Physician & Freestanding Center Regulatory Update

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Since 1992, Medicare has paid for the services of physicians, non-physician practitioners, and certain other suppliers under the Medicare Physician Fee Schedule (MPFS). For reimbursement purposes, relative values are assigned to more than 7,000 services to reflect the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice expenses typically involved in furnishing that specific service. After applying a geographic practice cost indicator, the resulting relative value units (RVUs) are summed for each service and multiplied by a fixed-dollar conversion factor to establish the payment amount for each visit or procedure.

The CY 2017 conversion factor is estimated to be $35.8887, which is slightly higher than the 2016 conversion factor of $35.8043. Table 8, below, shows the estimated impact that projects payment increases or decreases by specialty (without considering the potential conversion factor change).

Primary Care

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

Table 8. Estimated Impact of Projected Payment Increases or Decreases by Specialty*

SPECIALTY	ALLOWED CHARGES (MIL)	IMPACT OF WORK RVU CHANGES	IMPACT OF PE RVU CHANGES	IMPACT OF MP RVU CHANGES	COMBINED IMPACT
Hematology/Oncology	$1,751	0%	0%	0%	0%
Radiation Oncology	$1,726	0%	0%	0%	0%
Radiation Therapy Centers	$44	0%	0%	0%	0%

LEGEND

Specialty: The Medicare specialty code as reflected in the physician/supplier enrollment files.
Allowed Charges: The aggregate estimated PFS allowed charges for the specialty based on CY 2015 utilization and CY 2016 rates.
Impact of Work RVU Changes: This column shows the estimated CY 2017 impact on total allowed charges of the changes in the work RVUs, including the impact of changes due to new, revised, and misvalued codes.
Impact of Practice Expense RVU Changes: This column shows the estimated CY 2017 impact on total allowed charges of the changes in PE RVUs, including the impact due to new, revised, and misvalued codes and miscellaneous minor provisions.
Impact of Malpractice RVU Changes: This column shows the estimated CY 2017 impact on total allowed charges of the changes in the MP RVUs, which are primarily driven by the required five year review and update of MP RVUs.
Combined Impact: This column shows the estimated CY 2017 combined impact on total allowed charges of all the changes in the previous columns.

* Without considering the potential conversion factor change.

provide cognitive services. CMS believes the focus of the healthcare system has shifted to delivery system reforms, such as patient-centered medical homes, clinical practice improvement, and increased investment in primary and comprehensive care management and coordination services for chronic and other conditions. This shift requires more centralized management of patient needs and extensive care coordination among practitioners and providers, often on a non-face-to-face basis across an extended period of time.

For CY 2017, CMS finalized a variety of coding and payment changes as part of an ongoing effort to improve payment for primary care services. These updates include:

- Separate payment for codes describing non-face-to-face prolonged evaluation and management services
- Existing procedure codes that are revalued to describe prolonged face-to-face services
- Separate reimbursement for new codes that describe comprehensive assessment and care planning for patients with cognitive impairment, mobility-related impairment, and patients with behavioral health conditions.

Last, CMS will make separate payments for codes describing chronic care management for patients with greater complexity (refer to HCPCS codes **G0501** and **G0506**). CMS believes that these coding and payment changes will improve healthcare delivery for the types of services holding the most promise for healthier people and smarter spending and advance the agency's health equity goals.

Telehealth Services

CMS finalized the addition of ESRD-related services, advance care planning services, and critical care consultation codes to the current telehealth services list. CMS states that although the agency expects these changes to increase access to care in rural areas, based on recent utilization of similar services already on the telehealth list, there will not be a significant impact on PFS expenditures.

CMS also finalized a payment policy regarding the use of a new place of service code (**02 – Telehealth**), with telehealth defined as the location where health services and health-related services are provided or received, through telecommunications technology. Of note, the originating site will not use this place of service code. In addition, place of service code **02** will be used in addition to—not instead of—**modifiers GT** (Via interactive audio and video telecommunications) and **GQ** (Via asynchronous telecommunications system). The 2017 fee for code **Q3014** (Telehealth originating site facility fee) will be $25.40, up from $25.10 in CY 2016.

Physician Self-Referral Update

Section 6204 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), enacted on Dec. 19, 1989, added section 1877 to the Social Security Act. Section 1877, also known as the physician self-referral law:

1. Prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies; and
2. Prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those referred services.

CMS has reissued regulatory provisions prohibiting certain per-unit-of-service compensation formulas for determining rental charges in the exceptions for the rental of office space, rental of equipment, fair market value compensation, and indirect compensation arrangements. These provisions are necessary to protect against potential abuses, such as overutilization, steering patient choice, the potential reduction in quality of care and patient outcomes. CMS believes that most parties comply with these regulatory provisions since they originally became effective on Oct. 1, 2009, and the reissued regulation text is identical to the existing regulation text.

Qualified Medicare Beneficiaries

Federal law prohibits providers from collecting Medicare Part A and B deductibles, coinsurance, or copayments from beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB) Program. The QMB program is a Medicaid program that helps low-income individuals with Medicare cost-sharing liability. Under QMB, state Medicaid programs are supposed to pay these patients' Medicare cost-sharing, but Federal law allows the states to limit their payment to the difference between the Medicare payment and the Medicaid rate. Since Medicaid generally reimburses at a lower rate than Medicare, this usually means the provider does not receive any additional payment beyond the Medicare allowance.

Providers are required to accept the Medicare reimbursement (and Medicaid allowance, if any) as payment in full and may not bill the patients for any balance. The same rules apply to dual eligible beneficiaries who are enrolled in both Medicaid and Medicare Advantage plans. In July 2015 CMS released a study finding that confusion and inappropriate balance billing persisted, even in the presence of laws that prohibit these collections.

Some commenters noted that it can be difficult for providers to identify these beneficiaries, and CMS stated it is actively exploring additional mechanisms for Medicare providers to readily identify the QMB status of these patients. Regardless, CMS states that Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. CMS further recommends that providers take steps to educate themselves and their staff about QMBs to ensure that cost-share is not inappropriately collected prior to

treatment or billed to the patient after services are rendered.

Global Surgical Period

Since the inception of the MPFS, CMS has valued and paid for certain services, such as surgery, as part of global packages that include the procedure and the services typically provided during the period immediately before and after the procedure. There are three primary categories of global packages that are defined based on the number of post-operative days included in the global period: 0-day, 10-day, and 90-day.

In the CY 2015 final rule with comment period, CMS finalized the proposal to transition and revalue all 10- and 90-day global surgery services with 0-day global periods, beginning with the 10-day global services in CY 2017 and following with the 90-day global services in CY 2018. However, MACRA was enacted into law on April 16, 2015, and included a paragraph that prohibits CMS from implementing this global surgery policy change. MACRA requires CMS to develop, through rulemaking, a process to gather information needed to value surgical services and requires that this data collection shall begin no later than Jan. 1, 2017.

As part of the 2017 MPFS final rule, CMS also set forth guidelines for data collection regarding resources used when furnishing global services. The claim-based collection strategy reduces the burden on practitioners by requiring reporting only on high-volume/high-cost procedures, using an existing procedure code (**99024**, Postoperative follow-up visit, normally included in the surgical package), allowing some provider groups to report voluntarily while mandating larger practices in designated states to comply with reporting. Practitioners are encouraged to begin reporting post-operative visits for procedures furnished on or after Jan. 1, 2017, but the requirement to report will be effective for services related to global procedures furnished on or after July 1, 2017.

In mid-2017 CMS will also be surveying a large national sample of about 5,000 practitioners. Individuals in this group will be asked to describe 20 postoperative visits furnished to Medicare patients or other patients during the reporting period. Information to be collected includes:

- Procedure codes and dates of service for the global procedure
- Procedure place of service
- Procedural complications
- The level of the visit using existing codes
- Specific activities on the day of the visit
- Total time
- Practice expense items
- Other prior or anticipated care.

CMS will also send monitors to a small number of sites for direct observation, as well as survey Accountable Care Organizations (both Pioneer and Next Generation) about their global services.

CMS has statutory authority to withhold up to 5 percent of the practitioner's Medicare payment for noncompliance with required reporting. The agency does not plan to use this authority in 2017, but will consider using it in future years if claims-based reporting is not acceptable. At this time, the list of procedures that must be reported is not available; CMS will determine the codes for which reporting is required and display the list on the CMS website. Last, if the aggregated data result in proposals to revalue any global packages, that revaluation will be done through notice and comment rulemaking at a future time.

Potentially Misvalued Codes

The Protecting Access to Medicare Act of 2014 (PAMA) establishes an annual target for reductions in MPFS expenditures resulting from adjustments to RVUs of misvalued codes. If the estimated net reduction in expenditures for a year is equal or greater than the target for the year, reduced expenditures attributable to such adjustments shall be redistributed in a budget-neutral manner through an adjustment to the conversion factor. This policy applies to calendar years 2017 through 2020, with a target amount of 0.5 percent of the estimated expenditures under the MPFS for each of those four years.

CMS estimates the 2017 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.32 percent. Since this amount does not meet the 0.5 percent target established by the Achieving a Better Life Experience (ABLE) Act of 2014, payments under the MPFS must be reduced by the difference between the target for the year and the estimated net reduction in expenditures, known as the target recapture amount. This results in an estimated 0.18 percent decrease in the 2017 conversion factor.

Services Billed With Modifier 25

CMS states that several high volume procedure codes are typically reported with **modifier 25** (Significant, separately identifiable evaluation and management service on the same day of the procedure or other service), which unbundles payment for visits from the procedure; CMS believes that these services may be misvalued. As a result, CMS has identified 19 services that it intends to review as potentially misvalued and indicates that it will investigate this policy further in future rulemaking. None of the surgical procedures identified would be routinely performed by medical oncologists, hematologists, or radiation oncologists.

Valuation of Moderate Sedation Services

In prior rulemaking, CMS noted that practice patterns for certain procedures appear to be changing, with anesthesia increasingly being separately reported for these procedures even though payment for sedation services was included in the payment to the physician furnishing the primary procedure. In response, the American Medical Association (AMA) CPT Editorial Panel created new codes for reporting moderate sedation and the Specialty Society Relative Value Update Committee provided CMS with recom-

mended values for the moderate sedation codes and recommended adjustments to valuation of the procedure codes.

As part of this final rule, CMS is finalizing values for the new moderate sedation codes and adopting a uniform methodology for valuation of the procedural codes that currently include moderate sedation as an inherent part of the procedure. Table 9, right, shows a list of codes related to oncology services that will be impacted.

Phase-In of Significant RVU Reductions

PAMA specified that if the total RVUs for a service would otherwise be decreased by an estimated amount equal to or greater than 20 percent, the adjustments must be phased-in over a two-year period. This requirement applies only to services described by existing codes and not to services described by new or revised codes.

In the 2017 MPFS final rule, CMS finalized the proposal to reconsider in each year whether the total RVUs for the service would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year. Under this policy the 19 percent reduction in total RVUs would continue to be the maximum one-year reduction for all codes (except those considered new or revised), including those codes with phase-in values in the previous year. CMS identified three radiation oncology codes with significant RVU reductions in 2017:

- **77332**: Treatment devices, design and construction; simple
- **77334**: Treatment devices, design and construction; complex
- **77470**: Special treatment procedure.

CMS identified procedure code **77470** through the high expenditures by specialty screen, and proposed the RUC-recommended work RVU of 2.03. However, according to CMS the description of service and vignette describe different and unrelated treatments being performed by the physician and clinical staff for a typical patient, and this presents a disparity between the work RVUs and practice expense (PE) RVUs. CMS solicited comments on information that would clarify this apparent disparity to help determine appropriate PE inputs. In addition, the agency solicited comments to determine if creating two HCPCS G-codes, one that describes the work portion of this service and one that describes the practice expense portion, may be a potentially more accurate method of valuing and paying for the service or services described by this code. CMS states:

According to the description of work provided for this service, the physician performs cognitive work, such as planning, consideration of test results, and therapeutic treatment contingency planning that is in addition to what he or she would typically be performing for most radiation treatments. Meanwhile, the radiation therapist handles the treatment devices, performs tasks such as positioning the patient, and helps facilitate the scan of the patient. We believe that this may describe activities that are fundamentally disconnected. To illustrate our concern, we offer the example that this is akin to a physician removing a mole from a patient's hand while the clinical staff places a cast on the patient's foot; we see no compelling clinical evidence to indicate that the two tasks are related. In addition, the disparate diagnoses described by the vignettes further calls into question the degree to which the work and PE components are interrelated. While we agree that there should not be separate coding for each possible diagnosis for a particular service, in trying to accurately assess relative value, we believe that the work and PE components should be valued under unified assumptions about the typical service. We are finalizing the RUC-recommended work RVU and PE inputs as proposed; however, we continue to have serious concerns about the validity of this coding.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

PAMA requires CMS to establish a program to promote utilization of appropriate use criteria (AUC) for advanced diagnostic imaging services. Advanced diagnostic imaging services include diagnostic imaging exams performed using CT, MR, and nuclear medicine, including PET. AUC help professionals who order and furnish imaging services to make the most appropriate treatment decision for a specific clinical condition for an individual patient. CMS can only approve AUC that are developed or endorsed by provider-led entities, such as national professional medical specialty societies. In most cases the AUC will be evidence-based and CMS can approve more than one set of AUC for a given imaging service.

The 2017 MPFS final rule lists the first eight priority clinical areas for the AUC:

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

Ordering professionals will be required to consult AUC for *all* advanced imaging services, not just those in priority clinical areas, as long as the service is furnished in an applicable setting such as office or outpatient hospital and paid under an applicable payment system like the MPFS or OPPS. However, the priority clinical areas will be used to identify outlier ordering professionals in the future.

Medicare will initially pay for the imaging study regardless of whether it was recommended by the AUC. Eventually, however,

(*continued on page 34*)

Table 9. Codes for Oncology Services Impacted by Sedation Codes

CODE	DESCRIPTION
19298	Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time or subsequent to) partial mastectomy, includes imaging guidance
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple
32553	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intrathoracic, single or multiple
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (e.g., anesthetic, neurolytic agent) or fiducial marker(s) (including endoscopic ultrasound examination of the esophagus, stomach and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
49411	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple
49418	Insertion of tunneled intraperitoneal catheter (e.g., dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session, multi-source Cobalt 60 based
77600	Hyperthermia, externally generated; superficial (i.e., heating to a depth of 4 cm or less)
77605	Hyperthermia, externally generated; deep (i.e., heating to depths greater than 4 cm)
77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators
77615	Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators
0301T	Destruction of malignant breast tumor with externally applied focused microwave, including interstitial placement of disposable catheter with combined temperature monitoring probe and microwave focusing sensocatheter and ultrasound thermotherapy guidance

(*continued from page 32*)
CMS will identify those ordering professionals who are consistently failing to follow AUC recommendations, and these "outliers" will be required to obtain prior authorization for advanced imaging studies they wish to order. CMS will address outlier calculations, which may be used to determine whether clinicians will be subject to prior authorization.

The MPFS final rule also addressed clinical decision support mechanism (CDSM) requirements, stating that CDSMs are "electronic tools through which a clinician consults AUC to determine the level of clinical appropriateness for an advanced diagnostic imaging service for that particular patient's clinical scenario." CMS finalized the CDSM application to allow for preliminary qualification or full qualification based on whether the applicant can demonstrate that all requirements are met at the time of application. The application deadline for the first round of preliminary and full qualifying CDSMs is March 1, 2017.

The first list of qualified CDSMs will be posted no later than June 30, 2017, and CMS expects furnishing professionals to be required to begin reporting on Jan. 1, 2018. In addition, CMS is considering the mechanisms for appending AUC consultation information to the Medicare claim and will issue that information as part of the 2018 rulemaking. Among the mechanisms CMS is considering are the use of HCPCS G codes and HCPCS modifiers. Current exceptions to the use of AUC include:

- Patients with emergency medical conditions (including situations where such a condition is suspected but not yet confirmed)
- Inpatients (the Inpatient Prospective Payment System is not an applicable payment system)
- The ordering professional has a hardship exception, such as practicing in a rural area without sufficient Internet access.

CMS recognizes that the number of clinicians impacted by the scope of this program is massive as it will apply to every physician or other practitioner who orders or furnishes applicable imaging services. This crosses almost every medical specialty and could have a particular impact on primary care physicians since their scope of practice can be quite broad.

Other Issues

In addition to the major provisions listed above, the 2017 MPFS final rule addresses the Medicare Shared Savings Program (MSSP), Medicare Advantage provider enrollment, expansion of the Diabetes Prevention Program Model, the value-based payment modifier and physician feedback program, and recoupment or offset payments to providers sharing the same taxpayer identification number. OI

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