Holland & Knight

MEMORANDUM **November 10, 2016**

Re: CMS Releases CY 2017 Medicare Physician Fee Schedule Final Rule

On November 2, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model *(CMS-1654-F).*

CMS finalized many of its proposals, resulting in little change to the Final Rule. The Final Rule contains updates to the relative value units (RVUs) that are used to calculate physician payments and changes to various payment policies and quality programs for physicians and other qualified health professionals. A number of legislative mandates from the Affordable Care Act of 2010 (ACA), the Protecting Access to Medicare Act of 2014 (PAMA), Medicare Access and CHIP Reauthorization ACT of 2015 (MACRA), and the Achieving a Better Life Experience Act of 2014 (ABLE) have been implemented.

The overall impact of the changes in the 2017 final PFS varies by specialty. CMS estimates that the impact changes range from a negative 5 percent for interventional radiology to a positive one percent for several specialties. Table 52 (attached) shows the aggregated impact by specialty.

The Final Rule will be published in the *Federal Register* on November 15, 2016.

Key highlights include:

2017 MPFS Conversion Factor

The conversion factor for CY 2017 is $35.8887. This is a slight increase from the estimated $35.7751 in the CY 2017 proposed rule, and an increase as compared to a conversion factor of $35.8043 for CY 2016.

The Medicare Diabetes Prevention Program (MDPP)

CMS is finalizing its proposal to expand the duration and scope of the MDPP model. The MDPP expanded model will become effective nationwide beginning January 1, 2018.

While CMS finalized its proposal to expand the duration and scope of the DPP model test; CMS will not at this time allow organizations that deliver DPP virtually to be eligible to furnish MDPP services. CMS states that MDPP services "will be furnished in community and healthcare settings." Only organizations that have full CDC Diabetes Prevention Recognition Program (DPRP) recognition will be permitted to enroll in Medicare. Supplier enrollment will not begin January 1, 2017. Rather, it will begin once the 2017 round of regulations are complete, and before the model expansion becomes effective on January 1, 2018. Sub-regulatory guidance may be issued to help prepare for enrollment.

Improving Payment Accuracy for Primary Care

CMS finalized its proposals related to separate payments for Current Procedural Terminology (CPT) codes for non-face-to-face prolonged evaluation and management (E/M) services, revaluation of CPT codes for face-to-face prolonged services, a new code and payment for cognitive impairment assessment and planning, new codes and payment for behavioral health care using inter-professional care management, and separate payment for and changes to high complexity chronic care management codes.

Potentially Misvalued Codes and Misvalued Code Target

Per statute, CMS has a target for recapture amount for misvalued codes in the 2017 fee schedule of 0.5 percent. If the net reductions in misvalued codes in 2017 are less than 0.5 percent of the total revenue under the fee schedule, a reduction equal to the percentage difference between 0.5 percent and the percent of expenditures represented by misvalued codes reductions must be made to all PFS services.

In this proposed rule, CMS identified changes that, if finalized, would have met this target by achieving 0.51 percent in net expenditure reductions, therefore avoiding a broad overall reduction to PFS services.

After adjusting for comments in the final rule; however, misvalued code changes achieved only 0.32 percent in net expenditure reductions, resulting in a target recapture impact of -0.18 percent to the conversion factor.

Valuation of Moderate Sedation Services

CMS announced in 2014 that the agency wanted to separate moderate sedation services from procedure codes in all specialties in which the underlying service was originally valued with moderate sedation. Accordingly, CMS finalized new codes for moderate sedation services based on AMA RVS Update Committee (RUC) recommendations, and is augmenting the new moderate sedation CPT codes with an endoscopy-specific moderate sedation code, as well as finalizing valuation differences between gastroenterology and other specialties based on specialty survey data.

Medicare Telehealth-Eligible Services

CMS maintains a list of services eligible for Medicare payment when furnished via telehealth technology. When services on the list meet conditions specified by CMS (related to location, technology, authorized provider, eligible telehealth individual, *etc.*), Medicare pays a facility fee to the originating site and makes a separate payment to the distant site practitioner furnishing the service.

CMS is finalizing its proposal to add several services to the telehealth services list for 2017:

• ESRD–related services (90967-90969).

• Advance care planning codes (99497-99498).

• Telehealth consultations for a patient requiring critical care services (G0508 and G0509).

CMS is finalizing the adoption of a new Place of Service (POS) code for telehealth services (POS 02 Telehealth) for use by the distant provider. CMS believes a POS code for telehealth services would

provide consistency in reporting and identifying services furnished via telehealth. The POS code would be used in addition to the existing telehealth modifiers (GT and GQ). The originating site would continue to use the POS code that applies to the type of facility where the patient is located. CMS also finalized a policy to use facility PE RVUs to pay for telehealth services reported by physicians or practitioners reporting the telehealth POS code for CY 2017.

Appropriate Use Criteria (AUC) for Advanced Imaging Services

The Final Rule sets forth the second major set of directives around the implementation of Section 218(b) of the Protecting Access to Medicare Act (PAMA) which requires that ordering clinicians consult appropriate use criteria in deciding whether to order certain advanced diagnostic imaging services.

The Final Rule focuses on the second major implementation element – defining and providing a process for the qualification of clinical decision support mechanisms (CDSMs). It also identifies eight "priority clinical areas" where the adherence of ordering clinicians to available AUC will used to determine "outlier" physicians. It also identifies certain exemptions from the program.

The eight priority clinical areas identified are as follows: coronary artery disease (suspected or diagnosed); suspected pulmonary embolism; headache (traumatic and non-traumatic); hip pain; low back pain; shoulder pain (to include suspected rotator cuff injury); cancer of the lung (primary or metastatic, suspected or diagnosed); and cervical or neck pain.

Future rulemaking will establish the process by which clinicians must consult AUC for applicable advanced imaging services and document that consultation. Future rulemakings will also detail the process of identifying ""outlier" physicians who will be subject to certain prior authorization.

Updates to the Medicare Shared Savings Program (MSSP)

CMS finalized several proposed policies pertaining to the MSSP program. These include:

- Updating ACO quality reporting requirements, including changes to the quality measure set and the procedures for quality validation audits, revisions to terminology used in quality assessment, revisions that would permit eligible professionals in ACOs to report quality separately from the ACO, and updates to align with the Physician Quality Reporting System and the final Quality Payment Program;

- Modifying the assignment algorithm to align beneficiaries to an ACO when a beneficiary has designated an ACO professional as responsible for their overall care; and

- Establishing of beneficiary protection policies related to use of the Skilled Nursing Facility 3-day waiver.

Medicare Advantage

CMS has finalized a requirement for providers and suppliers who furnish services to MA beneficiaries. They must undergo screening and enrollment requirements akin to providers in other Medicare programs. Additionally, the rule prevents enrollment by those that have had their Medicare enrollment revoked or have been excluded by the Office of the Inspector General (OIG). CMS believes that the new requirements will help protect both beneficiaries and the Medicare Trust Funds. The enrollment

provisions will be included in CMS contracts with the designated plans and programs, and will begin in two years, effective on the first day of the plan year. A fact sheet provides a list of the types of providers and suppliers to which the new screening requirement will apply.

Geographic Practice Cost Indices

CMS revised its methodology used to calculate GPCI for U.S. territories to ensure consistency between Caribbean and Pacific territories; the resulting recalculation will increase overall MPFS payments in Puerto Rico. Additionally, in compliance with the PAMA, CMS will modify California's GPCIs to align with Metropolitan Statistical Areas (MSAs). The final locality structure will increase payments to physicians in urban localities; however, the structure may reduce payments in some others.

Value-Based Payment Modifier (VBPM) and Physician Feedback Program

With the implementation of the Merit-Based Incentive Payment System (MIPS), the VBPM will discontinue at the end of CY 2018. CMS will update the VM informal review policies and establish how the quality and cost composites under the VM would be implemented for the CY 2017 and CY 2018 payment adjustment periods. CMS is also finalizing policies for the circumstances where a Medicare Shared Savings Program or an ACO does not does not successfully report quality data on behalf of a group or solo practitioner for purposes of PQRS and how CMS can acquire this quality data. Lack of PQRS data negatively impacts a provider's VM calculation.

Mammography - Computer Aided Detection Bundling (CPT 77065, 77066 and 77067)

For CY 2017, the CPT Editorial Panel deleted CPT codes 77051, 77052, 77055, 77056, 77057, and created three new CPT codes, 77065, 77066 and 77067 to describe mammography services bundled with computer-aided detection (CAD). However, CMS learned between the span of the proposed and final rule, their claims processing system will not be able to accept the new CPT codes. CMS stated it would instead use G codes (G0202, G0204, G0206) with the same descriptors as the new CPT codes.

In the Final Rule, CMS identified that new coding and PE input would drastically change the payment for these mammography-related services which may be disruptive to access to these necessary services. CMS therefore finalized its proposal to accept the RUC-recommended work RVUs for these three codes, but crosswalk the PE RVUs for the technical component of the CY 2016 G-codes. CMS will continue to collect more pricing information for these equipment items.

Payment Incentives for the Transition from Traditional X-Ray Imaging to Digital radiography and Other Imaging Services

To implement provisions relating to the PFS reduction for X-rays taken using film that are furnished during CY 2017 or subsequent years, CMS established a new modifier (modifier "FX"). Beginning January 1, 2017, this modifier will be required for the technical component on claims for X-rays that are taken using film; this will include instances when the service is billed globally. The use of the modifier will result in a 20 percent reduction for the technical component of the X-ray service.

Multiple Procedure Payment Reduction Adjustment For Advanced Imaging Services

On December 18, 2015, Congress enacted H.R. 2029, the Consolidated Appropriations Act of 2016, bipartisan legislation that provided funding for the federal government for the 2017 fiscal year (October

1, 2015-September 30, 2016). Within this extensive legislation were radiology provisions related to the professional component multiple procedure payment reduction (PC MPPR) and reimbursement for analog (film) radiography, computed radiography (CR) and digital radiography (DR).

After intense lobbying, Congress included provisions within H.R. 2029 to lower the existing 25 percent PC MPPR to 5 percent effective 2017. CMS acknowledges this mandate in the final rule and will move forward with implementation on January 1, 2017.