

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

On July 3, 2014, the Centers for Medicare & Medicaid Services (CMS) released the physician fee schedule (PFS) proposed rule for calendar year (CY) 2015 (the “Proposed Rule”). The Proposed Rule was published in the Federal Register on July 11, 2014,¹ and CMS will accept comments on it until September 2, 2014.

1. Highlights of the Proposed Rule:

The Proposed Rule would:

- Project a conversion factor (CF) of \$35.7977, taking into account the zero percent update mandated by the Protecting Access to Medicare Act of 2014 (PAMA) for the first three months of 2015 and assuming no further reduction due to the statutory sustainable growth rate (SGR) formula for the remainder of 2015.
- Create a modifier to be reported with every code for physician and hospital services furnished in an off-campus provider-based department of a hospital. CMS seeks comment on possible uses of Medicare hospital outpatient cost data in revising the methodology for creating practice expense (PE) relative value units (RVUs).
- Solicit comments on a possible revision of the equipment cost formula to allow the maintenance factor to vary for particular equipment.
- Eliminate certain direct PE inputs related to use of film in imaging services and instead use digital inputs as proxies in calculating RVUs for such services. CMS seeks comment on the feasibility of developing task-level clinical labor direct PE inputs to facilitate the revision of clinical labor inputs to reflect the transition from film to digital.
- Delete existing G-codes for digital mammography and instead pay for all mammography services (film and digital) under the Current Procedural Terminology (CPT®)² codes for mammography services.
- Delete three of the four G-codes for prostate biopsy and revise the remaining code’s descriptor to define the service regardless of the number of specimens.
- Remove the direct PE input for the radiation treatment vault from all applicable Healthcare Common Procedure Coding System (HCPCS) codes.
- Create a new standard supply package for contrast-enhanced imaging services.
- Delete existing G-codes for stereotactic radiosurgery services provided using robotic methods and instead pay for all such services (robotic and non-robotic) under CPT codes.
- Solicit comments on whether CMS should establish non-facility PE RVUs for intravascular ultrasound services.

¹ 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, Proposed Rule, CMS-1612-P, 79 Fed. Reg. 40318 (July 11, 2014), available at: <http://www.gpo.gov/fdsys/pkg/FR-2014-07-11/pdf/2014-15948.pdf>.

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- Identify and revise potentially misvalued services under the PFS, including codes for high-expenditure services across specialties with Medicare allowed charges of \$10 million or more, as well as certain specified codes for mammography, abdominal aortic aneurysm ultrasound, and prostate biopsy.
- Revise the rules to implement the Sunshine Act disclosure law to eliminate a special exception for payments related to continuing medical education (CME) speaker compensation and to require reporting of the “marketed name” of all products related to a reportable payment, including medical devices.
- Solicit comments on whether CMS should expand Medicare payment for secondary interpretation of images under certain circumstances.
- Add certain new codes to the list of services eligible for Medicare telehealth payment, but not including certain electrocardiogram (ECG) or cervical colposcopy codes that had been requested.
- Revise the procedures for valuing new, revised, and potentially misvalued codes to allow new coding or valuation decisions to be published in a proposed rule (rather than an interim final rule) before taking effect.
- Further develop Medicare policies for payment for chronic care management services, as finalized in the CY 2014 final rule.
- Revise the definition of “colorectal cancer screening test” to allow Medicare beneficiaries to avoid coinsurance or deductibles for anesthesia provided in conjunction with screening colonoscopies.
- Pursuant to changes mandated by Congress in PAMA, remove the new process adopted in CY 2014 for revising payment under the Clinical Laboratory Fee Schedule (CLFS) to reflect technological changes and implement a streamlined local coverage determination (LCD) process for clinical diagnostic laboratory testing.
- Refine the Physician Quality Reporting System (PQRS) by shifting from positive incentive payments to negative payment adjustments, as required by statute, and adopting new measures and measures groups.
- Continue to expand the quality data and other information available on the Physician Compare website.
- Continue to implement the value-based payment modifier by expanding the modifier to all groups of physicians as well as all eligible professionals by CY 2017 and increasing the amount at risk from two percent to four percent of the group’s or individual’s Medicare payments.

The cumulative effect on total Medicare payments to physicians involved in provision of cancer care if all of the proposals except the cut to the conversion factor take effect would be:

Specialty	Allowed Charges (millions)	Combined Impact
Hematology/Oncology	\$1,803	+1%
Radiation Oncology	\$1,796	-4%
Radiology	\$4,497	-2%
Radiation Therapy Centers	\$60	-8%

Note that the addenda containing payment rates and other information no longer are 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-P.html>.

2. Conversion Factor

The Proposed Rule notes that PAMA replaced the reduction in the PFS update that would otherwise occur on January 1, 2015, with a zero percent update from January 1, 2015, to March 31, 2015. The Proposed Rule does not project a reduction to physician payment rates in 2015 based on the SGR formula. Rather, CMS states that “the impacts in this proposed rule are based upon this CF being applicable throughout the year.” However, CMS notes that “in the absence of further Congressional action, the applicable update for the remainder of the year will be based on the statutory SGR formula and the CF will be adjusted accordingly.” The current estimate of the CY 2015 conversion factor, after application of budget neutrality adjustments, is \$35.7977.

3. Use of Hospital Cost Data in PE RVU Process

During development of the CY 2014 rule, CMS proposed but declined to finalize a proposal to limit the total non-facility PFS payment amount to no more than the total combined amount that Medicare would pay to practitioners and facilities for the same code in the facility setting, based on the corresponding Outpatient Prospective Payment System (OPPS) or Ambulatory Surgical Center (ASC) payment rate. In the Proposed Rule, CMS notes that it continues to believe that there are various possibilities for using available hospital cost data to establish more accurate PE RVUs for PFS services. CMS also notes that PAMA granted CMS new authority to collect information from eligible professionals and other sources about the resources used to furnish services and to use alternative approaches in establishing PE RVUs, including use of data from other suppliers and providers of services. CMS does not propose any specific methodologies for creating PE RVUs based on hospital or other cost data, but seeks comment on the possible uses of Medicare hospital outpatient cost data (not the APC payment amount) in revising the PE methodology, either to set or to validate PFS resource cost assumptions.

CMS also explains that it is continuing to seek a better understanding of the shift of physician practices to provider-based arrangements. In order to gather more information about this trend and its impact on costs, CMS proposes to create a HCPCS modifier that would be reported with every code for physician and hospital services furnished in an off-campus provider-based department of a hospital, beginning January 1, 2015. CMS seeks comment on whether the proposed modifier would be the best mechanism for collecting information about the accuracy of service-level direct PE inputs and other PE data, particularly with respect to the different resource costs between traditional office and facility and off-campus provider-based settings.

4. Calculation of Equipment Cost: Maintenance Factor

CMS requests comment on a possible revision to the maintenance factor used in its calculation of equipment cost. Currently, CMS calculates equipment cost per minute as:

$1/(\text{minutes per year} \times \text{usage}) \times \text{price} \times ((\text{interest rate}/(1-(1/((1 + \text{interest rate}) - \text{life of equipment})))) + \text{maintenance})$

The maintenance factor is currently defined at 0.05, or 5% of the price, as finalized in the CY 1998 rulemaking. In the Proposed Rule, CMS notes that several stakeholders have suggested that the maintenance factor should be variable, and solicits comment on reliable data on maintenance costs that vary for particular equipment items.

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

Following and expanding upon a recommendation from the American Medical Association's RVU Update Committee (RUC), CMS proposes to eliminate certain direct PE inputs from a number of codes for digital imaging services to reflect the transition from film to digital technology in performing those services. CMS proposes to remove these film-related inputs not only from the services 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 says that it does not have data for the direct PE costs associated with a Picture Archiving and Communication System (PACS), but it proposes to use the cost of a desktop computer as a proxy for the cost of the PACS.

CMS also notes the RUC's recommendation that the inputs for clinical labor be revised to reflect the transition from film to digital technology, but notes the difficulty of implementing such revisions because the clinical labor time inputs are not broken down by particular clinical labor tasks. CMS is therefore considering revising the direct PE input database to include task-level clinical labor time for every code in the database, but is not proposing any changes to the PE inputs based on this proposed modification for CY 2015. Instead, CMS seeks comment on the feasibility of developing task-level clinical labor inputs.

6. Change in Codes for Digital Mammography Services

CMS proposes to delete certain G-codes (G0202, G0204, G0206) that were created in CY 2002 to allow providers to bill for mammography services provided using digital technology, as opposed to traditional film mammography services billed using CPT codes (77055, 77056, 77057). CMS notes that the typical mammography service is now furnished using digital technology, making the separate G-codes for digital mammography unnecessary. As a result, CMS proposes to delete the G-codes beginning in CY 2015 and to pay for all mammography services using the CPT codes. However, because the inputs for the CPT codes have not been reviewed recently, CMS proposes to value the CPT codes using the RVUs previously established for the mammography G-codes, which better reflect the use of digital technology. CMS also proposes to review those CPT codes as potentially misvalued, as described in further detail below.

7. Change in Codes for Prostate Biopsy Services

CMS also proposes to eliminate three of the four codes for prostate biopsy and to propose the remaining code as potentially misvalued for 2015, as discussed below. Specifically, CMS would eliminate G-codes G0417, G0418, and G0419 for 21-40, 41-60, and greater than 60 specimens respectively, and to maintain G0416 (Surgical pathology, gross and microscopic examination for prostate needle biopsies, any method; 10-20 specimens) but revise the descriptor to define the service regardless of the number of specimens. The agency asserts that the current coding structure may be confusing, especially since the number of specimens associated with prostate

biopsies is relatively homogenous, and G0416 represents the overwhelming majority of all Medicare claims submitted for the four G-codes. Since G0416 is currently valued for between 10-12 specimens, CMS is proposing to use the existing values for CY 2015, but seeks public comment on the appropriate work RVUs, work time, and direct PE inputs.

8. Deletion of Radiation Treatment Vault Direct PE Input

Following its review of information about the direct PE input for the “radiation treatment vault” used in several radiation treatment procedures, CMS proposes to delete the vault as a direct PE input. CMS explains that the direct PE input should be deleted because the vault is not in itself medical equipment that must be accounted for as a direct PE input but rather a structural component of the building required to house the radiation treatment equipment, which is accounted for in the indirect PE methodology just like other building and infrastructure costs for other PFS services. The radiation treatment vault therefore would be removed as a direct input for the following HCPCS codes: 77373, 77402-77416, 77418.

9. New Standard Supply Package for Contrast-Enhanced Imaging Services

CMS proposes to accept the RUC’s recommendation to create a new direct PE input standard supply package for contrast-enhanced imaging services, with a price of \$6.82. The price reflects the combined prices of the medical supplies included in the package that are listed in the Proposed Rule. CMS seeks comment on whether the items included in the package are used in the typical case.

10. Updates to Price for Existing Direct PE Inputs

CMS states that it is continuing to study the best way to improve the current process for updating the price of equipment and supplies to reflect typical market prices. CMS notes in particular that it continues to have difficulty determining the best way to use sample invoices for equipment and other supplies that it receives from various stakeholders. Although the Proposed Rule does not include any specific proposals regarding the process for updating prices for existing direct PE inputs, CMS states that it continues to seek stakeholder input on how best to use invoices and other price information in setting rates.

11. Change in Codes for Stereotactic Radiosurgery (SRS)

CMS proposes to delete certain G-codes (G0339, G0340) used to bill for SRS services provided using robotic methods. Taking into account comments received in response to a request for comments in last year’s rulemaking, CMS concludes that the CPT codes for SRS (77372, 77373) accurately describe both robotic and non-robotic SRS services, and that the direct PE inputs included in the CPT codes accurately reflect the typical resource inputs in providing either type of SRS service. Thus CMS proposes to recognize only the CPT codes for payment of SRS services and to delete the G-codes. The CPT codes have RVUs based on the recommendations of the American Medical Association (AMA) Relative Value Update Committee (RUC), and the G-codes currently are contractor priced.

12. Non-Facility PE RVUs for Intravascular Ultrasound

In response to a stakeholder request, CMS requests comment on whether it is appropriate to establish non-facility PE RVUs for two intravascular ultrasound CPT codes (37250 and 37251), and, if so, what inputs should be assigned to these codes.

13. 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. Public Nomination of Potentially Misvalued Codes

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
 - 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.
- Evidence that 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.

In the Proposed Rule for CY 2015, CMS addresses two codes nominated by the public as potentially misvalued and proposes one of the two codes (41530, submucosal ablation of the tongue base) as potentially misvalued based on changes in the equipment used in furnishing the service. CMS proposes not to review the other nominated code because it is not covered by Medicare.

b. CY 2015 Identification and Review of Potentially Misvalued Codes

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.

CMS notes that 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.

In the Proposed Rule, CMS proposes to evaluate approximately 65 codes as potentially misvalued because they represent high expenditure services across specialties with Medicare allowed charges of \$10 million or more, which CMS identifies as a prioritized subset of the new statutory category “codes that account for the majority of spending under the physician fee schedule.” CMS arrived at this list by identifying the top 20 codes for each specialty in terms of allowed charges, then removing any codes proposed as potentially misvalued since CY 2009 and any evaluation/management (E/M) codes. This list includes the codes for several drug administration services:

Code	Short Description
96372	Ther/proph/diag inj sc/im
96375	Tx/pro/dx inj new drug addon
96401	Chemo anti-neopl sq/im
96409	Chemo iv push sngl drug

In addition, as noted above, CMS proposes three mammography CPT codes (77055, 77056, 77057) as potentially misvalued. The Proposed Rule would delete the G-codes currently used to bill for mammography services using digital technology and instead would pay for mammography services under the CPT codes, but using the values previously established for the G-codes. Accordingly, CMS proposes the CPT codes as potentially misvalued because the values associated with the G-codes have not been reviewed since they were created in CY 2002. Similarly, as discussed above, CMS also proposes to eliminate three of the four codes for prostate biopsy and to propose the remaining code, G0416, as potentially misvalued for 2015. CMS also proposes 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.

14. Malpractice RVUs

For CY 2015, CMS proposes to implement the third comprehensive review and update of the malpractice RVUs. The methodology used to calculate the proposed CY 2015 review and update of the resource-based malpractice RVUs largely parallels the process used in CY 2010. CMS used information on specialty-specific malpractice premiums linked to a specific service based on the relative risk factors of the various specialties that provide that particular service. The agency weights malpractice premium information geographically and by specialty because malpractice premiums vary by state and by specialty. CMS obtained malpractice premium data from state departments of insurance, and, when not available, from state rate filing data from the Perr and Knight database. The most current data was from malpractice insurance rate filings with effective dates in 2011 and 2012. Because on average, malpractice RVUs only represent about 4.3% of the payment for a service under the PFS, implementation of the review of the malpractice RVUs will only have a small payment effect. In fact, according to CMS's estimated impact table on total allowed charges by specialty, the changes are estimated to be zero percent for hematology/oncology, radiation oncology, radiation therapy centers, and radiology.

15. Proposed Payment for Drug Administration Services

Comparison of Physician Fee Schedule Drug Administration Rates 2014 to Proposed 2015

HCPCS	DESCRIPTION	2014 Non-Facility Total	2014 Facility Total	Proposed 2015 Non-Facility Total	Proposed 2015 Facility Total	Non-Facility Change %	Facility Change %
90461	Im admin each addl component	\$12.54	NA	\$12.53	NA	-0.07%	NA
90471	Immunization admin	\$25.08	NA	\$25.42	NA	1.36%	NA
90472	Immunization admin each add	\$12.54	NA	\$12.53	NA	-0.07%	NA
90473	Immune admin oral/nasal	\$25.08	NA	\$25.42	NA	1.36%	NA
90474	Immune admin oral/nasal addl	\$12.54	NA	\$12.53	NA	-0.07%	NA
96360	Hydration iv infusion init	\$56.96	NA	\$57.63	NA	1.19%	NA
96361	Hydrate iv infusion add-on	\$15.05	NA	\$15.04	NA	-0.07%	NA

96365	Ther/proph/diag iv inf init	\$68.78	NA	\$69.81	NA	1.49%	NA
96366	Ther/proph/diag iv inf addon	\$18.63	NA	\$18.97	NA	1.85%	NA
96367	Tx/proph/dg addl seq iv inf	\$30.09	NA	\$30.43	NA	1.12%	NA
96368	Ther/diag concurrent inf	\$20.42	NA	\$20.76	NA	1.68%	NA
96369	Sc ther infusion up to 1 hr	\$194.88	NA	\$195.46	NA	0.30%	NA
96370	Sc ther infusion addl hr	\$15.40	NA	\$15.39	NA	-0.07%	NA
96371	Sc ther infusion reset pump	\$90.99	NA	\$89.85	NA	-1.25%	NA
96372	Ther/proph/diag inj sc/im	\$25.08	NA	\$25.42	NA	1.36%	NA
96373	Ther/proph/diag inj ia	\$19.34	NA	\$19.33	NA	-0.07%	NA
96374	Ther/proph/diag inj iv push	\$56.24	NA	\$56.92	NA	1.20%	NA
96375	Tx/pro/dx inj new drug addon	\$22.21	NA	\$22.19	NA	-0.07%	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	1.39%	NA
96402	Chemo hormon antineopl sq/im	\$31.88	NA	\$32.22	NA	1.05%	NA
96405	Chemo intralesional up to 7	\$81.32	\$30.45	\$81.26	\$30.43	-0.07%	-0.07%
96406	Chemo intralesional over 7	\$113.56	\$46.57	\$118.13	\$46.54	4.03%	-0.07%
96409	Chemo iv push snl drug	\$108.90	NA	\$110.97	NA	1.90%	NA
96411	Chemo iv push addl drug	\$61.26	NA	\$61.93	NA	1.10%	NA
96413	Chemo iv infusion 1 hr	\$133.26	NA	\$135.67	NA	1.81%	NA
96415	Chemo iv infusion addl hr	\$27.94	NA	\$27.92	NA	-0.07%	NA
96416	Chemo prolong infuse w/pump	\$138.99	NA	\$141.04	NA	1.48%	NA
96417	Chemo iv infus each addl seq	\$61.97	NA	\$62.65	NA	1.09%	NA
96420	Chemo ia push technique	\$104.24	NA	\$104.17	NA	-0.07%	NA
96422	Chemo ia infusion up to 1 hr	\$167.65	NA	\$171.11	NA	2.07%	NA
96423	Chemo ia infuse each addl hr	\$77.38	NA	\$79.11	NA	2.24%	NA
96425	Chemotherapy infusion method	\$180.55	NA	\$181.14	NA	0.33%	NA
96440	Chemotherapy intracavitary	\$854.73	\$142.22	\$863.44	\$142.47	1.02%	0.18%
96446	Chemotx admn prtl cavity	\$193.44	\$22.21	\$198.68	\$25.42	2.71%	14.44%
96450	Chemotherapy into cns	\$181.98	\$82.03	\$183.28	\$81.98	0.72%	-0.07%
96521	Refill/maint portable pump	\$135.05	NA	\$138.90	NA	2.85%	NA
96522	Refill/maint pump/resvr syst	\$111.05	NA	\$113.84	NA	2.51%	NA
96523	Irrig drug delivery device	\$24.72	NA	\$25.06	NA	1.38%	NA
96542	Chemotherapy injection	\$118.57	\$42.63	\$120.28	\$42.60	1.44%	-0.07%

16. Revisions to Physician Payment Transparency (Sunshine) Rules

CMS proposes certain limited 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. Most notably, CMS proposes to delete the special rules for reporting of payments provided to CME program sponsors as compensation for physician speakers. However, CMS also states in the Proposed Rule that when a manufacturer provides funding to a CME provider and does not either select or pay the covered recipient speaker

directly, or provide the CME provider with a distinct, identifiable set of covered recipients to be considered as speakers, that CMS will consider such a payment to be excluded from reporting under the separate exclusion for payments made indirectly through a third party where the manufacturer is unaware of the identity of the covered recipient.

The current rules also require manufacturers to report the name of any covered product associated with a reportable payment, but allow manufacturers to report the name of an associated device or medical supply using either the marketed name or the “product category” or “therapeutic area.” CMS proposes instead to require manufacturers to report all covered products, including medical devices, using the marketed name.

17. Payment for Secondary Interpretation of Images

In the Proposed Rule, CMS describes the current conditions under which Medicare will pay for secondary interpretation of an EKG, X-ray, or other image, and raises 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 payment, such as certain E/M services. CMS notes that technological advances have enabled greater sharing of existing images between providers and questions whether Medicare payment for secondary interpretation of images should be expanded. In particular, CMS seeks comment on the following questions:

- For which radiology services are physicians currently conducting secondary interpretations, and what, if any, institutional policies are in place to determine when existing images are utilized? To what extent are physicians seeking payment for these secondary interpretations from Medicare or other payers?
- Should routine payment for secondary interpretations be restricted to certain high-cost advanced diagnostic imaging services, such as those defined as such under section 1834(e)(1)(B) of the SSA, for example, diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography)?
- How should the value of routine secondary interpretations be determined? Is it appropriate to apply a modifier to current codes or are new HCPCS codes for secondary interpretations necessary?
- CMS believes most secondary interpretations would be likely to take place in the hospital setting. Are there other settings in which claims for secondary interpretations would be likely to reduce duplicative imaging services?
- Is there a limited time period within which an existing image should be considered adequate to support a secondary interpretation?
- Would allowing for more routine payment for secondary interpretations be likely to generate cost savings to Medicare by avoiding potentially duplicative imaging studies?
- What operational steps could Medicare take to ensure that any routine payment for secondary interpretations is limited to cases where a new imaging study has been averted while minimizing undue burden on providers or Part B contractors?

CMS states that it will review the comments received and consider whether any further action is appropriate, such as proposing through future rulemaking to allow for payment of subsequent interpretations of advanced diagnostic images in lieu of duplicative studies.

18. No Expansion of the Multiple Procedure Payment Reduction (MPPR) Policy

In recent years, CMS has greatly expanded the MPPR policy to adjust payment to reflect reduced resources for services that frequently are furnished together. For example, in the final rule for CY 2012, CMS finalized a proposal to apply a 25 percent MPPR to the professional component (PC) of advanced imaging services (CT, MRI, and ultrasound). In the final rule for CY 2013, CMS finalized a proposal to apply an MPPR to second and subsequent procedures for technical component (TC)-only services and the TC portion of global services for certain diagnostic cardiology and ophthalmology procedures furnished to the same patient on the same day, including certain imaging procedures.

The Proposed Rule does not include any new MPPR policies for CY 2015 or discuss any possible future expansion of the MPPR. In the CY 2014 rulemaking, CMS stated that it is continuing to look at expanding the MPPR based on efficiencies when multiple procedures are performed together, and that any specific proposals would be presented in future rulemaking and subject to public comment.

19. Proposed 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 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 proposes 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. However, CMS proposes not to add to the telehealth list several imaging services that requesters submitted in CY 2013, including several ECG codes and three cervical colposcopy codes. With respect to the ECG codes, CMS states that although the professional component (PC) of the ECG codes may be furnished remotely, those services do not meet the Medicare definition of telehealth services and are paid for under the same conditions that they would be if furnished in-person. With respect to the colposcopy codes, CMS states that the services are not similar to other telehealth services on the list and could not be added under Category 1, and the requester failed to submit evidence that the services should be added under Category 2.

20. Procedure for Valuing New, Revised, and Potentially Misvalued Codes

In the Proposed Rule, CMS acknowledges concerns expressed by a number of stakeholders that when CMS revises or establishes values for new, revised, and potentially misvalued codes via interim final rulemaking, the stakeholders are unaware of and do not have an opportunity to meaningfully comment on the new or revised values before the coding or valuation decision takes effect. Notably, when CMS makes such decisions by interim final rule, it then pays for the affected services in the following calendar year based on the decision in the interim final rule, and does not consider and respond to any comments on the interim final rule until the subsequent year. CMS

ascribes its decision to use interim final rulemaking for such coding and valuation decisions to the incongruity between the schedules for the AMA CPT Editorial Panel and the RUC review process and the schedule for the annual PFS rule.

To address these concerns, CMS proposes a new procedure for valuing new, revised, and potentially misvalued codes. Specifically, CMS proposes to make all changes to work and malpractice RVUs and to direct PE inputs for new, revised, and potentially misvalued codes under the PFS by proposing the changes in a proposed rule, beginning with the PFS proposed rule for CY 2016. For codes for which CMS does not receive RUC recommendations by January 15th of a given year, CMS would delay revaluing the code for one year or until the year in which it receives the RUC recommendations by January 15th. For such delayed codes, CMS proposes to adopt coding policies and payment rates that conform to the extent possible with the policies and rates in place for the previous year. For codes that are revised or deleted through the annual CPT coding changes, where CMS does not receive recommendations by January 15th, it proposes to create G-codes to describe the predecessor codes to the deleted or revised codes and to pay using those G-codes until the new or revised codes can be addressed in a proposed rule. For new codes that describe wholly new services, where CMS does not receive the RUC recommendations by January 15th, it proposes to establish values for the initial year under an interim final rule, or to use contractor pricing if information is still not available in time for an interim final rule.

CMS seeks comment on the proposed alternative process for establishing values for new, revised, and potentially misvalued codes, particularly whether the proposed new process is better than the current process, when the new process should be implemented, and whether there are alternatives to using G-codes to address the annual CPT changes.

21. Further Development of New Chronic Care Management Code

In the final rule for CY 2014, CMS established separate payment under the PFS for certain chronic care management services provided to certain patients under certain specified circumstances. CMS created a G-code to identify these services. The Proposed Rule would create new RVUs for the G-code. It would also loosen certain restrictions on billing for services provided incident to a practitioner, as those restrictions are applied to the new chronic care management service. Finally, the Proposed Rule would add to the existing scope of service requirements a requirement that chronic care management 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.

22. Payment for Colorectal Cancer Screening

Under 42 C.F.R. § 410.37, Medicare covers colorectal cancer screening tests under certain conditions. CMS proposes to revise the definition of “colorectal cancer screening test” under that provision to include anesthesia that is separately furnished in conjunction with a screening colonoscopy. CMS states that this revision will have the effect of extending the waiver of coinsurance and deductibles to anesthesia or sedation services furnished in conjunction with a screening colonoscopy, and thereby encouraging Medicare beneficiaries to seek such services. If it finalizes the proposal, CMS will create an appropriate modifier for use when billing under the relevant anesthesia codes in conjunction with colonoscopy screening.

23. Statutory Changes to the 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 is now 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 is not proposing any revisions to payment amounts for test codes under the CLFS based on technological changes and is proposing to delete the provision addressing the new process adopted in CY 2014. Instead, CMS will establish through future rulemaking the parameters for collection of private payer information as required by PAMA.

24. Local Coverage Determination Process for Clinical Diagnostic Laboratory Tests

PAMA also added section 1834A(g) of the SSA that requires that the process for making LCDs be used as the vehicle for local coverage policies for clinical diagnostic laboratory tests. CMS proposes a new process that would apply to all new clinical diagnostic testing draft LCDs published on or after January 1, 2015. It would not apply to most clinical diagnostic laboratory testing LCDs that are being revised. The proposed new process would anyone to request and LCD or for the Medicare Administrative Contractor (MAC) to initiate it. The MAC then would publish a draft LCD in the Medicare Coverage Database, and there would be a public comment period for at least 30 days. If the MAC Coverage Database no later than 45 calendar days after the close if the comment period, and the policy would be effective immediately upon publication. The LCD reconsideration and challenge process would be the same as for the current LCD process. Overall, CMS notes that it is trying to streamline the process to make it more efficient given the thousands of new clinical determines that a Carrier Advisory Committee (CAC) meeting would contribute to the quality of the final policy, the MAC could involve the CAC in the development of an LCD, and the comment period would be extended accordingly. The MAC would be required to respond to all public comments in writing and post their responses on a public website. The MAC would publish the final LCD in the Medicare diagnostic tests developed each year. CMS encourages public comment on all aspects of its proposed process.

25. Substitute Physician Billing Arrangements

Section 1842(b)(6)(D) of the SSA allows payment to be made to a physician for another physician's services under certain specific circumstances. CMS states that it is concerned about the operational and program integrity issues that result from the use of substitute physicians to fill staffing needs or to replace a physician who has permanently left a medical group or employer. The agency is deciding whether and how to adopt regulations interpreting section 1842(b)(6)(D) in a manner that will help alleviate these concerns. CMS asks a series of questions on substitute physician billing arrangements in the Proposed Rule and requests comments to better understand current industry practices and how policy changes limiting the use of substitute physicians might have on beneficiary access to care.

26. Physician Quality Reporting System

a. Background

In the Proposed 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.

b. Quality Measures and Measures Groups for CY 2015

For CY 2015, CMS proposes to discontinue 73 of the measures used in the 2014 PQRS and proposes 28 new individual measures for inclusion in the 2015 PQRS.

The measures that CMS proposes to discontinue in CY 2015 include:

- A radiology measure for inappropriate use of the “probably benign” assessment category in mammography screening
- Six perioperative care measures
- Three asthma measures
- Four coronary artery bypass graft (CABG) measures
- Eight hypertension measures
- Four back pain measures
- Four sleep apnea measures

The measures that CMS proposes to add include:

- One measure for avoidance of inappropriate use of imaging for adult emergency department (ED) patients with traumatic low back pain
- 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
- Two drug adherence measures for schizophrenia and bipolar disorder
- Two cataract surgery measures

CMS also proposes to add for the first time a number of “cross-cutting measures,” in accordance with the proposed criteria for satisfactory reporting of PQRS measures for the 2017 payment adjustment, which require eligible professionals or group practices to report at least two cross-cutting measures under certain reporting mechanisms. The 18 cross-cutting measures include five 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 CAHPS PQRS survey.

For reporting based on measures groups, CMS proposes to retain (with some modifications) the following 18 PQRS measures groups for the 2015 Physician Quality Reporting System:

- (1) Diabetes Mellitus;
- (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);
- (9) HIV/AIDS;
- (10) Asthma;
- (11) Inflammatory Bowel Disease (IBD);
- (12) Dementia;
- (13) Parkinson's Disease;
- (14) Cataracts;
- (15) Oncology;
- (16) Radiation Dose Optimization;
- (17) General Surgery; and
- (18) Total Knee Replacement.

The oncology measures group includes the following measures:

NQF/PQRS	Measure Title and Description	Measure Developer
0387/071	<p>Breast Cancer: Hormonal Therapy for Stage IC -IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period</p>	AMA-PCPI/ASCO/NCCN
0385/072	<p>Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients: Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period</p>	AMA-PCPI/ASCO/NCCN
0041/110	<p>Preventive Care and Screening: Influenza Immunization: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization</p>	AMA-PCPI
0419/130	<p>Documentation of Current Medications in the Medical Record: Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.</p>	CMS/QIP
0384/143	<p>Oncology: Medical and Radiation – Pain Intensity Quantified: Percentage of patients, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified</p>	AMA-PCPI

0383/144	Oncology: Medical and Radiation – Plan of Care for Pain: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain	AMA-PCPI
0028/226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user AMA-PCPI	

For CY 2015, CMS proposes to add two new measures groups. First, CMS proposes 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 proposes 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 proposes to eliminate four measures groups from CY 2014: perioperative care, back pain, ischemic vascular disease (IVD), and cardiovascular prevention. CMS also proposes to eliminate two additional measures groups from CY 2014 (chronic obstructive pulmonary disease and sleep apnea) unless a suitable steward for the measures can be found. Finally, the hypertension measures group that had been included in the list of measures groups available in CY 2014 is not listed in the Proposed Rule’s list of measures groups available for CY 2015, but there is no formal proposal to eliminate the hypertension measures group or explanation of its removal.

c. Reporting Mechanisms

For CY 2015, CMS proposes to again accept PQRS data via a number of reporting mechanisms, including claims, registry, direct Electronic Health Record (HER), certified survey vendor, and the Group Practice Reporting Option (GPRO). Whether a given reporting mechanism can 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 measures groups, as described below. Alternatively, as finalized in the CY 2014 final rule, eligible professionals and group practices may satisfy the PQRS requirements and avoid the payment adjustment through satisfactory participation in a Qualified Clinical Data Registry (QCDR). CMS proposes certain limited changes to the registry, direct EHR, and QCDR reporting mechanisms, including introduction of the requirement to report cross-cutting measures for certain reporting mechanisms and changes to the procedures for an entity to qualify as a QCDR.

CMS also notes in the Proposed Rule that it is considering allowing for the reporting of data from the Consumer Assessment of Healthcare Providers Surgical Care Survey (S-CAHPS) in the PQRS for reporting mechanisms beyond the QCDR, but that inclusion of S-CAHPS data is not feasible for CY

2015. CMS seeks comments on how to allow for reporting of S-CAHPS survey measures in CY 2016 for the CY 2018 payment adjustment.

d. Group Practice Reporting Option (GPRO)

For CY 2015, CMS proposes to 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 would have the option of reporting through the GPRO web-interface or certified survey vendor (CG-CAHPS) reporting mechanisms, while group practices of up to 99 eligible professionals would have the option of reporting using the claims, qualified registry, EHR, or administrative claims reporting mechanisms.

27. 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 is posting 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 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.

As part of the future development of Physician Compare, CMS proposes 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 2 or more eligible professionals, as well as all measures reported by Shared Savings Program ACOs. As always, information would be publicly reported only if it meets certain sample size and reliability standards, and there would be a 30-day preview period before the information is published on the website. CMS also seeks comment on a proposal to create composite scores based on the PQRS GPRO measures groups, if technically feasible, and publishing those scores in 2016. CMS also proposes to publish benchmarks for PQRS GPRO performance using the methodology used for the Shared Savings Program and to publish those benchmarks on Physician Compare in 2016. Finally, CMS proposes to expand public reporting on Physician Compare in 2015 and 2016 to group practices not participating in the GPRO (for certain measures) and to individual eligible professionals (for all

PQRS measures reported through the registry, EHR, or claims mechanism and for certain QCDR data).

28. Medicare EHR Incentive Program

The HITECH Act authorizes incentive payments to providers for the adoption and “meaningful use” of certified EHR technology. The Proposed Rule does not include detailed proposals regarding the implementation of the EHR Incentive Program, which is being implemented largely through a series of standalone rules.

29. Value-Based Payment Modifier

a. Background

Under the ACA, CMS is required to implement a value-based payment modifier that would adjust payment 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 expands upon that guidance in the Proposed 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 beginning with the modifier applied to 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 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 was revised for the 2016 modifier to 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 increased 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. Proposals for Continued Implementation in CY 2015

In the Proposed 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 proposes to expand the modifier to all physicians and non-physician eligible professionals, including physicians in groups of 2 or more eligible professionals and solo practitioners. In addition, and consistent with the previous year's expansion, CMS proposes to make the quality-tiering methodology mandatory for all eligible professionals in CY 2017, except that groups of 2-9 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.

In addition, CMS proposes 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. For physician groups, the definition of the categories would remain the same. Thus, for the 2017 modifier (again, based on 2015 PQRS reporting), CMS proposes that Category 1 would 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. Category 1 would also include solo practitioners who meet the criteria for satisfactory reporting or satisfactory QCDR participation as individuals. As in previous years, Category 2 would include any eligible professionals who do not fall into Category 1.

The Proposed Rule would 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. Thus, if a group falls into Category 2 for the 2017 modifier, it would be subject to an automatic 4 percent reduction. If a group falls into Category 1, the maximum downward adjustment would be 4 percent for groups with low quality and high cost, and 2 percent for groups with average quality and high cost or low quality and average cost. Likewise, the maximum upward adjustment would be 4 percent for groups with high quality and low cost, and 2 percent for groups with average quality and low cost or high quality and average cost. Upward adjustments would be subject to an adjustment factor based on the total number of downward adjustments that are applied.

The Proposed Rule includes detailed proposals on how the value-based payment modifier for 2017 will be applied to non-physician eligible professionals and to physicians participating in the Shared Savings Program, Pioneer ACOs, or other specialized CMS programs. CMS also proposes to expand the informal inquiry process to allow for corrections to the application of the modifier and to implement certain limited revisions to the calculation of the cost composite score used in calculating the final value-based payment modifier for each group or eligible professional. Finally, CMS states that it is considering allowing hospital-based physicians to elect the inclusion of Hospital Value-Based Purchasing Program performance into the calculation of their PFS value-based payment modifier in future years, and seeks comment on a number of alternatives raised in the Proposed Rule.