develop requirements in the 2018 PFS rulemaking. CMS encourages stakeholders to provide additional information about the requirements for claims reporting at any time through the AUC program email box ImagingAUC@cms.hhs.gov.

In response to comments, CMS states that it is not establishing requirements regarding the communication of the imaging order from the ordering professional to the furnishing professional.

e. Exceptions to Consulting and Reporting Requirements

- CMS finalizes its proposal to provide for an exception to the AUC consultation and reporting requirements for an applicable imaging service ordered for an individual with an emergency medical condition. CMS notes that to meet this exception, the clinician needs to determine that the medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual (or a woman's unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
- The second exception is for an applicable imaging service ordered for an inpatient and for which payment is made under Medicare Part A.

CMS finalizes its proposal that ordering professionals who are granted a significant hardship exception for purposes of the Medicare EHR Incentive Program payment adjustment will be also granted a significant hardship exception for the AUC consultation requirement. CMS finalizes that the year the practitioner is exempted from the EHR Incentive Program payment adjustment is the same year that the practitioner will be exempted from consulting AUC.

D. Release of Part C Medicare Advantage Bid Pricing Data and Part C and Part D Medical Loss Ratio (MLR) Data

CMS finalizes its proposed release to the public of MA bid pricing data (but not Part D pricing data) on a specific schedule, subject to certain exclusions. It also finalizes its proposed Parts C and D Medical Loss Ratio (MLR) data release but adds two exceptions to its proposed list of data to be excluded from public release. The data releases will be reflected in newly added contract terms.

1. Release of MA Bid Pricing Data

CMS finalizes its proposal to provide for the annual release to the public (after the first Monday in October) of pricing data that CMS accepted or approved for a contract year at least five years prior to the upcoming calendar year (with exclusions).

a. Terminology

“MA bid pricing data” means the pricing-related information that MAOs must submit for each MA plan for the annual bid submission in a form and manner specified by CMS for MSAs. “MA bid pricing data” operationally includes all the figures that MAOs input and those that are calculated within the Bid Pricing Tools (BPTs).

More specifically, CMS includes for purposes of the bid data submission the estimated revenue required by an MA plan for providing original Medicare benefits and mandatory supplemental health care benefits, if any (composed of direct medical costs by service type, administrative costs and return on investment) and the plan pricing of enrollee cost-sharing for original Medicare

benefits and mandatory supplemental benefits. The definition also references the MA bid pricing data elements, which includes more detail about the Medicare covered and supplemental bid amounts (e.g., such as the actuarial bases for the bid amounts, projected enrollment, and data specific to regional MA plans). In addition, the definition includes incorporating beneficiary rebates. Thus, for plans that bid below the benchmark for their service areas, the term includes the beneficiary rebate amounts that are allocated in the BPTs to the uses allowed in law: reduction of cost-sharing below original Medicare levels, offering additional benefits not covered by original Medicare, and reduction of the Part D basic premium, the Part D supplemental premium, and/or the Part B premium.

b. Exclusions from Release

CMS finalizes its proposal to exclude certain information from the data that will be released:

1. For an MA plan that includes Part D benefits, information pertaining to the Part D bid amount.¹³
2. Additional information that CMS requires to verify the actuarial bases of the bids: narrative information on the base period factors, manual rates, cost-sharing methodology, optional supplemental benefits and other required narratives; and supporting documentation. (CMS reiterates in the final rule's preamble that the release of such information could provide an unfair commercial advantage to certain entities and likely would impair its ability to obtain such information in the future.)
3. Any information that could be used to identify beneficiaries and other individuals. (CMS finalizes its preamble language to exclude from release any MA bid pricing data based on fewer than 11 Medicare beneficiaries, a threshold below which individual-level data can be discerned. Such data will be suppressed in the public release file for the MA plan bid. CMS does not include this specific threshold in the regulatory text because it believes that technology and the ability to reverse-engineer data to identify beneficiaries may change over time. CMS may revisit this threshold as it administers the data releases and will make adjustments as necessary to ensure that it does not disclose data that could be used to identify beneficiaries.)
4. Bid review correspondence (between CMS, its contractors and the MAOs) and internal bid reports.

c. Timing of MA Bid Pricing Data Release

Under the finalized rule, MA bid pricing data will be released on an annual basis after the first Monday in October.

2. Release of MLR Data

MAOs and Part D plan sponsors are required by statute to report MLR data to CMS.

a. Overview and Terminology

¹³ CMS did not propose release of Part D pricing data because such data are generally protected from public release under 1860D-15(f) of the Act. No similar provision applies to MA bid pricing data.

CMS finalizes its proposal to release to the public certain MLR data submitted by MAOs and Part D sponsors. These data include for MAOs the average per member per month CMS payment for A/B benefits for each MA plan offered, standardized to the 1.0 (average risk score) beneficiary. Part C MLR data are defined as the data the MAOs and Part D sponsors submit to CMS in their annual MLR Reports. CMS will release the Part C MLR data and Part D MLR data, respectively, for each contract for each contract year, no earlier than 18 months after the end of the applicable contract year.

b. Exclusions from the Release of Part C and Part D MLR Data

CMS finalizes its proposed four categories of information to be excluded from release: (1) narrative description that MAOs and Part D sponsors submit to support the amounts that they include in their MLR Reports, such as descriptions of the methods used to allocate expenses; (2) information that is reported at the plan level, such as the number of member months associated with each plan under a contract; (3) any information that could be used to identify Medicare beneficiaries and other individuals; and (4) MLR review correspondence.

CMS also adds two additional exclusions: First, related to Part D MLR data it excludes from release any MLR data submitted for a single-plan contract. CMS says that contract-level data for single-plan contracts is equivalent to plan-level data, which it regards as more competitively sensitive because it is at a lower level of aggregation. Second, with respect to Part C MLR data, and Part D MLR data, exclusion of any MLR data submitted for a contract in a contract year for which the contract is determined to be non-credible for MA contracts and Part D contracts. CMS adopts this new exclusion of non-credible contracts' MLR data because these contracts' MLRs are more vulnerable to the effects of random variations in claims experience and may fail to reflect their efficiency or relative value.

CMS will not disclose data for a contract if the total number of beneficiaries was fewer than 11 but CMS does not include this in the regulatory text so as to be able to revise this threshold if necessary to protect personally identifiable information of beneficiaries. In addition

c. Timing of Release of Part C and Part D MLR Data

CMS finalizes its proposal to release to the public the MLR data for each contract for each contract year, no earlier than 18 months after the end of the applicable contract year. CMS explains that for Part C and Part D MLR reporting, the data are due about 12 months after the end of the contract year. After CMS receives MAOs' and Part D sponsors' MLR reports, it expects to take up to six months to review and finalize the data.

E. 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 (QMB) program.

F. Recoupment of Offset of Payments to Providers Sharing the Same Taxpayer Identification Number (TIN)

Medicare payments to providers and suppliers may be offset or recouped, in whole or in part, by a Medicare contractor if the contractor or CMS has determined that a provider or supplier has been overpaid. CMS notes it has historically used the Medicare provider billing number or National Provider Identifier (NPI) to recoup overpayments until these debts were paid in full or eligible for referral to the Department of Treasury (Treasury) for further collection action. Treasury uses various tools to collect the debt, including federal payments against entities that share the same TIN.

The ACA, allows the Secretary to make any necessary adjustments to the payments of an applicable provider of services or supplier to satisfy any amount due from an obligated provider of services or supplies. The statute defines an applicable provider of services or supplier (*applicable provider*) as a provider of services or supplies that has the same TIN as the one assigned to the obligated provider of services or supplier. The statute defines the obligated provider of services or supplier (*obligated provider*) as a provider of services or supplier that owes a past-due overpayment to the Medicare program. CMS states that for purposes of this provision, the applicable and obligated providers must share a TIN, but may possess a different billing or NPI than one another.

CMS provides the following example: A health care system may own a number of hospital providers and these providers may share the same TIN but have different NPI numbers. If one of the hospitals in the system receives a demand letter for a Medicare overpayment, then the hospital (Hospital A) will be considered the obligated provider while the other hospitals in the same TIN (Hospitals B and C) will be considered the applicable providers. CMS states this authority allows it to recoup the obligated provider Hospital A, against any or all of the applicable providers, Hospital B and C, with which it shares a TIN.

G. Accountable Care Organizations (ACO) Participants Who Report Physician Quality Reporting System (PQRS) Quality Measures Separately

CMS finalizes its proposal to permit EPs that bill under the TIN of an ACO participant to report separately for purposes of the 2017 and 2018 payment adjustment when the ACO fails to report on behalf of the EPs who bill under the TIN of an ACO participant.

CMS finalizes that for the reporting period for the 2018 PQRS payment adjustment (January 1, 2016 through December 31, 2016), EPs who bill under the TIN of an ACO participant have the option of reporting separately as individual EPs or group practices. If the ACO fails to satisfactorily report, CMS will consider this separately reported data for purposes of determining whether the EPs or group practices are subject to the 2018 PQRS payment adjustment. Since affected EPs are not able to register for the PQRS GPRO by the applicable deadline for the PQRS GPRO (June 30 was the registration deadline), CMS eliminates the registration process for groups submitting data using third party entities. CMS finalizes that an affected EP may report either as an individual EP or as a group practice. CMS notes that individual EPs will not be able to use the claims reporting option and group practices will not be able to use the Web Interface and certified survey vendor options.

Consistent with the 2018 PQRS payment adjustment, CMS finalizes its proposal to permit EPs that bill through the TIN of an ACO participant to report separately for purposes of the 2017 PQRS payment adjustment if the ACO failed to report on behalf of the EPs who bill under the TIN of an

ACO participant. The established reporting period for the 2017 PQRS payment adjustment was January 1, 2015 through December 31, 2015. CMS establishes a secondary PQRS reporting period for the 2017 PQRS payment adjustment for individual EPs or group practices who bill under the TIN of an ACO participant if the ACO failed to report during the previously established reporting period for the 2017 PQRS payment adjustment. This option will not be available to EPs that failed to report for purposes of PQRS outside the Shared Savings Program.

CMS finalizes that the secondary reporting period for the 2017 PQRS payment adjustment would coincide with the reporting period for the 2018 PQRS payment adjustment (January 1, 2016 through December 31, 2016). CMS will assess the individual EP or group practice's 2016 data using the applicable satisfactory requirement for the 2018 PQRS payment adjustment (including, but not limited to, the applicable PQRS measure set). Affected EPs may utilize the secondary reporting period as an individual EP or as a group practice using the registry, QCDR, direct EHR product or EHR data submission reporting options. CMS finalizes that the informal review submission period for this secondary reporting period for the 2017 payment adjustment will occur during the 60 days following the release of the PQRS feedback reports for the 2018 PQRS payment adjustment.

CMS notes that individual EP or group practice data could be used for the secondary reporting period for the 2017 payment adjustment or for the 2018 payment adjustment or for both payment adjustments if the ACO in which the affected EPs participate failed to report for purposes of the applicable payment adjustment. CMS stresses that if an affected individual EP or group decides to use the secondary reporting period for the 2017 payment adjustment, the affected EP or group practice should expect to receive a PQRS payment adjustment for services furnished in 2017 until CMS is able to determine that the EP or group practice satisfactorily reported PQRS for the purposes of the 2017 PQRS payment adjustment. The EP or group practice will also avoid the automatic downward VM adjustment, but will not qualify for an upward adjustment. (See discussion in section III.L. of this summary).

H. Medicare Advantage Provider Enrollment

The final rule adopts the proposed requirements that MAO providers and suppliers be enrolled in Medicare in an approved status with several modifications as described below. An "approved status" is a status whereby a provider or supplier is enrolled in, and is not revoked from, the Medicare program. A provider or supplier that has submitted an application, but has not completed the enrollment process with their respective MAC, is not enrolled in an approved status. A provider or supplier that is currently revoked from Medicare is not in an approved status. Out-of-network or non-contract providers and suppliers are not required to enroll in Medicare to meet the requirements of this rule. MAOs that fail to ensure compliance on the part of their providers and suppliers will be subject to sanctions and termination.

1. Provisions of the Final Regulation

CMS finalizes as proposed that an MAO is prohibited from paying, directly or indirectly, on any basis, for items or services (other than emergency or urgently needed services) furnished to a Medicare enrollee by any individual or entity that is excluded by the Office of the Inspector General (OIG) or is revoked from the Medicare program. An exception is provided under paragraph (b) that if an MAO receives a request for payment by, or on behalf of, an individual or entity excluded by the OIG or revoked in the Medicare program, the MAO must notify the enrollee and the excluded or

revoked individual or entity in writing. In the final rule, CMS modifies this exception to say that *payment may not be made to, or on behalf of, an individual or entity that is excluded by the OIG or is revoked in the Medicare program. (The proposed rule would have prohibited making such payments following the first payment.)* CMS states that, based on further analysis, it determined that its proposed first time allowance for payment violates statute.

CMS finalizes as a condition of contracting with CMS, that an MAO must agree to provide documentation that all providers and suppliers in the MA or MA-PD plan who could enroll in Medicare are enrolled in an approved status. The authorized individual is required to thoroughly describe how the entity and MA plan met, or will meet, all the requirements described in this part, including providing documentation that all providers and suppliers are enrolled in Medicare in an approved status.

CMS finalizes its proposals to add:

- Provisions that require MAOs, Cost plans, and PACE organizations to require all first-tier, down-stream and related entities and contracted entities to agree to comply with the provider and supplier enrollment provision.
- Its authority to terminate a contract if an MAO or PACE organization fails to meet provider and supplier enrollment requirements in accordance with §422.222 and payment prohibitions in §422.224.
- Provisions giving CMS the authority to impose sanctions in the case of an MAO or PACE organization that fails to meet the provider and supplier enrollment requirements.

These provisions are effective the first day of the next plan year that begins 2 years from the date of publication of the CY 2017 PFS final rule with comment period. For PACE organizations, the requirements become effective on the first day of the calendar year that is 2 years after the publication of this final rule.

I. Proposed Expansion of the Diabetes Prevention Program (DPP) Model

CMS finalizes its proposal to expand the duration and scope of the Diabetes Prevention Program (DPP) model test and refers to the expanded model as the Medicare Diabetes Prevention Program (MDPP). The MDPP will become effective nationwide beginning January 1, 2018.

CMS is not finalizing its proposals related to preliminary recognition to provide MDPP services and virtual MDPP services. CMS is also not finalizing policies related to payment and program integrity safeguards, including specific policies regarding monitoring and enforcement actions for supplier enrollment. CMS intends to address these issues in future rulemaking.

CMS intends to begin supplier enrollment before the model becomes effective. It intends for organizations to be able to enroll as MDPP suppliers at the completion of the 2018 rulemaking cycle. CMS may issue subregulatory guidance to assist in this preparation before 2018 rulemaking is finalized.

1. Background

The National Diabetes Prevention Program (DPP) administered by the Centers for Disease Control and Prevention (CDC), is a structured health behavior change program delivered in community and health care settings by trained community health workers or health professionals. The program consists of 16 intensive “core” sessions of a CDC-approved curriculum in a group-based setting that provides practical training for overcoming challenges to sustaining weight loss and a healthy lifestyle. Monthly maintenance sessions help to ensure that the participants maintain healthy behavior. The primary goal of the intervention is at least 5 percent average weight loss among participants.¹⁴

2. MDPP Benefit Description

CMS finalizes 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 also finalizes 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 modifies its proposal and finalizes that MDPP suppliers must use any CDC-approved curriculum. CMS notes the CDC-preferred curriculum is available at <http://www.cdc.gov/diabetes/prevention/lifestyle-program/curriculum.html>.

CMS states it will not require a minimum or maximum number of beneficiaries that an MDPP supplier must/may serve but will monitor for signs of adverse selection of beneficiaries and propose specific program integrity requirements in future rulemaking, as appropriate.

3. Beneficiary Eligibility

MDPP Eligible Beneficiaries

CMS finalizes its proposal that coverage of MDPP services would be available for beneficiaries who meet all of the following criteria:

1. Are enrolled in Medicare Part B;
2. Have as of the date of attendance at the first Core Session a body mass index (BMI) of at least 25 if not self-identified as Asian and a BMI of at least 23 if self-identified as Asian¹⁵;
3. Have within the 12 months prior to attending the first Core session a hemoglobin A1c (HbA1c) test with a value between 5.7 and 6.4 percent, or a fasting plasma glucose of 110-125 mg/dL, or a 2-hour post-glucose challenge of 140-199 mg/dL;
4. Have no previous diagnosis of Type 1 or Type 2 diabetes (a previous diagnosis of gestational diabetes is eligible for MDPP); and
5. Does not have end-stage renal disease (ESRD).

CMS will permit beneficiaries who meet the above criteria to obtain MDPP by self-referral, community-referral, or health care practitioner-referral.

¹⁴Additional information about the National DPP is available at <http://www.cdc.gov/diabetes/prevention/lifestyle-program/index.html>.

¹⁵ The CDC DPP Standards have defined a lower BMI for self-identified Asian individuals based on data that show Asians develop abnormal glucose levels at a lower BMI.

CMS states that the blood tests that are used to demonstrate MDPP eligibility align with the CDC standards for eligibility and with the American Diabetes definition for pre-diabetes. These tests, however, are not covered as part of the MDPP services and occur before the start of the beneficiary's participation in MDPP. CMS acknowledges that HgA1c is not covered for purposes of screening for pre-diabetes, but that the oral glucose tolerance test and fasting plasma glucose test, are covered for pre-diabetes screening under Medicare.

Limitations on Coverage

CMS finalizes its proposal that eligible beneficiaries can participate in MDPP only once.

4. Enrollment of MDPP Suppliers

a. MDPP Supplier Enrollment Requirements

CMS finalizes its proposal to permit organizations that meet the supplier enrollment eligibility criteria to enroll in Medicare as MDPP suppliers. CMS modifies its proposal for existing Medicare providers or suppliers and finalizes that existing Medicare providers or suppliers are also required to adhere to the same enrollment requirements as MDPP suppliers if they wish to furnish and bill for MDPP suppliers.

CMS finalizes that MDPP suppliers would be subject to enrollment regulation set forth in 42 CFR part 424, subpart P. In addition, CMS finalizes that potential MDPP suppliers would be screened according to the high categorical risk category. As suppliers, enrolled MDPP organizations would be obligated to comply with all statutes and regulations that establish applicable requirements for Medicare suppliers.

CMS plans to issue additional details through guidance or future rulemaking to help guide organizations in applying for an NPI.

CMS clarifies that any organization that obtains CDC DPRP recognition will be eligible to enroll in Medicare as a MDPP suppliers. CMS notes that CDC recognizes organization, not individuals and thus any claims submitted for MDPP services would be billed by the MDPP supplier and not by an individual or any other enrollment type a supplier may have.

CMS states that RHCs and FQHCs can enroll as MDPP suppliers if they meet the enrollment criteria but MDPP is not a RHC or FQHC services. A clinic that chooses to furnish MDPP services could exclude all costs related to furnishing MDPP services from its cost report and instead submit claims for MDPP services under its separate MDPP supplier enrollment.

b. CDC DPRP Recognition

CMS finalizes its proposal that an entity must have full CDC DPRP recognition as a requirement to enroll in Medicare as an MDPP supplier. CMS is not finalizing any proposals related to preliminary CDC recognition and will address this in future rulemaking.

Because the CDC has not adopted standard for preliminary recognition, CMS does not finalize its related proposals to preliminary recognition status. CMS anticipates that CDC will address

standards for preliminary recognition when it published updated DPRP Standards for public comment in 2018.

c. Coach Requirements

CMS finalizes its proposal that DPP organizations must enroll in Medicare to become MDPP suppliers, and that coaches will not enroll in Medicare for purposes of furnishing MDPP services. CMS finalizes that coaches must obtain NPIs. In addition, MDPP suppliers must submit the active and valid NPIs of all coaches who will furnish MDPP services on behalf of the MDPP supplier as an employee or contractor. Upon enrollment, MDPP suppliers must submit, and update within 30 days of any changes, a roster of coaches, including individual's first and last name, SSN and NPI to CMS. CMS notes this will help ensure the coaches meet program integrity standards.

d. Information Technology (IT) Infrastructure and Capabilities

CMS finalizes that MDPP suppliers will be required to submit claims to Medicare using standard claims forms and procedures. CMS will provide technical assistance to MDPP suppliers to comply with Medicare claims submission standards.

CMS finalizes its proposal to require MDPP suppliers to maintain a crosswalk between the beneficiary identifiers they submit to CMS for billing purposes and the beneficiary identifiers they provide CDC and that MDPP suppliers provide this crosswalk to a CMS evaluator on a regular basis.

CMS finalizes its proposal to require MDPP suppliers to maintain records that document the MDPP services provided to beneficiaries, including the eligibility status, sessions attended, coaches furnishing the session, the date and place of services sessions attended, and weight. Consistent with the requirements, CMS finalizes records be retained for 7 years from the date of service and that MDPP suppliers would provide CMS or a Medicare contractor access to these records upon request.

5. Policies for Future Rulemaking

MDPP Reimbursement Structure

After consideration of comments, CMS defers finalizing the proposed reimbursement structure to future rulemaking.

J. Medicare Shared Savings Program

1. ACO Quality Reporting

a. Changes to the Quality Measure Set Used in Establishing the Quality Performance Standard

CMS finalizes its proposal to modify the quality measure set that an ACO is required to report in order to better align the MSSP quality measure set with the measures recommended by the Core Quality Measure Collaborative and for reporting through the QPP final rule. Overall, CMS will add three measures and retire or replace six measures. The total number of measures will decrease from

34 to 31 measures. Table 42 in the final rule lists the quality measure set.¹⁶ CMS will add ACO-44 Use of Imaging Services for Low Back Pain as proposed, but will retain it as pay for reporting in all 3 years of the ACO's agreement period. Commenters were concerned about the narrow age range of this measure (aged 18-50) and the potential for small case sizes that could result from such a limited age range.

The three ACO measures CMS adds—all to the care coordination/patient safety domain—are listed below. Two of these measures (ACO-12 and ACO-43) would be designated as pay for reporting in 2017 and 2018 and then phase into pay for performance starting with Performance Year (PY)2 of an ACO's first agreement period. ACO-44 will be pay for reporting in all 3 years.

- *ACO-12 Medication Reconciliation Post-Discharge (NQF #0097)*. This measure was developed by the Core Quality Measure Collaborative in coordination with other providers and stakeholders. This measure is intended to address adverse drug events (ADEs) through medication reconciliation, as a means to improve care coordination. To align the QPP proposal, CMS will replace the Documentation of Current Medications in the Medical Record measure (ACO-39) by reintroducing Medication Reconciliation (ACO-12) in the Care Coordination/Patient Safety domain.
- *ACO-44 Use of Imaging Studies for Low Back Pain (NQF #0052)*. This measure was added to address a gap in measures related to resource utilization and align with the ACO measures recommended by the Core Quality Measures Collaborative core measure set. This measure was adopted in the QPP final rule for EHR reporting.
- *ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ PQI #91)*. This is an AHRQ composite measure, currently used in the Physician VBP modifier, which includes reporting on admissions related to dehydration, bacterial pneumonia, and urinary tract infections. These admissions may occur as a result of inadequate access to ambulatory care or poorly coordinated ambulatory care. CMS notes that this measure will be risk-adjusted for demographic variables and comorbidities.

CMS also modifies the EHR measure (ACO-11) to align with the Advanced APM criteria under the QPP and will consider this to be a newly introduced measure (discussed in more detail in the summary in section III.K.2)

CMS retires or replace six measures. CMS notes that this will reduce provider burden as this will reduce the number of measures that must be reported. In addition, CMS states that these six measures do not align with the core measure set recommendations from the Core Quality Measures Collaborative and the measures reporting through the CMS web interface in the QPP final rule:

- ACO-9 Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5).
- ACO-10 Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8).

¹⁶ CMS also lists ACO-11 Use of Certified EHR Technology as a new measure. CMS is proposing substantial revisions to this existing measure, and, as such, CMS proposes considering it as a newly introduced measure.

- ACO-21 Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented.
- ACO-31 Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).
- ACO-33 Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%).
- ACO-39 Documentation of Current Medications in the Medical Record.

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. Each of the four domains, equally weighted at 25%, will include the following number of quality measures:

- Patient/Caregiver Experience of Care – 8 measures
- Care Coordination/Patient Safety – 10 measures
- Preventive Health – 8 measures
- At Risk Population – 5 measures (including 3 individual measures and a 2-component diabetes composite measure)

With the removal of the 6 additional measures, the total possible points for the Preventive Health domain will decrease from 18 to 16 points, and the At-Risk Population domain will decrease from 12 to 8.

b. Improving the Process Used to Validate ACO Quality Data Reporting

CMS finalizes proposed changes to the audit process with modification. CMS finalizes a policy that requires 3 phases of medical record review: (1) audit enough medical records to achieve a 90 percent confidence interval; (2) conduct the audit in a single phase; and (3) calculate an overall audit performance rate.

First, CMS finalizes a policy to audit enough medical records to achieve a 90 percent confidence interval that the true audit match rate is within 5 percentage points of the calculated result. This will increase the number of records audited per measure (more than the current 30), but CMS does not anticipate more than 50 records will be required per audit measure based on its analysis.

Second, CMS finalizes its proposal to modify its regulations in order to conduct the quality validation audit in a single step rather than the current multi-phased process. During the single step, CMS would review all submitted medical records and calculate the match rate. CMS modifies its proposed policy that there *would not* be an opportunity for ACOs to correct and resubmit data for any measure with a >10 percent mismatch. Instead, CMS finalizes a policy under which CMS will adjust an ACO's overall performance score to reflect audit findings when the ACO has audit mismatch of greater than 10 percent. CMS will retain discretion not to apply this adjustment to the ACO's score in certain unusual circumstances where it would be inappropriate to apply the adjustment.

Absent unusual circumstances, CMS will adjust the ACO's overall quality score proportional to its audit performance. For example, if an ACO's quality score is 75 percent and the ACO's audit

match rate is 80 percent, the ACO's audit-adjusted quality score is 60 percent. This score would be used to determine the percentage of any earned savings that the ACO may share or the percentage of any losses for which the ACO is accountable.

Third, CMS finalizes its proposal to provide for an assessment of the ACO's overall audit match rate across all measures, instead of assessing the ACO's audit mismatch rate at the measure level. CMS will calculate an overall audit match rate which will be derived by dividing the total number of audited records that match the information reported in the Web Interface by the total number of records audited.

In addition, CMS finalizes its proposal to add a new requirement that if any ACO has an audit match rate of less than 90 percent, the ACO may be required to submit a corrective action plan (CAP) for CMS approval. CMS notes that it maintains the right to terminate or impose other sanctions on any ACO that does not report quality data accurately, completely or timely.

CMS will apply these policies to the quality validation audits beginning in 2017.

c. Technical Changes Related to Quality Reporting Requirements

CMS finalizes several technical changes including changes to clarify overall quality performance standards that must be met by ACOs and a modification to the "minimum attainment" requirement.

CMS first wants to clarify in its regulations that while there are certain standards that must be met for each measure or in each domain, there is one overall quality performance standard that must be met in each performance year by an ACO. Failure to meet the quality performance standard in a given performance year makes ACOs ineligible to share in savings, even if generated, and such ACOs may be subject to compliance actions.

Second, CMS addresses the concept of the minimum attainment level and its use in determining whether an ACO has met the quality performance standard. CMS notes that in guidance, it has interpreted the quality performance requirements for domains to apply only to pay for performance measures. As such, CMS notes that under its current interpretation of its rules, it is not possible to take compliance actions against an ACO in its first performance year for failure to achieve the minimum attainment level on at least 70 percent of the measures in a domain because there are no pay for performance measures on which to assess performance on a domain.

CMS finalizes its proposal to take all measures (i.e., pay for reporting and pay for performance measures) into account when determining ACO performance at the domain level for purposes of compliance actions.

d. Technical Changes to Application of Flat Percentages for Quality Benchmarks

CMS finalizes its proposal to no longer apply the flat percentage policy to performance measures calculated as ratios, such as the Ambulatory Sensitive Conditions Admissions measures and the All-Cause Readmission measure. CMS states that applying the flat percentages has caused confusion in the interpretation of quality results. CMS also makes two technical changes to address typographical errors.

e. Incorporation of Other Reporting Requirements Related to PQRS

CMS finalizes its proposal require that an ACO report on behalf of the eligible professionals who bill under the TIN of an ACO participant for purposes of the of the 2017 and 2018 PQRS payment adjustment. Under this revised provision the prohibition on separate quality reporting for purposes of the PQRS payment for 2017 and 2018 will be removed. CMS reiterates its intent that data reported by an ACO will continue to be preferentially used for purposes of other CMS initiatives that rely on such data, including the PQRS and the VM. If an EP who bills under the TIN of an ACO participant chooses to report apart from the ACO, the EP's data may be used for purposes of PQRS and VM only when complete ACO reported data is not available. CMS emphasizes that only quality data reported by the ACO can be used to assess the ACO's performance under the Shared Savings Program.

2. Alignment with the Quality Payment Program

In its review of the MSSP rules, CMS identified several modifications to program rules to better support and align CMS' efforts related to the QPP. These modifications include sunsetting MSSP alignment with PQRS and EHR Incentive Program,

a. Proposals Related to Sunsetting PQRS and EHR Incentive Program Alignment and Alignment with APM Reporting Requirements under the Quality Payment Program

CMS notes that the VM, PQRS and the EHR incentive programs are sunsetting and the last quality reporting period under these programs is 2016, which would impact payments in 2018. Quality reporting under the QPP would begin in 2017 for payment year 2019.

CMS finalizes several changes to align with the policies in the QPP final rule:

- Amend §§425.504 and 425.506 to indicate that these reporting requirements apply to ACOs and their EPs through the 2016 performance year.
- Require that ACOs, on behalf of EPs who bill under the TIN of an ACO participant, must submit all the ACO CMS web interface measures required by the Shared Savings Program using a CMS web interface, to meet reporting requirements for the quality performance category under MIPS. This will parallel the current requirement for reporting on behalf of EPs who bill under the TIN of an ACO participant for purposes of PQRS.
- Maintain flexibility for EPs to report quality performance category data separately from the ACO, and therefore there are no provisions that will restrict an EP from reporting outside the ACO. CMS notes no quality data reported apart from the ACO will be considered for purposes of assessing the quality performance of the ACO.

b. Proposals related to alignment with the Quality Payment Program

In order to align its MSSP policies with the QPP final rule, CMS finalizes its proposal to modify the title and specifications of the EHR quality measure (ACO -11). CMS changes the specifications of the EHR measure to assess the ACO on the degree of CEHRT use by all providers and suppliers designated as EPs under the QPP that are participating in the ACO rather than narrowly focusing on

the degree of use of CEHRT of only the primary care physicians participating in the ACO. CMS also will modify the title of the measure to remove the reference to PCPs. Given that the specifications will be extensive, CMS will consider this to be a newly introduced measure and be considered pay for reporting for the 2017 and 2018 performance years.

During the years in which this measure is designated as pay for reporting, CMS also finalizes its proposal to include the requirement that at least one EP participating in the ACO must meet the reporting requirements under the Advancing Clinical Information performance category under the QPP. Further, CMS also finalizes its proposal that during pay for performance years, assessment of EHR adoption will be measured based on a sliding scale.

CMS also finalizes its policy that any future changes to the CMS web interface measures will be adopted through rulemaking for the QPP and that such changes will be applicable to ACO quality reporting under the MSSP.

3. Incorporating Beneficiary Preference into ACO Assignment

Stakeholders have also expressed interest in giving beneficiaries the opportunity to voluntarily “align” with the ACO in which their primary care provider participates, referred to as beneficiary attestation. Stakeholders believe that this could potentially reduce year-to-year churn in beneficiary assignment lists and increase beneficiary engagement to the ACO in which their primary care provider participates. CMS had tested an approach in Pioneer ACO model, which it refers to as “the manual process”. CMS states that the manual process developed thus far appears to be resource intensive for ACOs and may not significantly impact beneficiary assignment to ACOs.

To address the resource intensive aspects of “the manual process”, CMS finalizes its proposal to implement an automated approach under which it could determine which healthcare provider a FFS beneficiary believes is responsible for coordinating their overall care (their “main doctor”) using information that is collected in an automated and standardized way directly from beneficiaries (through a system established by CMS, such as MyMedicare.Gov), rather than requiring individual ACOs, ACO participants, or ACO professionals to directly obtain this information from beneficiaries annually and then communicate these beneficiary attestations to CMS. CMS makes two modifications from its proposal.

First, CMS no longer intends to develop a manual voluntary alignment process as an alternative for ACOs participating in Track 3 until an automated system is available. Instead, CMS will focus its efforts on developing and implementing an automated voluntary alignment process with the intent to begin with the 2018 performance year. If no automated system is available at that time, then voluntary alignment will not be used.

CMS will align beneficiaries prospectively for all tracks at the beginning of each performance and benchmark year – provided that the beneficiary is eligible for assignment to the ACO in which their designated “main doctor” is participating. CMS anticipates that for the first year of the automated process, beneficiaries will use MyMedicare.Gov to designate their “main doctor”.

If a beneficiary designates as their “main doctor” a practitioner that is affiliated with an ACO, they will be added to the ACO’s list of assigned beneficiaries if certain conditions are met:

- The beneficiary must have had at least one primary care service during the assignment window with a physician who is an ACO professional in the ACO and who is a primary care physician or who has one of the primary specialty designations.
- The beneficiary must meet the assignment eligibility criteria established and must not be excluded. Such exclusion criteria shall apply to all tracks for purposes of alignment based on beneficiary designation information.
- The beneficiary must have designated an ACO professional who is a primary care physician, a physician with a specialty designation included at §425.402(c) of this subpart, or a nurse practitioner, physician assistant, or clinical nurse specialist as responsible for their overall care
- The designation must be made in the form and manner and by a deadline determined by CMS

In addition, CMS notes if a beneficiary designates as their “main doctor” a practitioner that is unaffiliated with any ACO, then the beneficiary will not be assigned to an ACO even if the beneficiary would have otherwise been included in the ACO’s assigned beneficiary population under the assignment methodology.

CMS also finalizes its proposal that the ACO, ACO participants, ACO providers/suppliers, ACO professionals, and other individuals or entities performing functions or services related to ACO activities are prohibited from directly or indirectly, committing any act or omission, or adopting any policy that coerces or otherwise influences a Medicare beneficiary’s decision to designate or not to designate an ACO professional as responsible for coordinating their overall care. This includes but is not limited to the following:

- Offering anything of value to the Medicare beneficiary as an inducement for influencing the Medicare beneficiary’s decision to designate or not to designate an ACO professional as responsible for coordinating their overall care;
- Withholding or threatening to withhold medical services or limiting or threatening to limit access to care; and
- Including any voluntary alignment or change of preference forms requiring a beneficiary signature with any other materials or forms (only applicable in the manual process).

4. SNF 3-Day Rule Waiver Beneficiary Protections

CMS finalizes the SNF 3-day waiver beneficiary protections. Specifically, CMS finalizes its proposal to modify the waiver to include a 90-day grace period to allow sufficient time for CMS to notify the ACO of any beneficiary exclusions, and for the ACO then to inform its SNF affiliates, ACO participants, and ACO providers/suppliers of those exclusions. CMS cites examples where the grace period may be necessary. For example, CMS states concern that there could be limited situations when a beneficiary’s Part B coverage terminates during a quarter when the beneficiary is also receiving SNF services. In this situation there could be a communication lag that could cause the SNF affiliate to unknowingly admit a beneficiary who no longer qualifies for the waiver and the beneficiary could be financially liable for such services.

CMS also finalizes its proposal that it will make no payment to the SNF, and the SNF may not charge the beneficiary for the non-covered SNF services, 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 waiver-approved 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.

In this situation, CMS would apply the following rules:

- CMS would make no payment to the SNF affiliate for such services.
- The SNF affiliate must not charge the beneficiary for the expenses incurred for such services; and the SNF affiliate must return to the beneficiary any monies collected for such services.
- The ACO may be required to submit a corrective action plan to CMS for addressing what actions the ACO will take to ensure that the SNF 3-day rule waiver is not misused in the future. If after being given an opportunity to act upon the corrective action plan the ACO fails to come into compliance, approval to use the waiver will be terminated.

5. Technical Changes

a. Financial reconciliation for ACOs that fall below 5,000 Assigned Beneficiaries

Specifically, CMS finalizes its proposal that in the event an ACO falls below 5,000 assigned beneficiaries at the time of financial reconciliation, the ACO participating under a two-sided risk track will be eligible to share in savings (or losses) and the MSR/MLR will be set at a level consistent with the choice of MSR/MLR that the ACO made at the start of the agreement period. For example, if at the beginning of the agreement period the ACO chose a 1.0 percent MSR/MLR and the ACO's assigned population falls below 5,000, the MSR/MLR will remain 1.0 percent for purposes of financial reconciliation. CMS makes a minor editorial revision to paragraph (b)(1)(ii) in order to eliminate a redundant reference. Commenters were supportive of the proposal.

b. Requirement for Merged of Acquired TINs

CMS finalizes a technical change to clarify that the merged/acquired TIN is not required to remain Medicare enrolled after it has been merged or acquired and no longer used to bill Medicare. CMS states that it was not its intent to establish such a requirement and believes there would be no program purpose to require the TIN of a merged or acquired entity to maintain Medicare enrollment if it is no longer used to bill Medicare.

K. Value-Based Payment Modifier (VM)

1. Expansion of the Informal Inquiry Process to Allow Corrections for the VM

CMS finalizes its proposal to update the VM informal review policies and establish how the quality and cost composites would be affected for the 2017 and 2018 payment adjustment periods when an unanticipated program issue arises. CMS states that it has learned that re-running QRURs and recalculating the quality composite is not always practical or even possible and is operationally complex.

Due to the volume and complexities of the informal review issues, CMS needs to update the VM informal review policies and establish how the quality and cost composites under the VM would be affected if unanticipated issues arise. CMS notes that the intent of these proposals is not to provide relief for EPs and groups who fail to report under PQRS, but rather to provide a mechanism for addressing unexpected issues.

Table 44, summarizes CMS’ proposals, which are finalized without any modification. CMS will apply these policies for the 2017 and 2018 VM.

Table 44: Quality and Cost Composite Status for TINs Due to Informal Review Decisions and Widespread Quality and Cost Data Issues

	Scenario 1 TINS Moving from Category 2 to Category 1 as a Result of PQRS or VM Informal Review Process		Scenario 2 Non-GPRO Category 1 TINs with Additional EPs Avoiding PQRS Payment Adjustment as a Result of PQRS Informal Review Process		Scenario 3 Category 1 TINs with Widespread Quality Data Issues		Scenario 4 Category 1 TINs with Widespread Claims Data Issues	
Composite Score	Initial	Revised	Initial	Revised	Initial	Revised	Initial	Revised
Quality	N/A	Average	Low	Average	N/A	Average	Low	Average
	N/A	Average	Average	Average	N/A	Average	Average	Average
	N/A	Average	High	High	N/A	Average	High	High
Cost	Low	Low	Low	Low	Low	Low	Low	Low
	Average	Average	Average	Average	Average	Average	Average	Average
	High	Average	High	High	High	Average	High	Average

Scenario 1: TINs Moving from Category 2 to Category 1 as a Result of PQRS or VM Informal Review Process

If a TIN is initially classified as Category 2, and subsequently through the PQRS or VM informal review process, the TIN is classified as Category 1, CMS will classify the TINs quality composite as “average quality” instead of recalculating the quality composite. If the TIN is classified as “average cost” or “low cost”, the TIN will retain the calculated cost designation. CMS will revise a cost composite initially classified as “high cost” to “average cost”. CMS notes this will alleviate concerns from stakeholders that a TIN may receive a downward VM payment adjustment as a result of being classified as average quality and high costs.

CMS notes that groups or solo practitioners who submit an informal review request will not automatically be covered by this finalized policy. CMS will verify on informal review that the information was submitted and did meet the criteria to avoid the PQRS payment adjustment to be included in Category 1.

Scenario 2: Non-GPRO Category 1 TINs with Additional EPs Avoiding PQRS Payment Adjustment as a Result of PQRS Informal Review Process

For the 2017 and 2018 VM, Category 1 will include groups that have at least 50 percent of the group's EPs meet the criteria to avoid the 2017 PQRS payment adjustment as individuals. If a TIN is classified as Category 1 for the 2017 VM by having at least 50 percent of the group's EPs meet the criteria to avoid the 2017 payment adjustment as individuals, and subsequently, through the PQRS informal review process, it is determined that additional EPs that are in the TIN also meet the criteria to avoid the 2017 and 2018 PQRS payment adjustment as individuals, then CMS finalizes the following policies to determine the TIN's quality and cost composites:

- If the TIN's quality composite is initially classified as "low quality", CMS will reclassify the TIN's quality as "average quality." If the TIN's quality composite is initially classified as "average" or "high" quality then the TIN will retain the quality designation.
- CMS will maintain the initial cost composite.

CMS notes that TINs whose EPs submit an informal review request will not automatically be covered by the policy proposed. CMS will verify on informal review that an EP did submit complete and accurate data and did meet the criteria to avoid the PQRS payment adjustment as an individual in order for the TIN to be included in Category 1.

Scenario 3: Category 1 TINs with Widespread Quality Data Issues

When there is a systematic issue with any of a Category 1 TIN's quality data that renders it unusable for calculating a TIN's quality composite, CMS will classify the TIN's quality composite as "average quality". CMS notes it considers widespread quality data issues, as issues that impact multiple TINs and it is unable to determine the accuracy of the data submitted. For the cost composite, CMS will calculate the TIN's cost composite using the quality-tiering methodology. If the TIN is classified as "high cost", CMS will reclassify the TIN's cost composite as "average cost". If the TIN is classified as "average" or "low" cost, the TIN will retain the cost calculation. CMS notes that it will continue to show and designate these groups as high costs in their annual QRURs so they have the opportunity to understand and improve their performance.

CMS notes that groups or solo practitioners will only be covered by this policy once CMS verifies that the group or solo practitioners did submit complete and accurate data and did meet the criteria to avoid the PQRS payment adjustment as an individual in order for the TIN to be included in Category 1.

Scenario 4: Category 1 TINs with Widespread Claims Data Issues

If CMS determines after the release of QRURs that there is a widespread claims data that impacts the calculation of the quality and/or cost composite for Category 1 TINs, CMS will recalculate the quality and cost composite for affected TINs. CMS states it considers widespread claims data issues as issues that impact multiple TINs and requires the recalculation of the quality and/or cost composites.

After recalculating the composites, if the TIN's cost composite is classified as either "low" or "high", then CMS will reclassify the quality composite as "average quality". If the TIN is classified as "average quality", "high quality", "average cost" or "low cost", then the TIN will retain the calculated quality or cost tier designation. CMS will assign "average quality" if the quality composite is classified as "low quality" and assign "average cost" if the cost composite is classified as high after recalculating the quality and cost composites.

2. Application of the VM to Participate TINs in Shared Savings Program ACOs that Do Not Complete Quality Reporting

CMS finalizes its proposal to remove the prohibition on EPs who are part of a group or solo practitioner that participates in a Shared Savings ACO, for purposes of PQRS reporting in 2017 and 2018 payment adjustments, to report outside the ACO.

For purpose of the 2018 payment adjustment period, CMS finalizes its proposal to use the data reported by the EPs as a group or as individuals outside of the ACO to determine whether the TIN falls in Category 1 or Category 2 under the VM. If a group or individual report quality data outside of the ACO and meet the criteria to avoid the PQRS payment adjustment for 2018, then the groups and individuals will be included in Category 1 for the 2018 VM. CMS will classify their quality composite for the VM for the 2018 payment adjustment as average quality. CMS finalized in the 2015 PFS final rule that the cost composite for groups and solo practitioners that participate in a Shared Savings ACO will be classified as average cost.

CMS finalized similar proposals for the 2017 payment adjustment period. If EPs who are part of a group or a solo practitioner that participated in a Shared Savings Program ACO in 2015 that did not successfully report quality data and decide to use the secondary PQRS reporting period, CMS stresses it is important for these individuals to expect to be initially classified as Category 2 and receive an automatic downward adjustment under the VM for items and services furnished in 2017.

CMS states it plans to communicate with the ACOs (and their participant TINs) that did not successfully report quality data on behalf of their EPs for purposes of PQRS for the 2017 PQRS payment adjustment to inform them about the option to report during the secondary PQRS reporting period.

L. Physician Self-referral Updates

1. Unit-based Compensation in Arrangements for the Rental of Office Space or Equipment

a. The CY 2017 PFS Proposed Rule: Re-proposal of Limitation on the Types of Per-unit of Service Compensation Formulas for Determining Office Space and Equipment Rental Charges

CMS finalizes its proposal without modifications a requirement that rental charges for the 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 by the lessor to the lessee. CMS states it is used the authority granted to the Secretary to re-propose this requirement in the exceptions for the rental of office space and equipment, respectively. CMS states it is used the authority granted to the Secretary re-propose this requirement in the exceptions for fair market value compensation and indirect compensation arrangements, respectively.

CMS emphasizes that it is not finalizing an absolute prohibition on rental charges based on units of services furnished; in general, per-unit of service rental charges for the rental of office space or equipment are permissible. CMS states it is finalizing a limit on the general rule by prohibiting per-unit of service rental charges where the lessor generates the payment from the lessee through a referral to the lessee for a service to be provided in the rental office space or using the rented

equipment. Per-unit of service rental charges for the rental of office space or equipment are permissible, but only in those instances where the referral for the service to be provided in the rental office or using the rented equipment did not come from the lessor.

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

CMS specifies that the entire scope of designated health services (DHS) for purposes of the physician self-referral prohibition is defined in a list of CPT/HCPCS codes (the Code List) which is updated annually to account for both changes in the most recent CPT and HCPCS publications and changes in Medicare coverage policy and payment status. The updated comprehensive Code List effective January 1, 2017 is available on the CMS website at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/List_of_Codes.html.

Tables 45 and 46 of the rule (listed in the appendix) identify additions and deletions to the list.

IV. Regulatory Impact Analysis

TABLE 50: Calculation of the Final 2017 PFS Conversion Factor

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

TABLE 51: Calculation of the Final 2017 Anesthesia Conversion Factor

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

2017 PFS Impact Discussion

The most widespread specialty impacts of the RVU changes are generally related to changes to RVUs for specific services resulting from the Misvalued Code Initiatives, including finalized RVUs for new and revised codes. Column F of Table 52 shows the estimated 2017 combined impact on total allowed charges by specialty of all the proposed RVU and other changes. These impacts range from a rather modest increase of 1 percent for multiple specialties—family practice, general practice, internal medicine, multispecialty clinic, and physical/occupational therapist—to a significant decrease of 5 percent for independent laboratories, and a 2 percent decrease for ophthalmology and urology.

TABLE 52: CY 2017 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**	
TOTAL	\$89,866	0%	0%	0%	0%	
ALLERGY/IMMUNOLOGY	\$231	0%	1%	0%	1%	
ANESTHESIOLOGY	\$1,982	0%	0%	0%	0%	
AUDIOLOGIST	\$61	0%	0%	0%	0%	
CARDIAC SURGERY	\$324	0%	0%	0%	0%	
CARDIOLOGY	\$6,485	0%	0%	0%	0%	
CHIROPRACTOR	\$784	0%	0%	0%	0%	
CLINICAL PSYCHOLOGIST	\$734	0%	0%	0%	0%	
CLINICAL SOCIAL WORKER	\$606	0%	0%	0%	0%	
COLON AND RECTAL SURGERY	\$161	0%	0%	0%	0%	
CRITICAL CARE	\$311	0%	0%	0%	0%	
DERMATOLOGY	\$3,308	0%	0%	0%	0%	
DIAGNOSTIC TESTING FACILITY	\$754	0%	-1%	0%	-1%	
EMERGENCY MEDICINE	\$3,145	0%	0%	0%	0%	
ENDOCRINOLOGY	\$460	0%	0%	0%	0%	
FAMILY PRACTICE	\$6,110	0%	1%	0%	1%	
GASTROENTEROLOGY	\$1,747	-1%	0%	0%	-1%	
GENERAL PRACTICE	\$456	0%	0%	0%	1%	
GENERAL SURGERY	\$2,172	0%	0%	0%	0%	
GERIATRICS	\$213	0%	1%	0%	1%	
HAND SURGERY	\$182	0%	0%	0%	0%	
HEMATOLOGY/ONCOLOGY	\$1,751	0%	0%	0%	0%	
INDEPENDENT LABORATORY	\$706	0%	-5%	0%	-5%	
INFECTIOUS DISEASE	\$656	0%	0%	0%	0%	
INTERNAL MEDICINE	\$10,915	0%	1%	0%	1%	
INTERVENTIONAL PAIN MGMT	\$769	0%	-1%	0%	0%	
INTERVENTIONAL RADIOLOGY	\$317	-1%	0%	0%	-1%	
MULTISPECIALTY CLINIC/OTHER PHYS	\$129	0%	0%	0%	1%	
NEPHROLOGY	\$2,210	0%	0%	0%	0%	

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**	
NEUROLOGY	\$1,521	0%	0%	0%	0%	
NEUROSURGERY	\$789	-1%	0%	0%	-1%	
NUCLEAR MEDICINE	\$47	0%	0%	0%	0%	
NURSE ANES / ANES ASST	\$1,214	0%	0%	0%	0%	
NURSE PRACTITIONER	\$2,988	0%	0%	0%	0%	
OBSTETRICS/GYNECOLOGY	\$651	0%	0%	0%	0%	
OPHTHALMOLOGY	\$5,492	-1%	-2%	0%	-2%	
OPTOMETRY	\$1,219	0%	-1%	0%	-1%	
ORAL/MAXILLOFACIAL SURGERY	\$49	0%	-1%	0%	-1%	
ORTHOPEDIC SURGERY	\$3,695	0%	0%	0%	0%	
OTHER	\$27	0%	0%	0%	0%	
OTOLARNGOLOGY	\$1,210	0%	0%	0%	-1%	
PATHOLOGY	\$1,135	0%	-2%	0%	-1%	
PEDIATRICS	\$61	0%	0%	0%	0%	
PHYSICAL MEDICINE	\$1,068	0%	0%	0%	0%	
PHYSICAL/OCCUPATIONAL THERAPY	\$3,407	0%	1%	0%	1%	
PHYSICIAN ASSISTANT	\$1,964	0%	0%	0%	0%	
PLASTIC SURGERY	\$378	0%	0%	0%	0%	
PODIATRY	\$1,972	0%	0%	0%	0%	
PORTABLE X-RAY SUPPLIER	\$106	0%	0%	0%	0%	
PSYCHIATRY	\$1,265	0%	0%	0%	0%	
PULMONARY DISEASE	\$1,765	0%	0%	0%	0%	
RADIATION ONCOLOGY	\$1,726	0%	0%	0%	0%	
RADIATION THERAPY CENTERS	\$44	0%	0%	0%	0%	
RADIOLOGY	\$4,683	0%	0%	0%	-1%	
RHEUMATOLOGY	\$537	0%	0%	0%	0%	
THORACIC SURGERY	\$357	0%	0%	0%	0%	
UROLOGY	\$1,772	-1%	0%	0%	-2%	
VASCULAR SURGERY	\$1,046	0%	0%	0%	-1%	

** Column F may not equal the sum of columns C, D, and E due to rounding.

The following is an explanation of the information for Table 52:

- Column A (Specialty): Identifies the specialty for which data is shown.
- Column B (Allowed Charges): The aggregate estimated PFS allowed charges for the specialty based on 2015 utilization and 2016 rates. Allowed charges are the Medicare fee schedule amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all specialties to arrive at the total allowed charges for the specialty.
- Column C (Impact of Work RVU Changes): This column shows the estimated 2017 impact on total allowed charges of the changes in the work RVUs, including the impact of changes due to potentially misvalued codes.
- Column D (Impact of PE RVU Changes): This column shows the estimated 2017 impact on total allowed charges of the changes in the PE RVUs.
- Column E (Impact of MP RVU Changes): This column shows the estimated 2017 impact on total allowed charges of the changes in the MP RVUs.
- Column F (Combined Impact): This column shows the estimated 2017 combined impact on total allowed charges of all the changes in the previous columns

V. Appendix

TABLE 45—ADDITIONS TO THE PHYSICIAN SELF-REFERRAL LIST OF CPT 1/ HCPCS CODES

Clinical Laboratory Services	
0008M	Onc breast risk score
Physical Therapy, Occupational Therapy, and Outpatient Speech–Language Pathology Services	
97161	Pt eval low complex 20 min
97162	Pt eval mod complex 30 min
97163	Pt eval high complex 45 min
97164	Pt re-eval est plan care
97165	Ot eval low complex 30 min
97166	Ot eval low complex 30 min
97167	Ot eval high complex 60 min
97168	Ot re-eval est plan care
Radiology and Certain Other Imaging Services	
0422T	Tactile breast img uni/bi
76706	Us abdl aorta screen aaa
77065	Dx mammo incl cad uni
77066	Dx mammo incl cad bi
77067	Scr mammo bi incl cad
A9515	Choline c–11
A9587	Gallium Ga–68
A9588	Fluciclovine F–18
A9597	Pet, dx, for tumor id, noc
A9598	Pet dx for non-tumor id, noc
C9461	Choline C 11, diagnostic
C9744	Abd us w/contrast
Q9982	Flutemetamol f18 diagnostic
Q9983	Florbetaben f18 diagnostic
Radiation Therapy Services and Supplies	
{No additions}	
Drugs Used by Patients Undergoing Dialysis	
{No additions}	
Preventive Screening Tests, Immunizations and Vaccines	
77063	Breast tomosynthesis bi
77067	Scr mammo bi incl cad
90674	CCIIV4 vac no prsv 0.5 ml im
90687	IIV4 vacc splt 0.25 ml im
G0499	HepB screen high risk indiv

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TABLE 46—DELETIONS FROM THE PHYSICIAN SELF-REFERRAL LIST OF CPT 1/ HCPCS CODES

Clinical Laboratory Services	
{No deletions}	
Physical Therapy, Occupational Therapy, and Outpatient Speech–Language Pathology Services	
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
Radiology and Certain Other Imaging Services	
77051	Computer dx mammogram add-on
77052	Comp screen mammogram add-on
77055	Mammogram one breast
77056	Mammogram both breasts
77057	Mammogram screening
A9544	I131 tositumomab, dx
C9458	Florbetaben f18
C9459	Flutemetamol f18
Radiation Therapy Services and Supplies	
0019T	Extracorp shock wv tx ms nos
A9545	I131 tositumomab, rx
Drugs Used by Patients Undergoing Dialysis	
{No deletions}	
Preventive Screening Tests, Immunizations and Vaccines	
77052	Comp screen mammogram add-on
77057	Mammogram screening

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