

## Summary of Selected Provisions of the Medicare Physician Fee Schedule Final Rule for Calendar Year 2015

On October 31, 2014, the Centers for Medicare & Medicaid Services (CMS) released the physician fee schedule (PFS) final rule for calendar year (CY) 2015 (the “Final Rule”). The Final Rule was published in the Federal Register on November 13, 2014,<sup>1</sup> and CMS will accept comments on certain provisions of the rule that are open for comment until December 30, 2014.

### 1. Highlights of the Final Rule

The Final Rule:

- Establishes a conversion factor of \$35.8013 for services furnished under the PFS between January 1, 2015, and March 31, 2015, due to the zero percent update mandated by the Protecting Access to Medicare Act (PAMA), and a conversion factor of \$28.2239 for services furnished between April 1, 2015, and December 31, 2015, due to the sustainable growth rate (SGR) formula.
- Creates a new Healthcare Common Procedure Coding System (HCPCS) modifier and two new place of service (POS) codes required to be reported with every code for physician and hospital services furnished in an off-campus provider-based department of a hospital.
- Acknowledges comments on a possible revision of the practice expense (PE) relative value unit (RVU) equipment cost formula to allow the maintenance factor to vary for equipment whose maintenance costs vary, but requests further comments and evidentiary support for a change in the maintenance factor.
- Eliminates certain direct PE inputs related to use of film in imaging services in favor of using a desktop computer input as a proxy direct PE input in calculating RVUs for such imaging services, to reflect the shift from film-based imaging to digital imaging.
- Implements a number of new policies for mammography services, including creation and valuation of new add-on codes for 3-D screening and diagnostic mammography and review of current mammography codes as potentially misvalued, but does not finalize the deletion of G-codes currently used to bill for digital mammography, which will instead be retained and billed with the 3-D add-on codes.
- Does not finalize its proposal to delete the direct PE input for the radiation treatment vault from all applicable HCPCS codes.
- Creates a new standard supply package for contrast-enhanced imaging services.
- Does not finalize its proposal to delete existing G-codes for stereotactic radiosurgery services provided using robotic methods and instead pay for all such services (robotic and non-robotic) under the equivalent Current Procedural Terminology (CPT®<sup>2</sup>) codes.
- Identifies certain services as potentially misvalued under the PFS, including high-expenditure services across specialties with Medicare allowed charges of \$10 million or more (for which

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<sup>1</sup> CMS, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015, Final Rule with Comment Period, CMS-1612-FC, 79 Fed. Reg. 67548 (Nov. 13, 2014), available at: [www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf](http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf).

<sup>2</sup> CPT copyright 2013 American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the AMA.

CMS will defer review until a later date), as well as certain specified codes for mammography and abdominal aortic aneurysm ultrasound (which CMS will review in 2015).

- Revises the procedures for valuing new, revised, and potentially misvalued codes to ensure that new coding or valuation decisions are published in a proposed rule (rather than an interim final rule) before taking effect.
- Creates interim final values for two new breast ultrasound CPT codes.
- Defers revaluation of revised radiation therapy CPT codes until CY 2016 and creates equivalent G-codes to bill for these services (at CY 2014 rates) in CY 2015, and solicits comment on appropriate payment for superficial radiation therapy.
- Adds seven codes to the list of services subject to the cap on payment for the technical component of certain imaging services at the lesser of the PFS or hospital outpatient prospective payment system (OPPS) rates.
- Declines to adopt payment for two new advance care planning codes.
- Revises the rules to implement the Sunshine Act disclosure law to eliminate an explicit exception for payments related to continuing medical education (CME) (but with additional guidance on when such payments are reportable) and to require reporting of the “marketed name” of all products related to a reportable payment, including medical devices.
- Acknowledges comments on whether to expand Medicare payment for secondary interpretation of images under certain circumstances but defers any such expansion.
- Adds new codes to the list of services eligible for Medicare telehealth payment, but not the electrocardiogram (ECG) or cervical colposcopy codes that had been requested to be added to the list.
- Further develops Medicare policies for payment for chronic care management services and finalizes a payment of \$42.60 for a new CPT code to describe such services.
- Revises the definition of “colorectal cancer screening test” to waive coinsurance or deductibles for anesthesia provided in conjunction with screening colonoscopies.
- Declines to finalize proposed changes to the process for developing Local Coverage Determinations (LCDs) for lab tests and, pursuant to changes mandated by Congress in PAMA, removes the new process adopted in CY 2014 for revising payments under the Clinical Laboratory Fee Schedule (CLFS).
- Refines the Physician Quality Reporting System (PQRS) by shifting from positive incentive payments to negative payment adjustments, as required by statute, revising available measures and measures groups, and adjusting available mechanisms for meeting the PQRS requirements.
- Continues to expand the quality data and other information available on the Physician Compare website.
- Creates a new hardship exception to the 2015 Electronic Health Records (EHR) Incentive Program payment adjustment for certain providers and extends the deadline for seeking the exception.
- Continues to implement the value-based payment modifier by expanding the modifier to all groups of physicians as well as all physician eligible professionals by CY 2017 and increasing the amount at risk from two percent to four percent of Medicare payments for groups of 10 or more eligible professionals.

The cumulative effect on total Medicare payments to physicians involved in provision of cancer care based on the finalized proposals (excluding the conversion factor) is projected to be:

Specialty	Allowed Charges (millions)	Combined Impact
Hematology/Oncology	\$1,811	+1%
Radiation Oncology	\$1,794	0%
Radiology	\$4,523	-1%
Radiation Therapy Centers	\$57	+1%

Note that the addenda containing payment rates and other information are not printed in the Federal Register. The addenda are available only on the CMS web site at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html>.

## 2. Conversion Factor

The Final Rule notes that PAMA replaced the reduction in the PFS conversion factor that would otherwise have occurred on January 1, 2015, with a zero percent update for services furnished from January 1, 2015, through March 31, 2015. Adjusting for budget neutrality, the conversion factor for January 1, 2015, through March 31, 2015, will be \$35.8013. However, because the statutory update applies only to services furnished in the first three months of CY 2015, CMS projects a reduction in the conversion factor for the remainder of CY 2015 based on the SGR formula. Thus, the conversion factor for PFS services furnished from April 1, 2015, through December 31, 2015, will be \$28.2239, a reduction of 21.2 percent from the CY 2014 conversion factor. As usual, CMS notes that it is required to implement the reductions in the conversion factor by law and urges Congress to adopt a long-term revision to the SGR formula.<sup>3</sup>

## 3. Use of Hospital Cost Data in PE RVU Process and Data Collection on Services Furnished in Off-Campus Provider-Based Hospital Departments

CMS finalizes, with modifications, its proposal to gather information about the growing trend toward hospital acquisition of physicians' offices and how the subsequent treatment of those locations as off-campus provider-based outpatient departments affects Medicare payments and beneficiary cost-sharing.<sup>4</sup> In the Proposed Rule, CMS proposed to exercise its data collection authority under PAMA by creating a new HCPCS modifier that must be reported with physician and hospital claims for services provided in a provider-based department (PBD).

In the Final Rule, CMS finalizes the requirement to include the new HCPCS modifier with hospital claims. With respect to physician claims, CMS instead will create two new place of service (POS) codes that physicians must use when they bill for claims provided in a PBD. The HCPCS modifier will be mandatory as of January 1, 2016, although hospitals can report the modifier voluntarily before that time. CMS clarifies that the requirement to report the modifier applies only to off-campus PBDs and does not apply to services furnished in a remote location of a hospital or an emergency department. CMS explains that this rule incorporates the definition of "campus" from the provider-based rules at 42 CFR § 413.65(a)(2) to be the "physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but

<sup>3</sup> 79 Fed. Reg. at 67742.

<sup>4</sup> *Id.* at 67571-72.

are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus." The POS codes will be mandatory as soon as they are established by the CMS POS Workgroup, which CMS does not expect to occur until at least July 1, 2015. CMS will provide advance notice of the availability of the POS codes.<sup>5</sup> CMS explains that additional instruction and provider education will be forthcoming in sub-regulatory guidance and that if providers have individual, specific questions, they should consult with the appropriate CMS regional office.

The Final Rule clarifies that the requirement to report the new modifier or codes is solely a data collection requirement and does not modify Medicare payment for services furnished in PBDs. However, CMS also states that it continues to believe that there are various possibilities for using available hospital cost data to establish more accurate PE RVUs for services under the PFS, and acknowledges the comments received in response to its solicitation in the Proposed Rule. CMS states that it will consider these comments as it continues to think about mechanisms to improve the accuracy of PE values.<sup>6</sup>

#### **4. Calculation of Equipment Cost: Maintenance Factor**

In the Final Rule, CMS addresses comments that it received on possible revisions to the maintenance factor used in the calculation of equipment cost for the PE RVU methodology. The Final Rule does not revise or propose revisions to the maintenance factor. Instead, CMS requests additional comments and evidentiary support for possible future revisions.<sup>7</sup>

CMS calculates equipment cost per minute as:  $(1/(\text{minutes per year} * \text{usage})) * \text{price} * (\text{interest rate}/(1-(1/((1 + \text{interest rate}) - \text{life of equipment})))) + \text{maintenance}$ . The maintenance factor is currently defined at 0.05, or 5 percent of the price, as finalized in the CY 1998 rulemaking. In the Proposed Rule, CMS noted that several stakeholders have suggested that the maintenance factor should be variable and solicited "reliable data" on maintenance costs that vary for particular equipment items.

In the Final Rule, CMS states that it received several comments on variable equipment costs, which it will consider in future rulemaking, but that it does not consider "high-level summary data from informal surveys" or "assertions that a particular maintenance rate is typical" to be "reliable data."<sup>8</sup> Instead, CMS states that multiple invoices containing equipment prices accompanied by maintenance contracts would provide support for a maintenance factor other than 5 percent. CMS also notes that it solicited and received comments on how to incorporate usage fees and other per-use equipment costs that do not vary based on equipment time and will consider the comments that were submitted in future rulemaking.

#### **5. Migration from Film to Digital PE Inputs for Digital Imaging Services**

The Final Rule implements CMS's proposal to migrate from film to digital PE inputs for digital imaging services by eliminating certain direct PE inputs for digital imaging codes and by retaining or adding, as necessary, a direct PE input for use of a desktop computer as a proxy for the Picture

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<sup>5</sup> *Id.* at 67572.

<sup>6</sup> *Id.* at 67569.

<sup>7</sup> *Id.* at 67557.

<sup>8</sup> *Id.*

Archiving and Communication System (PACS) equipment used in digital imaging procedures.<sup>9</sup> The Final Rule lists the codes affected by the transition from film to digital inputs.

Under the Final Rule, CMS will follow and expand upon the recommendation of the American Medical Association's RVU Update Committee (RUC) by removing the film-related inputs not only from the codes recommended by the RUC but also from all other procedures in the direct PE database, both because CMS believes it is appropriate to use digital inputs as a proxy for the services that may still use film and because CMS expects the use of digital technology to continue to become more widespread. CMS also noted that it will proceed with its proposal to revise the direct PE input database to include task-level clinical labor time for every code in the database for purposes of increased transparency, but will not make any changes to those PE inputs at this time.

The Final Rule also rejects comments opposing use of the desktop computer as a proxy for the PACS equipment and finalizes that proposal. CMS acknowledges comments stating that the PACS equipment is significantly more expensive than a desktop computer and that it is difficult to obtain invoice documentation for the PACS workstation because such items are typically included in a bundled price. However, CMS finalizes the proposal to use the desktop computer as a proxy because it believes that "use of a proxy to price the appropriate inputs . . . is preferable to continuing to use inputs that we know are no longer typical,"<sup>10</sup> and because no commenter submitted an invoice for the PACS system or suggested an alternative proxy.

## **6. Mammography Services – Changes to Codes and Values**

The Final Rule includes a number of changes to codes and values for mammography services billed under the PFS.

CMS declines to finalize its proposal to delete the G-codes (G0202, G0204, G0206) currently used to bill for mammography services furnished using digital technology, as opposed to traditional film mammography services billed using CPT codes (77055, 77056, 77057). Instead, CMS will maintain both the G-codes and the CPT codes for CY 2015 while it considers revaluation of all mammography services by reviewing the family of mammography codes as potentially misvalued.

However, CMS will make revisions for CY 2015 to distinguish between 2-D digital mammography and 3-D digital mammography, also referred to as "digital breast tomosynthesis" (DBT). CMS will modify the code descriptions to make clear that the G-codes are specific to 2-D digital mammography. When providers perform 3-D mammography services, they should use one of two new add-on codes. For 3-D screening mammography services, providers should bill G0202 (screening mammography, digital) along with new CPT code 77063 (screening digital breast tomosynthesis; bilateral) as an add-on code.<sup>11</sup> For 3-D diagnostic mammography services, providers should bill either G0204 (diagnostic mammography, digital, bilateral) or G0206 (diagnostic mammography, digital, unilateral), along with new HCPCS code G0279 (diagnostic digital breast tomosynthesis, unilateral or bilateral) as an add-on code. With respect to the new add-on codes, CMS is establishing identical interim final RVUs for each code for CY 2015; these include the direct PE input for the digital breast tomosynthesis equipment described below.<sup>12</sup> With respect to the pre-

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<sup>9</sup> *Id.* at 67561-63.

<sup>10</sup> *Id.* at 67562-63.

<sup>11</sup> *Id.* at 67668.

<sup>12</sup> *Id.*

existing mammography CPT codes, CMS will continue to value those codes using CY 2014 work and PE RVUs.<sup>13</sup>

The Final Rule also addresses CMS's planned review of valuation for mammography services as a whole. As noted above, CMS finalizes its proposal to review all of the mammography codes (other than the new tomosynthesis codes) as potentially misvalued, noting that the codes have not been reviewed in more than ten years. CMS acknowledges comments expressing concern that payment for mammography services is already insufficient and may be further reduced, but states that it lacks adequate information to respond to these concerns until the services are reviewed.<sup>14</sup>

CMS also addresses the three new CPT codes that the CPT Editorial Panel created for CY 2015 to describe DBT: 77061 (digital breast tomosynthesis; unilateral), 77062 (digital breast tomosynthesis; bilateral), and 77063 (screening digital breast tomosynthesis; bilateral). CMS will wait to value 77061 and 77062 as stand-alone codes until it has received recommendations from the RUC for the other mammography codes so that it can review the entire family of mammography codes together.<sup>15</sup> As noted above, however, CMS is establishing and assigning RVUs to code 77063 as an add-on code for CY 2015. In addition, the Final Rule establishes a new direct PE input for these new codes. CMS notes that the RUC panel recommended that CMS create a new "breast tomosynthesis room" as a PE input for these codes. CMS declines to establish a "room" due to its concerns about the items proposed to be included and about the transparency of equipment "rooms" in general. Instead, CMS will create a new equipment item "DBT unit" to describe the digital breast tomosynthesis equipment used to perform these procedures. The DBT unit will be priced at \$381,380, based on the average price from invoices submitted to CMS.<sup>16</sup>

## 7. Radiation Treatment Vault Direct PE Input

CMS declines to finalize its proposal to remove the "radiation treatment vault" as a direct PE input for several radiation treatment procedures. CMS had proposed to remove the vault as a direct PE input on the grounds that the vault is a structural component of the building required to house radiation treatment equipment and therefore is accounted for in the indirect PE methodology just like other building and infrastructure costs. For CY 2015, CMS will not finalize this proposal and will continue to include the vault as a direct PE input for all applicable codes. However, CMS states that it intends to "further study the issues raised by the vault and how it relates to our PE methodology."<sup>17</sup>

The final rule notes that all but one commenter opposed the proposal. CMS acknowledges several concerns expressed by commenters, for example, that Medicare payment for radiation oncology services has declined overall in recent years, that it is impossible for stakeholders to assess the impact of removing the vault as a direct input at the same time that Medicare is implementing the revised code set for radiation treatment services, and that the change in payment due to removing the vault could make it more difficult for Medicare patients to access to oncology services. The Final Rule also notes, but rejects, commenters' arguments that the radiation treatment vault should be treated as a direct PE input because it is essential to provision of radiation therapy services and

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<sup>13</sup> *Id.* at 67580.

<sup>14</sup> *Id.* at 67579-80.

<sup>15</sup> *Id.* at 67668.

<sup>16</sup> *Id.* at 67675.

<sup>17</sup> *Id.* at 67564-65.

cannot be used separately from the linear accelerator used in those procedures, or because the IRS treats the vault as separate from the building itself.

## **8. New Standard Supply Package for Contrast-Enhanced Imaging Services**

CMS finalizes its proposal to create a new direct PE input standard supply package for contrast-enhanced imaging services, with a revised price of \$7.06. The price reflects the combined prices of the medical supplies included in the package, which are listed in the Final Rule (including a revised price for the IV starter kit). CMS notes that one commenter suggested that a power injector should also be included in the standard supply package and seeks comment on whether the power injector is used whenever the other items in the package are used or only in certain instances.<sup>18</sup>

## **9. Coding for Stereotactic Radiosurgery (SRS)**

CMS declines to finalize its proposal to certain G-codes (G0339, G0340) used to bill for SRS services provided using robotic methods and recognize only the equivalent CPT codes for SRS (77372, 77373). The Final Rule notes that most comments received in response to the Proposed Rule opposed the proposal and argued that the direct PE inputs for the CPT codes do not adequately reflect the resources used in furnishing robotic SRS services. CMS concludes that it lacks sufficient information to decide whether to finalize its proposal and therefore will not delete the G-codes for CY 2015 while it works with stakeholders to identify an alternate approach and will reconsider the issue in future rulemaking.<sup>19</sup>

## **10. Potentially Misvalued Codes**

CMS is required under the Affordable Care Act (ACA) periodically to identify and review potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as potentially misvalued. In addition, CMS is required by statute to review the RVUs established under the PFS no less often than every five years. In the CY 2012 final rule, CMS finalized its proposal to consolidate the formal Five-Year Review of Work and PE RVUs with the annual review of misvalued codes mandated by the ACA.

### **a. Background: Identification of Potentially Misvalued Codes via Public Nomination and Statutory Categories**

The CY 2012 final rule established a process for annual public nomination of potentially misvalued codes. The process requires commenters to submit the code with supporting documentation during the 60-day public comment period following release of the annual PFS final rule.

Under the process established in the CY 2012 rulemaking, documentation in support of a nomination of a code as potentially misvalued may include:

- Documentation in the peer reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
  - Technique
  - Knowledge and technology

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<sup>18</sup> *Id.* at 67566-67.

<sup>19</sup> *Id.* at 67567.

- Patient population
- Site-of-service
- Length of hospital stay
- Physician time
- An anomalous relationship between the code being proposed for review and other codes.
- Evidence that technology has changed physician work, that is, diffusion of technology.
- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.
- Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey, or flawed crosswalk assumptions in a previous evaluation.
- Prices for certain high cost supplies or other direct PE inputs that are used to determine PE RVUs are inaccurate and do not reflect current information.
- Analyses of physician time, work RVU, or direct PE inputs using other data sources (for example, Department of Veteran Affairs (VA) National Surgical Quality Improvement Program (NSQIP), the Society for Thoracic Surgeons (STS), and the Physician Quality Reporting Initiative (PQRI) databases).
- National surveys of physician time and intensity from professional and management societies and organizations, such as hospital associations.

CMS also will continue to identify potentially misvalued codes for review by the AMA RUC based on the statutory categories under section 1848(c)(2)(K)(ii) of the Social Security Act (SSA):

- Codes and families of codes for which there has been the fastest growth;
- Codes or families of codes that have experienced substantial changes in practice expenses;
- Codes that were recently established for new technologies or services;
- Multiple codes that are frequently billed in conjunction with furnishing a single service;
- Codes with low relative values, particularly those that are often billed multiple times for a single treatment;
- Codes which had not been subject to review since the implementation of the RBRVS (“Harvard valued”); and
- Codes potentially misvalued as determined by the Secretary.

In addition, as CMS noted in the Proposed Rule for CY 2015, PAMA expanded the list of statutory categories to add the following nine categories of potentially misvalued codes:

- Codes that account for the majority of spending under the PFS;
- Codes for services that have experienced a substantial change in the hospital length of stay or procedure time;
- Codes for which there may be a change in the typical site of service since the code was last valued;
- Codes for which there is a significant difference in payment for the same service between different sites of service;
- Codes for services where there may be efficiencies when a service is furnished at the same time as other services;
- Codes with high intra-service work per unit of time;
- Codes with high PE RVUs; and
- Codes with high cost supplies.

b. CY 2015 Identification and Review of Potentially Misvalued Codes

In the Final Rule for CY 2015, CMS notes that the public nominated two codes as potentially misvalued and finalizes its proposal to review one of those codes (41530, submucosal ablation of the tongue base).

CMS also finalizes but defers its proposal to review additional codes as potentially misvalued based on a screen of high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS finalizes the screen, rejecting comments that challenged whether the screen is appropriate or whether CMS has the authority to use the screen to identify potentially misvalued codes. However, in recognition of resource constraints due to the ongoing revaluation of services with global periods, CMS will defer review of specific codes based on the high-expenditure screen until a future rulemaking. At that time, CMS will re-run the high-expenditure screen and will propose the specific set of codes to be reviewed as potentially misvalued.

As noted above, CMS will review three mammography CPT codes (77055, 77056, 77057) as potentially misvalued. CMS also finalizes its proposal to review HCPCS code G0389 (ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening) as potentially misvalued based on changes to the equipment inputs in CY 2014 for a related CPT code; CMS will maintain the 2013 work and PE RVUs for the code until its review is complete.

## **11. Procedure for Valuing New, Revised, and Potentially Misvalued Codes**

The Final Rule adopts, with modifications, CMS's proposed revisions to the procedure for valuing new, revised, and potentially misvalued codes. In the Proposed Rule, CMS acknowledged concerns expressed by a number of stakeholders about the current procedure, in which CMS often revises or establishes values for new, revised, and potentially misvalued codes via interim final rulemaking. In such cases, stakeholders often do not have an opportunity to meaningfully comment on the new or revised values before the coding or valuation decision takes effect.

To address these concerns, CMS proposed a new procedure in which new and revised codes would be adopted through full notice and comment rulemaking rather than an interim final rule. Specifically, CMS would implement new and revised codes by announcing the changes in a proposed rule, beginning with the proposed rule for CY 2016. CMS proposed that if it did not receive RUC recommendations by January 15th of a given year, it would delay revaluing the code until it did receive the RUC recommendations by January 15th. In the meantime, Medicare would pay for the services either under G-codes that describe predecessor codes (for deleted or revised codes) or under values established in an interim final rule or by contractor pricing (for codes describing wholly new services).

CMS adopts this proposal with modifications.<sup>20</sup> CY 2016 will serve as a transition year. CMS will include proposals for new, revised, and potentially misvalued codes in the CY 2016 proposed rule if it receives the RUC recommendations in time to include those proposals; if not, CMS will establish interim final values for CY 2016 as under the current procedure. CMS also will delay adoption of two new code sets, including the radiation therapy treatment set described below, which are slated for adoption in CY 2015; CMS will propose values for those codes in the CY 2016 proposed rule

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<sup>20</sup> *Id.* at 67607-08.

instead. For CY 2017 and beyond, CMS adopts the new procedure as proposed, except that CMS will extend the deadline for RUC recommendations to February 10th of a given year to allow the RUC more time while still giving CMS time to formulate its proposals. With respect to the use of G-codes where CMS does not receive RUC recommendations by February 10th, CMS acknowledges commenters' concerns about using G-codes but still finalizes its proposal. CMS states that it will seek to minimize the use of G-codes and asks that the RUC and stakeholders take steps to ensure that CMS receives RUC recommendations as early as possible. CMS notes that the CPT Editorial Panel and the RUC intend to adjust their timelines and processes so that most, if not all, of the annual coding changes and valuation recommendations can be addressed in the proposed rule.

## **12. Payment for Breast Ultrasound Procedures**

The Final Rule creates interim final values for two new breast ultrasound CPT codes created by the CPT Editorial Panel for CY 2015.<sup>21</sup> The new codes, 76641 (ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete) and 76642 (ultrasound, breast, unilateral, real time with image documentation, including axilla when performed, limited), replace the single CPT code 76645 (ultrasound, breast(s), (unilateral or bilateral), real time with image documentation). CMS assigns to each new code the RUC-recommended work RVUs: 0.73 for 76641 and 0.68 for 76642. Because the new codes both describe a unilateral ultrasound, providers billing for a bilateral procedure should include a bilateral payment indicator for the appropriate code, which will adjust the payment to 150 percent of the unilateral procedure. As noted below, these codes will be added to the list of procedures subject to the cap on payment for certain imaging procedures.

## **13. Payment for Radiation Therapy Procedures**

The Final Rule delays until CY 2016 the revaluation of the code set for radiation therapy procedures, which the CPT Editorial Panel revised for CY 2015 following identification of some of the radiation therapy codes as potentially misvalued. CMS explains that it is delaying revaluation of these codes to take into account the revised process for revaluing potentially misvalued codes, as well as in response to comments urging CMS not to revalue these codes through an interim final rule due to the potentially significant effect on payment to radiation therapy centers.

CMS also will delay use of the revised codes until CY 2016. For CY 2015, CMS will adopt a series of G-codes equivalent to the 2014 CPT codes to allow providers to continue billing for radiation therapy services as they did in CY 2014. CMS will maintain the inputs for these codes at the CY 2014 levels, and all payment policies applicable in CY 2014 will apply to the replacement G-codes.<sup>22</sup> As noted below, two of the G-codes (G6001 and G6002) will be added to the list of procedures subject to the cap on payment for the technical component of certain imaging procedures.

CMS lists the revised CPT codes subject to this delay, along with the equivalent G-codes, in the Final Rule at Table 27.<sup>23</sup> A version of the table is copied below.

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<sup>21</sup> *Id.* at 67666.

<sup>22</sup> *Id.* at 67666-67.

<sup>23</sup> *Id.* at 67667.

CY 2014 CPT Code	CY 2015 G-Code	Description
76950	G6001	Ultrasonic guidance for placement of radiation therapy fields
77421	G6002	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy
77402	G6003	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 MeV
77403	G6004	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 MeV
77404	G6005	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 MeV
77406	G6006	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 MeV or greater
77407	G6007	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: up to 5 MeV
77408	G6008	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 6-10 MeV
77409	G6009	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 11-19 MeV
77411	G6010	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 20 MeV or greater
77412	G6011	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam: up to 5 MeV
77413	G6012	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam: 6-10 MeV
77414	G6013	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam: 11-19 MeV
77416	G6014	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam: 20 or greater MeV
77418	G6015	Intensity-modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session
0073T	G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high-resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session
0197T	G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3-d positional tracking, gating, 3-d surface tracking), each fraction of treatment

Finally, CMS notes that due to changes in the prefatory text for CPT code 77401, that code is now effectively bundled with many other procedures supporting superficial radiation therapy. CMS acknowledges comments expressing concern that providers now are unable to bill for codes that were previously billed in addition to 77401, likely resulting in a significant reduction in payment. The Final Rule solicits comment on whether the new code set combined with the change in the prefatory

text allows for appropriate reporting for services associated with superficial radiation therapy and whether the payment continues to reflect the relative resources required to furnish these services.<sup>24</sup>

#### **14. New Codes Added to Imaging Cap List**

The Final Rule adds, on an interim final basis, seven new codes to the list of procedures subject to the payment cap on the technical component of certain imaging services under the Deficit Reduction Act of 2005 (DRA) at the lesser of the PFS rate or the OPSS rate.<sup>25</sup> The proposed addition of the codes is open to public comment. The new codes subject to the DRA cap are:

- 76641 (ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete)
- 76642 (ultrasound, breast, unilateral, real time with image documentation, including axilla when performed, limited)
- 77085 (dual-energy DXA, bone density study, 1 or more sites; axial skeleton, including vertebral fracture assessment)
- 77086 (vertebral fracture assessment via DXA)
- 77387 (guidance for localization of target volume for delivery of radiation treatment)
- G6001 (ultrasonic guidance for placement of radiation therapy fields)
- G6002 (stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy)

#### **15. Payment for Advance Care Planning**

The Final Rule acknowledges but declines to adopt payment for two new advance care planning codes adopted by the CPT Editorial Panel for CY 2015: 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) and add-on code 99498 (each additional 30 minutes). CMS states that it will consider whether to pay for these codes after it has had the opportunity to “go through notice and comment rulemaking.”<sup>26</sup>

#### **16. Revisions to Physician Payment Transparency (Sunshine) Rules**

In the Proposed Rule, CMS proposed revisions to the regulations adopted to implement Section 6002 of the ACA (commonly known as the Sunshine Act), which requires manufacturers of covered drugs, devices, biologicals, and medical supplies to publicly report payments and other transfers of value that they make to physicians and teaching hospitals. CMS finalizes its revisions to the text of the Sunshine regulations but also offers detailed guidance on certain aspects of manufacturer reporting obligations that are affected by the revised rules.<sup>27</sup>

Most notably, CMS finalizes its proposal to delete the special rules for reporting of payments provided to CME program sponsors as compensation for physician speakers, and the preamble to the Final Rule provides additional guidance on the conditions under which manufacturers must

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<sup>24</sup> *Id.*

<sup>25</sup> *Id.* at 67712.

<sup>26</sup> *Id.* at 67670-71.

<sup>27</sup> *Id.* at 67758-61.

report payments to physician speakers and attendees of CME programs. The changes to the rules will take effect beginning with payments made in CY 2016.

CMS also finalizes its proposal to require manufacturers to use the “marketed name” and therapeutic area or product category of a product when reporting the name of a covered product associated with a reportable payment. The current regulation allows manufacturers to report the name of an associated device or medical supply using either the marketed name, the “product category,” or the “therapeutic area.” The revised rules will remove this flexibility and require manufacturers to report marketed name for any associated devices and medical supplies, with the exception of non-covered products and products associated with research payments. This change also will take effect beginning with payments made in CY 2016. CMS also finalizes its proposed provision that would require reporting stock, stock option, or any other ownership interest form of payment or other transfer of value in distinct categories.

## **17. Payment for Secondary Interpretation of Images**

In the Proposed Rule, CMS described the current conditions under which Medicare will pay for secondary interpretation of an EKG, X-ray, or other image, and raised several questions for comment about payment for secondary interpretation of images. Currently, Medicare payment is available for a secondary interpretation, either as a separate payment using a modifier for unusual circumstances requiring a secondary interpretation or as part of another service, such as certain E/M services. The Proposed Rule noted that technological advances have enabled greater sharing of existing images between providers and questioned whether Medicare payment for secondary interpretation of images should be expanded. In particular, CMS sought comment on a number of questions, including the circumstances under which physicians currently conduct secondary interpretations and whether they seek payment for these interpretations; whether more routine payment for secondary interpretation should be restricted to certain high-cost advanced diagnostic imaging services; considerations for valuing secondary interpretation services; the settings in which secondary interpretations chiefly occur; and considerations for operationalizing more routine payment of secondary interpretation in a manner that would minimize burden on providers and others.

In the Final Rule, CMS states that it received many comments in response to its solicitation, including comments on the merits of the proposals as well as information about how to implement expansion of Medicare payment for secondary interpretation of images. Most commenters agreed that there would be some cost savings from implementation of an expanded secondary interpretation policy, and many indicated that they already are providing such services. CMS acknowledges the comments and states that any changes to the current policy on payment for secondary interpretation of images will be addressed in future rulemaking.<sup>28</sup>

## **18. Changes to Medicare Telehealth Services List**

For Medicare to pay for telehealth services under the PFS, the service must be on the Medicare list of telehealth services and several additional requirements must be met. CMS provides the public the opportunity on an ongoing basis to submit requests to add codes to the telehealth services list. A code submitted for addition to the list must fall into one of two categories: Category 1 (similar to

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<sup>28</sup> *Id.* at 67732-33.

services already listed) or Category 2 (not similar to services already listed, but accurately described by the appropriate code when furnished via telehealth, and furnishing via telehealth produces clinical benefit to the patient).

CMS finalizes its proposal to add several new codes to the telehealth list based on requests submitted in CY 2013, including three CPT codes for psychotherapy services, two CPT codes for prolonged physician services in the office setting, and two HCPCS codes for annual wellness visits. As noted in the Proposed Rule, however, CMS will not add several imaging services that requesters submitted in CY 2013, including several ECG codes (because they do not meet the Medicare definition of telehealth services) and three cervical colposcopy codes (because they are not similar to other services on the telehealth list under Category 1 and the requestor did not submit evidence that they met the requirements for Category 2).<sup>29</sup>

## **19. Further Development of New Chronic Care Management Code**

In the final rule for CY 2014, CMS established separate payment under the PFS for chronic care management services, using a new G-code covering chronic care management services provided to certain patients under specified circumstances. The Proposed Rule for CY 2015 proposed new RVUs for the G-code and proposed revisions to the requirements to bill for services under the new CCM code and the scope of service requirements for the code.

The Final Rule notes that the CPT Editorial Panel created a new CPT code (99490) for CY 2015 that describes similar services to the CCM G-code and finalizes the adoption of the new CPT code for CCM services rather than the G-code.<sup>30</sup> However, CMS finalizes payment for the new CPT code at \$42.60 for CY 2015, the value proposed for the G-code.<sup>31</sup>

CMS also finalizes its proposal to revise its “incident to” regulation to permit the CCM and non-face-to-face portion of the transitional care management (TCM) services provided by clinical staff incident to the services of a practitioner to be furnished under the general supervision of a physician or other practitioner.<sup>32</sup> The Final Rule also finalizes CMS’s proposal to add a scope of service requirement that CCM services must be furnished with the use of certified electronic health record technology and an electronic care plan accessible to all providers in the practice.<sup>33</sup> Finally, CMS finalizes its proposed policy that CMS will not pay practitioners participating in the Comprehensive Primary Care or Multi-Payer Advanced Primary Care Practice demonstrations for CCM services furnished to any beneficiary attributed by these initiatives to the practice.<sup>34</sup>

## **20. Payment for Colorectal Cancer Screening**

CMS finalizes its proposal to extend the Medicare waiver of coinsurance and deductibles for colorectal cancer screening to anesthesia or sedation services furnished in conjunction with a screening colonoscopy. Under 42 C.F.R. § 410.37, Medicare covers colorectal cancer screening

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<sup>29</sup> *Id.* at 67598-603.

<sup>30</sup> *Id.* at 67719.

<sup>31</sup> Final Rule Addendum B, available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html>.

<sup>32</sup> 79 Fed. Reg. at 67720-21.

<sup>33</sup> *Id.* at 67725-26.

<sup>34</sup> *Id.* at 67729.

tests under certain conditions. The Final Rule revises the definition of “colorectal cancer screening test” under that provision to include anesthesia that is separately furnished in conjunction with a screening colonoscopy, which also extends the waiver of coinsurance and deductibles for screening colonoscopies to these additional services. CMS states that this revision will encourage Medicare beneficiaries to seek screening colonoscopies.

CMS further clarifies that the waiver of deductible will apply to anesthesia services furnished in conjunction with a colorectal cancer screening test even when a polyp or other tissue is removed during a colonoscopy. CMS also advises that anesthesia professionals should bill for their services using the 33 modifier to reflect the waiver of coinsurance and deductible for anesthesia furnished in conjunction with screening colonoscopy. Anesthesia professionals should report the PT modifier to allow waiver of the deductible for anesthesia furnished in conjunction with situations that began as a screening test but for which another service (such as colonoscopy with polyp removal) was actually furnished, but coinsurance continues to apply to these services.<sup>35</sup>

## **21. Clinical Laboratory Fee Schedule (CLFS)**

In the final rule for CY 2014, CMS adopted a detailed new process to adjust payment amounts under the CLFS to reflect technological advances in clinical laboratory testing. However, with Congress’s enactment of PAMA on April 1, 2014, CMS now is required to implement a new Medicare payment system for clinical diagnostic laboratory tests based on private payer rates and no longer has the authority to create adjustments for technological changes for tests furnished on or after PAMA’s enactment date. As a result, CMS proposed to delete the regulatory provision addressing the new process adopted in CY 2014 and to establish through future rulemaking the parameters for collection of private payer information as required by PAMA. The Final Rule adopts these proposals.<sup>36</sup>

However, CMS declines to finalize its proposals to streamline and expedite the existing process for developing LCDs for clinical diagnostic laboratory tests. The Final Rule acknowledges comments on these proposals, including opposition to the proposed reductions in notice and comment periods, and states that CMS will explore the possibility of future notice and comment rulemaking on changes to the LCD process.<sup>37</sup>

## **22. Physician Quality Reporting System (PQRS)**

### **a. Background**

In the Final Rule, CMS continues to implement the PQRS mandated by the ACA. CY 2015 is the first year in which providers are no longer eligible to receive an incentive for satisfactory reporting. Instead, for the first time, eligible professionals who do not satisfactorily report in CY 2015 will receive a -1.5 percent adjustment to the amount paid by Medicare for a service under the PFS. The payment adjustment will increase to -2.0 percent in CY 2016 and subsequent years.

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<sup>35</sup> *Id.* at 67730-32.

<sup>36</sup> *Id.* at 67750-51.

<sup>37</sup> *Id.* at 67755-56.

b. Quality Measures and Measures Groups for CY 2015

In the Final Rule, CMS finalizes 50 of the 73 current measures that it proposed to discontinue for the CY 2015 PQRS.<sup>38</sup> CMS finalizes 20 of the 28 new measures that it proposed to add for the CY 2015 PQRS.<sup>39</sup>

The current measures that the Final Rule discontinues for CY 2015 include:

- Three perioperative care measures
- Three asthma measures
- Three coronary artery bypass graft (CABG) measures
- Eight hypertension measures
- Four back pain measures

Note that CMS does not finalize the discontinuation of a radiology measure for inappropriate use of the “probably benign” assessment category in mammography screening, but will consider the removal of this measure in future years.

The new measures that the Final Rule adds for CY 2015 include:

- Two Hepatitis C screening measures: screening for patients who are active injection drug users and screening for all patients at high risk
- Two lung cancer measures: pathology reports based on biopsy/cytology specimens with diagnosis of non small cell lung cancer; pathology reports based on resection specimens with diagnosis of primary lung carcinoma
- A drug adherence measure for schizophrenia
- Two cataract surgery measures

CMS also finalizes its proposal to add to the PQRS a number of “cross-cutting measures.” These cross-cutting measures are added in accordance with the revised criteria for satisfactory reporting of PQRS measures for the 2017 payment adjustment, which (as modified in the Final Rule) will require eligible professionals or group practices to report at least one cross-cutting measure under certain reporting mechanisms. The 19 cross-cutting measures (including one measure added in response to public comment) include several preventive care and screening measures; a measure of childhood immunization status; a measure of documentation of current medications in the medical record; a measure for receipt of specialist reports; and a measure for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) PQRS survey.<sup>40</sup>

For reporting based on measures groups, CMS finalizes (with some modifications) the following 22 PQRS measures groups for the 2015 Physician Quality Reporting System:

- (1) Diabetes;
- (2) Chronic Kidney Disease (CKD);
- (3) Preventive Care;
- (4) Coronary Artery Bypass Graft (CABG);
- (5) Rheumatoid Arthritis;
- (6) Hepatitis C;
- (7) Heart Failure;
- (8) Coronary Artery Disease (CAD);

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<sup>38</sup> *Id.* at 67825-53.

<sup>39</sup> *Id.* at 67807-18.

<sup>40</sup> *Id.* at 67800-07.

- (9) HIV;
- (10) Asthma;
- (11) Inflammatory Bowel Disease (IBD);
- (12) Dementia;
- (13) Parkinson's Disease;
- (14) Cataracts;
- (15) Oncology;
- (16) Radiation Dose Optimization;
- (17) General Surgery;
- (18) Total Knee Replacement;
- (19) Acute Otitis Externa;
- (20) Coronary Obstructive Pulmonary Disorder (COPD);
- (21) Sinusitis; and
- (22) Sleep Apnea.<sup>41</sup>

These finalized measures groups include two new measures groups that CMS finalizes for CY 2015. First, CMS finalizes a new sinusitis measures group encompassing six quality measures: documentation of current medications in the medical record; percentage of visits for patients 18 and older with documentation of pain assessment and documentation of follow-up plan where pain is present; screening and cessation intervention for tobacco use; antibiotic prescribed for acute sinusitis; appropriate choice of antibiotic (amoxicillin for acute bacterial sinusitis); and computerized tomography for acute sinusitis (overuse).

Second, CMS finalizes a new acute otitis externa measures group encompassing eight quality measures: topical therapy; systemic antimicrobial therapy; documentation of current medications in the medical record; pain assessment and follow-up; risk assessment for falls; plan of care for falls; screening and cessation intervention for tobacco use; and screening for high blood pressure.

CMS finalizes its proposal to eliminate four current measures groups: perioperative care, back pain, ischemic vascular disease (IVD), and cardiovascular prevention. CMS does not finalize its proposal to eliminate two additional measures groups (chronic obstructive pulmonary disease and sleep apnea) because it was able to find new a steward for each measure. Finally, the hypertension measures group that had been included in the list of measures groups available in CY 2014 was not listed in the Proposed Rule's list of measures groups available for CY 2015, and is not listed in the Final Rule's list of measures groups, but there was no formal proposal to eliminate the hypertension measures group or explanation of its removal.

### c. Reporting Mechanisms

For CY 2015, CMS again will accept PQRS data via a number of reporting mechanisms, including claims, registry, or direct EHR. Whether a given reporting mechanism may be used depends on the measure to be reported. Eligible professionals and group practices also may satisfy the PQRS reporting requirements by reporting on a certain number of the measures groups listed above. Group practices also have the alternative of meeting PQRS requirements by participating in the Group Practice Reporting Option (GPRO), as described further below. Finally, eligible professionals

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<sup>41</sup> *Id.* at 67883-93.

and group practices also may satisfy the PQRS requirements and avoid the payment adjustment through satisfactory participation in a Qualified Clinical Data Registry (QCDR).

In the Final Rule, CMS finalizes limited changes to the registry and direct EHR reporting mechanisms, including the new requirement to report cross-cutting measures for certain reporting mechanisms, as well as changes to the QCDR satisfactory participation option, including changes to the procedures for an entity to qualify as a QCDR and the criteria for satisfactory participation.

d. Group Practice Reporting Option (GPRO)

For CY 2015, CMS will continue to offer group practices selected to participate in the GPRO different options for reporting depending on the size of the group practice: group practices of at least 25 eligible professionals will have the option of reporting through the GPRO web interface, while group practices of any size will have the option of reporting using the qualified registry or EHR reporting mechanisms. CMS also finalizes that group practices of 100 or more eligible professionals who participate in the GPRO must have all CAHPS measures reported on its behalf via a CMS-certified survey vendor, in addition to satisfying the requirements of one of the three reporting mechanisms described above.

### **23. Physician Compare Website**

The ACA required CMS to develop a Physician Compare website providing public information on Medicare-enrolled physicians; CMS launched this website in late 2010 and since has expanded the website's contents. The ACA also required CMS to implement a plan no later than January 1, 2013, for making information on physician performance publicly available on the Physician Compare website. The Physician Compare website now identifies those eligible professionals who satisfactorily report under PQRS, who are successful electronic prescribers under the Medicare eRx program, and/or who successfully participate in the Medicare EHR Incentive Program. The website also identifies which group practices satisfactorily report under the PQRS GPRO and/or are successful electronic prescribers.

As the first stage in its plan to make physician performance information available on Physician Compare, CMS posted in 2014 performance information on certain measures collected through the GPRO web interface during 2012, if the information meets minimum sample size and reliability standards. CMS also plans to post in late 2014 information collected in 2013 through the GPRO web interface under certain additional GPRO measures, if the information meets the minimum sample size and reliability standards. In addition, Accountable Care Organizations (ACOs) that publicly report certain data through the Shared Savings Program will have their performance on quality measures reported on Physician Compare in the same manner, at the ACO level. CMS also plans to post in late 2014 data from the Clinician and Group CAHPS (CG-CAHPS) for group practices of 100 or more eligible professionals reporting data under the GPRO and for ACOs participating in the Shared Savings Program.

In the Final Rule, CMS finalizes proposals that it made to expand Physician Compare in CY 2015 and CY 2016, but defers other proposals to a future rulemaking. CMS finalizes its proposal to expand Physician Compare in CY 2016 to publicly report all 2015 PQRS GPRO measures across all group reporting mechanisms (GPRO web interface, registry, EHR) for groups of two or more eligible professionals, as well as all measures reported by Shared Savings Program ACOs. As always,

information will be publicly reported only if it meets sample size and reliability standards, and there will be a 30-day preview period before the information is published on the website. CMS also finalizes its proposal to expand public reporting on Physician Compare in 2015 and 2016 to individual eligible professionals, for all PQRS measures reported through the registry, EHR, or claims mechanism (except new measures) and for certain QCDR data. However, CMS does not finalize its proposal to establish benchmarks for PQRS GPRO performance and publish performance on those benchmarks on Physician Compare, due to concerns about misleading consumers; CMS will discuss this proposal more thoroughly with stakeholders before making any new proposals about benchmarks in future rulemaking. CMS also acknowledges comments in response to its request regarding a proposal to create composite scores based on the PQRS GPRO measures groups and will consider such a proposal in future rulemaking, but the Final Rule does not establish such composite score reporting for CY 2015.

## **24. Medicare EHR Incentive Program**

The HITECH Act authorizes incentive payments and, beginning in 2015, downward payment adjustments to providers to incentivize the adoption and “meaningful use” of certified EHR technology. Although CMS has been implementing this incentive program largely through a series of standalone rules, the Final Rule does include interim final revisions to the EHR Incentive Program related to the excessive hardship exception for purposes of the 2015 payment adjustment. Under the interim final revisions, CMS exercises its discretionary authority to recognize a hardship exception under the existing category of “extreme and uncontrollable circumstances.” The exception will be applicable only with respect to the 2015 payment adjustment, and only if both of the following criteria are met:

- The provider must not have been able to fully implement the 2014 Edition CEHRT (Certified EHR Technology) due to delays in 2014 Edition CEHRT availability; and
- The provider must not have been able to attest by their attestation deadline in 2014.

For providers that meet these two criteria, the deadline for seeking an exception to the 2015 payment adjustment is extended to November 30, 2014.<sup>42</sup>

## **25. Value-Based Payment Modifier**

### **a. Background**

Under the ACA, CMS is required to implement a value-based payment modifier to adjust payment to providers based on quality of care compared to cost, not later than January 1, 2015. CMS published initial implementation guidance in the final rules for CYs 2012 through 2014 and continues its implementation of the modifier in the CY 2015 Final Rule.

As required by the statute, and as finalized in the CY 2013 final rule, CMS will begin implementation of the value-based payment modifier for 2015 and 2016 PFS payments, based on performance in 2013 and 2014, respectively.

The 2015 modifier (based on 2013 PQRS reporting) will be applied only to groups of physicians with 100 or more eligible professionals. CMS will apply the modifier depending on whether the group falls into Category 1 or Category 2. If the group has self-nominated for the PQRS GPRO and

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<sup>42</sup> *Id.* at 67905-07.

reported at least one measure or has elected the PQRS administrative claims option for CY 2013, the group falls into Category 1 and will have two options: (1) accept a zero percent modifier for 2015 PFS payments; or (2) if the group satisfactorily reported for the PQRS incentive or chose the administrative claim reporting mechanism for CY 2013, follow a quality-tiering approach under which the group's 2015 PFS payments will increase for high quality and low cost performance or decrease for low quality and high cost performance, with a maximum reduction of 1 percent. If the group does not fall into Category 1, then it falls into Category 2 and will receive a -1 percent modifier for 2015 PFS payments.

The 2016 modifier (based on 2014 PQRS reporting) will be applied to groups of physicians with 10 or more eligible professionals. For the 2016 modifier, the quality-tiering methodology will be mandatory, but groups of 10-99 eligible professionals (meaning those who had just become subject to the modifier) will be subject only to a neutral or upward adjustment. Groups of 100 or more eligible professionals will be subject to upward, neutral, or downward adjustments. In addition, Category 1 for the 2016 modifier will include groups of physicians that meet the criteria for satisfactory reporting under the PQRS via the GPRO reporting option, as well as groups that do not participate in the GPRO but at least 50 percent of whose physicians meet the PQRS reporting criteria as individuals. The amount of payment at risk from the 2016 modifier will increase from 1 percent to 2 percent.

Under the quality-tiering approach finalized in the CY 2013 final rule, CMS will calculate the exact amount of the value-based payment modifier by calculating a quality composite score and a cost composite score for the group, then combining the two scores for an overall modifier score.

The quality composite score is calculated by creating a standardized score for each quality measure that the group reports through its chosen PQRS reporting mechanism (e.g., registry or administrative claims). CMS also will include a score on three outcomes measures, including an acute condition readmission measure, a chronic condition readmission measure, and an all-cause readmission measure. CMS then classifies the quality measures into six domains (clinical care, patient experience, population/community health, patient safety, care coordination, and efficiency) and weights the group's performance in each domain equally to arrive at a quality composite score. (Domains with no quality measures reported are not included.)

The cost composite score is calculated using five cost measures, divided into two domains: a total per capita cost measure (including both Medicare Parts A and B), and four per capita cost measures for beneficiaries with specified chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes). CMS calculates the group's performance on each cost measure for the beneficiaries attributed to that group, then weights the group's performance in each domain equally to arrive at a cost composite score. (Cost measures with insufficient data are not included.)

Finally, CMS combines the group's quality composite score and cost composite score to arrive at a final value-based modifier. The calculation of the final modifier is based on a table that divides groups into three tiers of quality performance and three tiers of cost performance. For example, for the 2015 modifier, groups offering high quality at low cost will be assigned a +1 percent modifier (adjusted for budget neutrality), groups offering average quality at average cost will be assigned a 0 percent modifier, and groups offering low quality at high cost will be assigned a -1 percent modifier.

b. Continued Implementation in CY 2015 under the Final Rule

In the Final Rule, CMS continues implementation and expansion of the value-based payment modifier with the goal, as required by the ACA, of applying the modifier to all physicians and groups of physicians starting in 2017.

For the 2017 value-based payment modifier (based on 2015 PQRS reporting), CMS proposed to expand the modifier to all physicians and non-physician eligible professionals, including physicians in groups of two or more eligible professionals and solo practitioners. In addition, and consistent with the previous year's expansion, CMS proposed to make the quality-tiering methodology mandatory for all eligible professionals in CY 2017, except that groups of two to nine eligible professionals and solo practitioners (meaning those who had just become subject to the modifier) would be subject only to a neutral or upward adjustment. Groups of 10 or more eligible professionals would be subject to upward, neutral, or downward adjustments.

CMS finalizes these proposals with modifications. The 2017 modifier will cover physicians in groups of two or more eligible professionals and physicians who are solo practitioners.<sup>43</sup> However, CMS will not extend the modifier to non-physician eligible professionals (including both non-physicians in groups and non-physician solo practitioners) until 2018.<sup>44</sup> CMS finalizes that groups of two to nine eligible professionals and physician solo practitioners will be subject only to a neutral or upward adjustment for the CY 2017 payment modifier; likewise, non-physicians will be subject only to a neutral or upward adjustment for the CY 2018 payment modifier.<sup>45</sup>

In addition, CMS will finalize its proposal to modify slightly the definition of the two categories used to determine how the value-based payment modifier applies, due to the expansion of the modifier to solo practitioners. Thus, for purposes of the 2017 modifier (again, based on 2015 PQRS reporting), Category 1 will include:

- Groups of physicians that meet the criteria for satisfactory reporting under the PQRS via the GPRO reporting option;
- Groups that do not participate in the GPRO but at least 50 percent of whose physicians meet the PQRS reporting criteria or satisfactory QCDR participation as individuals; and
- Solo practitioners who meet the criteria for satisfactory reporting or satisfactory QCDR participation as individuals.

As in prior years, Category 2 will include any eligible professionals who do not fall into Category 1.<sup>46</sup>

In the Proposed Rule, CMS proposed to again increase the amount of payment at risk due to the value-based payment modifier, this time from 2 percent for the 2016 modifier to 4 percent for the 2017 modifier. The Final Rule adopts this proposal, but with the modification that the amount at risk for groups of 2-9 eligible professionals and solo practitioners will remain at 2 percent.

Under the Final Rule, if a group or solo practitioner falls into Category 2 for the 2017 modifier (because it does not meet the PQRS requirements in 2015), the following automatic reduction in its Medicare payments will apply:

- For groups of 10 or more eligible professionals, an automatic four percent reduction.

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<sup>43</sup> *Id.* at 67936.

<sup>44</sup> *Id.* at 67937.

<sup>45</sup> *Id.* at 67934, 67937.

<sup>46</sup> *Id.* at 67937-39.

- For groups of 2-9 eligible professionals and solo practitioners, an automatic two percent reduction.

If a group or solo practitioner falls into Category 1 (because it meets one of the criteria described above), quality-tiering adjustments will apply as follows:

- For groups of 10 or more eligible professionals, the maximum upward adjustment will be four percent for groups with high quality and low cost, and two percent for groups with average quality and low cost or high quality and average cost. Likewise, the maximum downward adjustment will be four percent for groups with low quality and high cost, and two percent for groups with average quality and high cost or low quality and average cost.
- For groups of two to nine eligible professionals and solo practitioners, the maximum upward adjustment will be two percent for groups with high quality and low cost, and one percent for groups with average quality and low cost or high quality and average cost. There are no downward adjustments.

Upward adjustments will be subject to an adjustment factor based on the total number of downward adjustments that are applied.<sup>47</sup>

The Final Rule also includes detailed guidance on how the value-based payment modifier for 2017 will be applied to physicians participating in the Shared Savings Program, Pioneer ACOs, or other specialized CMS programs. CMS also finalizes its proposal to expand the informal inquiry process to allow for corrections to the application of the modifier and adopts additional detail on the procedural requirements for such a corrections request. Finally, the Proposed Rule sought and the Final Rule acknowledges comments regarding inclusion of Hospital Value-Based Purchasing Program performance in the calculation of the PFS value-based payment modifier for physicians who meet some threshold of services rendered in the hospital setting. CMS will consider these comments and propose any changes in this regard through future rulemaking.

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<sup>47</sup> *Id.* at 67951-53.

**Comparison of 2014 and Final 2015 Physician Fee Schedule Payment Rates for Drug Administration Services (calculated using the conversion factor for Jan. 1 – Mar. 31, 2015)**

<b>HCPDS</b>	<b>DESCRIPTION</b>	<b>2014 Non-Facility Total</b>	<b>2014 Facility Total</b>	<b>2015 Non-Facility Total</b>	<b>2015 Facility Total</b>	<b>Non-Facility Change %</b>	<b>Facility Change %</b>
96360	Hydration iv infusion init	\$56.96	NA	\$58.00	NA	1.83%	NA
96361	Hydrate iv infusion add-on	\$15.05	NA	\$15.39	NA	2.32%	NA
96365	Ther/proph/diag iv inf init	\$68.78	NA	\$69.81	NA	1.50%	NA
96366	Ther/proph/diag iv inf addon	\$18.63	NA	\$18.97	NA	1.86%	NA
96367	Tx/proph/dg addl seq iv inf	\$30.09	NA	\$30.43	NA	1.13%	NA
96368	Ther/diag concurrent inf	\$20.42	NA	\$20.76	NA	1.69%	NA
96369	Sc ther infusion up to 1 hr	\$194.88	NA	\$196.19	NA	0.67%	NA
96370	Sc ther infusion addl hr	\$15.40	NA	\$15.39	NA	-0.06%	NA
96371	Sc ther infusion reset pump	\$90.99	NA	\$90.22	NA	-0.85%	NA
96372	Ther/proph/diag inj sc/im	\$25.08	NA	\$25.42	NA	1.37%	NA
96373	Ther/proph/diag inj ia	\$19.34	NA	\$19.69	NA	1.79%	NA
96374	Ther/proph/diag inj iv push	\$56.24	NA	\$56.92	NA	1.21%	NA
96375	Tx/pro/dx inj new drug addon	\$22.21	NA	\$22.55	NA	1.55%	NA
96376	Tx/pro/dx inj same drug adon	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	0.00%
96379	Ther/prop/diag inj/inf proc	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	0.00%
96401	Chemo anti-neopl sq/im	\$73.79	NA	\$74.82	NA	1.40%	NA
96402	Chemo hormon antineopl sq/im	\$31.88	NA	\$32.22	NA	1.06%	NA
96405	Chemo intralesional up to 7	\$81.32	\$30.45	\$82.34	\$30.43	1.26%	-0.06%
96406	Chemo intralesional over 7	\$113.56	\$46.57	\$119.58	\$46.90	5.30%	0.71%
96409	Chemo iv push sngl drug	\$108.90	NA	\$110.98	NA	1.91%	NA
96411	Chemo iv push addl drug	\$61.26	NA	\$62.29	NA	1.69%	NA
96413	Chemo iv infusion 1 hr	\$133.26	NA	\$136.04	NA	2.09%	NA
96415	Chemo iv infusion addl hr	\$27.94	NA	\$27.93	NA	-0.06%	NA
96416	Chemo prolong infuse w/pump	\$138.99	NA	\$141.42	NA	1.74%	NA
96417	Chemo iv infus each addl seq	\$61.97	NA	\$62.65	NA	1.10%	NA
96420	Chemo ia push technique	\$104.24	NA	\$104.90	NA	0.63%	NA
96422	Chemo ia infusion up to 1 hr	\$167.65	NA	\$171.13	NA	2.08%	NA
96423	Chemo ia infuse each addl hr	\$77.38	NA	\$79.12	NA	2.25%	NA
96425	Chemotherapy infusion method	\$180.55	NA	\$181.51	NA	0.53%	NA
96440	Chemotherapy intracavitary	\$854.73	\$142.22	\$867.11	\$141.77	1.45%	-0.31%
96446	Chemotx admn prtl cavity	\$193.44	\$22.21	\$201.92	\$28.64	4.38%	28.95%
96450	Chemotherapy into cns	\$181.98	\$82.03	\$183.30	\$81.63	0.73%	-0.50%
96521	Refill/maint portable pump	\$135.05	NA	\$139.27	NA	3.12%	NA
96522	Refill/maint pump/resvr syst	\$111.05	NA	\$114.21	NA	2.84%	NA
96523	Irrig drug delivery device	\$24.72	NA	\$25.06	NA	1.39%	NA
96542	Chemotherapy injection	\$118.57	\$42.63	\$120.65	\$42.60	1.75%	-0.06%