Detailed Summary of the Proposed Rule for the Hospital Outpatient Prospective Payment System

The Centers for Medicare and Medicaid Services (CMS) released its proposed rule for calendar year (CY) 2017 changes to the Hospital Outpatient Prospective Payment System (HOPPS) on July 6, 2016. This proposed rule has a 60-day comment period closing on September 6, 2016. These changes, if finalized, would be effective January 1, 2016. Following is a detailed summary of the proposed rule.

HOPPS Conversion Factor

CMS is proposing a 1.55% increase to the OPPS conversion factor bringing it up to $74.909. Additionally, CMS is proposing to implement a reduced conversion factor of $73.411 (-1.498%) for hospitals failing to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements.

Proposed Comprehensive APCs (C-APCs) for CY 2017

In keeping with their long-term goal of creating a HOPPS version of an episode-of-care CMS is proposing to formally define a comprehensive ambulatory payment category (C–APC) as "a classification for the provision of a primary service or specific combination of services and all adjunctive services and supplies provided to support the delivery of the primary or specific combination of services."

Similar to previous year's expansion of the C-APC methodology, for (CY) 2017 CMS is implementing 25 new C-APCs, bringing the total number of C-APC's to 62 as of January 1, 2017. Many of the new C-APCs are major surgery APCs within the various existing C-APC clinical families. CMS is also proposing three new clinical families to accommodate new C-APCs including nerve procedures, excision, biopsy, incision and drainage procedures, as well as airway endoscopy procedures.

See the table below for a list of C-APC's which include codes pertaining to radiology:

APC	Group Title	Relative Weight	Payment Rate
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	16.5036	$1,236.27
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	33.3838	$2,500.75
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	58.6710	$4,394.99
5153	Level 3 Airway Endoscopy	16.8791	$1,264.40
5154	Level 4 Airway Endoscopy	32.0832	$2,403.32
5155	Level 5 Airway Endoscopy	57.7347	$4,324.85
5302	Level 2 Upper GI Procedures	17.6151	$1,319.53
5303	Level 3 Upper GI Procedures	33.1825	$2,485.67
5341	Abdominal/Peritoneal/Biliary and Related Procedures	38.0609	$2,851.10
5373	Level 3 Urology and Related Services	21.9147	$1,641.61
5414	Level 4 Gynecologic Procedures	27.6899	$2,074.22
5431	Level 1 Nerve Procedures	20.7851	$1,556.99

APC Restructure for Diagnostic Imaging

In this propose rule, CMS continues to more aggressively package services in order for this payment system to be more prospective by restructuring their ambulatory payment classifications (APCs) to reduce the number of existing APCs which include more codes within specific ranges of costs. In this proposed rule, CMS is proposing to consolidate the CY 2016 17 Imaging APCs to 8 for CY 2017. In anticipation of CMS' goals, the ACR recommended such a restructure which is intended to keep radiology together within the diagnostic imaging family but to re-categorize the imaging APCs to be more clinically similar with respect to resource use. However, the placement of services into the 8 new categories (ACR requested 9) produces a mixture of what ACR suggested and a different mix of how CMS proposes to present the diagnostic imaging codes. CMS removed interventional radiology imaging studies and placed them in the vascular family as ACR had recommended because it is a better clinical fit. CMS also decided to exclude the nuclear medicine codes from this restructure and maintains them in their own separate APCs. Below is Table 11 and 12 from the proposed rule which shows the current diagnostic imaging APCs which are categorized by modality and then the new proposed APCs sorted primarily by resource use. The ACR feels that, in concept, sorting diagnostic imaging studies by resource use, regardless of modality, will help to keep radiology studies together in their own clinical family and further stabilize their payments.

CY 2016 APC	CY 2016 APC Group Title
5521	Level 1 X-Ray and Related Services
5522	Level 2 X-Ray and Related Services
5523	Level 3 X-Ray and Related Services
5524	Level 4 X-Ray and Related Services
5525	Level 5 X-Ray and Related Services
5526	Level 6 X-Ray and Related Services
5531	Level 1 Ultrasound and Related Services
5532	Level 2 Ultrasound and Related Services
5533	Level 3 Ultrasound and Related Services
5534	Level 4 Ultrasound and Related Services
5561	Level 1 Echocardiogram with Contrast
5562	Level 1 Echocardiogram with Contrast
5570	Computed Tomography without Contrast
5571	Level 1 Computed Tomography with Contrast and Computed Tomography Angiography
5572	Level 2 Computed Tomography with Contrast and Computed Tomography Angiography
5581	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast
5582	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast

Proposed CY 2017 APC	Proposed CY 2017 APC Group Title
5521	Level 1 Diagnostic Radiology without Contrast
5522	Level 2 Diagnostic Radiology without Contrast
5523	Level 3 Diagnostic Radiology without Contrast
5524	Level 4 Diagnostic Radiology without Contrast
5525	Level 5 Diagnostic Radiology without Contrast
5571	Level 1 Diagnostic Radiology with Contrast
5572	Level 2 Diagnostic Radiology with Contrast
5573	Level 3 Diagnostic Radiology with Contrast

Proposal to Change the Beginning Eligibility Date for Device Pass-Through Payment Status

CMS is proposing to allow for quarterly expiration of pass-through status for devices, drugs, biologicals and radiopharmaceuticals to insure better data for placement of these new products into their final APC placement once the pass-through period has expired. For new devices, biologicals and drugs payment may be made under the OPPS temporarily via the use of transitional pass-through payments for at least two but no more than three years. The pass-through period for new drugs and devices begins in the quarter that the application is approved by CMS. Therefore drugs and devices with pass-through status beginning in the first quarter of the year would receive the full three years of eligibility in the regulatory cycle; those that went into effect in the third quarter would be priced on two and a half years-worth of data. With the new proposal, allowing the pass-through period to expire quarterly would allow for a period of time closer to the statutory limit of 3 years for each item on pass-through status. In addition, CMS is proposing to calculate the cost of device-intensive procedure payments at the HCPCS code level instead of at the APC level in order to ensure that device-intensive status is properly assigned to all device-intensive procedures. CMS estimates pass-through totals to equal approximately 0.24% of the total OPPS spending.

Payment of Devices, Drugs, Biologicals and Radiopharmaceuticals

CMS is proposing to continue to pay for devices, drugs, biologicals and radiopharmaceuticals that do not have pass-through status and are paid separately at the statutory default of average sales price (ASP) plus 6 percent.

Packaging Threshold

CMS is proposing to raise the packaging threshold for therapeutic radiopharmaceuticals to $110. This means that CMS would package drugs with a per-day cost less than or equal to $110 and identify those with a per-day cost greater than $110 and pay separately. All non-pass-through, separately payable therapeutic radiopharmaceuticals would be paid at ASP plus 6 percent.

Proposed Changes to Packaged Items and Services

CMS packages many radiology items and services into surgical primary services. For example, all interventional radiology radiologic supervision and interpretation codes (75600-75989) are considered packaged into their corresponding surgical code(s) where costs are captured off of a claim from multiple codes billed and one consolidated payment is made. However, CMS recognizes that there are times when a radiology S&I code may be billed separately and allows for their separate payment under those conditions. The status indicators CMS use to identify these codes with multiple payment conditions are Q1 and Q2. CMS is proposing to change its packaging logic for status indicators Q1 and Q2 to make the decision to package or pay separately at the claim level rather than based on the date of service. CMS states in the proposed rule that this new packaging logic will result in a greater volume of conditionally packaged costs (and thus data) of items and services. The ACR is unsure at this point of the ramifications of this

proposal and will be further evaluating whether it supports this proposal or has specific comments.

Proposed Treatment of New and Revised CY 2016 Category I and III CPT Codes That Will Be Effective Jan. 1, 2016

In this proposed rule, CMS is proposing the APC assignment of a number of new and revised Category I and III CPT Codes. The codes specific to radiology can be found in the table below.

CY 2017 OPPS/ASC Proposed Rule 5-Digit Placeholder Code	Long Descriptor	CMS Proposed APC	SI	Bundled
364X1	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	5241	S	Yes
364X2	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	N/A	N	Yes
369X1	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report	5181	T	Yes
369X2	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	5192	J1	Yes
369X3	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s) peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	5193	J1	Yes

CY 2017 OPPS/ASC Proposed Rule 5-Digit Placeholder Code	Long Descriptor	CMS Proposed APC	SI	Bundled
369X4	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)	5192	J1	Yes
369X5	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	5193	J1	Yes
369X6	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of an intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	5194	J1	Yes
369X7	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	N/A	N	Yes
369X8	Transcatheter placement of an intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	N/A	N	Yes

CY 2017 OPPS/ASC Proposed Rule 5-Digit Placeholder Code	Long Descriptor	CMS Proposed APC	SI	Bundled
369X9	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	N/A	N	Yes
372X1	Transluminal balloon angioplasty (except lower extremity artery(s) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	5192	J1	Yes
372X2	Transluminal balloon angioplasty (except lower extremity artery(s) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within	N/A	N	Yes
372X3	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein	5192	J1	Yes
372X4	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)	N/A	N	Yes
623X5	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	5442	T	
623X6	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	5442	T	Yes

CY 2017 OPPS/ASC Proposed Rule 5-Digit Placeholder Code	Long Descriptor	CMS Proposed APC	SI	Bundled
623X7	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	5442	T	
623X8	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	5442	T	Yes
623X9	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	5443	T	
62X10	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	5443	T	Yes
62X11	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	5443	T	
62X12	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	5443	T	Yes
767X1	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	5522	S	

CY 2017 OPPS/ASC Proposed Rule 5-Digit Placeholder Code	Long Descriptor	CMS Proposed APC	SI	Bundled
770X1	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	N/A	A	Yes
770X2	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	N/A	A	Yes
770X3	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	N/A	A	Yes
922X4	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral	5722	S	
991X2	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older	N/A	N	
991X5	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)	N/A	N	
991X3	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient younger than 5 years of age	N/A	N	
991X4	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older	N/A	N	

CY 2017 OPPS/ASC Proposed Rule 5-Digit Placeholder Code	Long Descriptor	CMS Proposed APC	SI	Bundled
991X6	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)	N/A	N	

Proposed Treatment of New and Revised CY 2016 Category I and III CPT Codes That Will Be Effective January 1, 2016

In the 2015 proposed rule, CMS began the process of assigning new and revised Category I and III CPT Codes to APCs with status indicators for comment in the proposed rule cycle which are then considered final in the final rule and effective January 1 of the calendar year immediately to follow. The new and revised Category I and III CPT Codes are found in OPPS Addendum B and assigned the new comment indicator "NP" to indicate that it is a new or substantially revised code for the next calendar year (CY). For CY 2017 CMS is proposing to introduce an additional comment indicator "NC" to identify that the new or revised code has received a final APC assignment and status indicator in the final rule and that no further comments will be accepted. There are some new and revised CPT codes that do not make it into the proposed rule in time for consideration, the APC placement and payment status indicators for these new codes may be discussed in the final rule, are then open for comment in its 60-day comment period and considered interim for the CY immediately to follow. The payment status indicators tell stakeholders whether or not a service represented by a code is payable under the OPPS or any other payment system and to which OPPS policies these codes apply.

Implementation of Section 603 of the Bipartisan Budget Act of 2015 Relating to Payment for Certain Items and Services Furnished by Certain Off-Campus Departments of a Provider

CMS is proposing to make site neutral payments to new off-campus sites which provide items and services to outpatients based on the Medicare Physician Fee Schedule (MPFS) technical component rate and would deny their eligibility for payment under HOPPS. This proposal stems from Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74) which requires that certain items and services furnished by certain off-campus sites shall not be considered covered outpatient department services for purposes of OPPS payment and shall instead be paid "under the applicable payment system" beginning January 1, 2017.

CMS makes several proposals related to which off-campus providers and which items and services are "excepted" from application of payment changes under this provision. CMS' proposed exceptions include:

- All services furnished in an emergency department—emergency and non-emergency
- On-campus locations defined as "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 are located within 250 yards of the main buildings, and any other areas determined on an individual basis by the CMS RO, to be part of the provider's campus"
- Off-campus PBDs located within 250 yards of a remote location of a hospital facility
- CMS considers the option of change of ownership and proposes that the excepted status for the off-campus PBD would be transferred to new ownership only if ownership of the main provider also is transferred and the Medicare provider agreement is accepted by the new owner. If the provider agreement is terminated, all excepted off-campus PBDs would no longer be excepted.

For 2016, hospital outpatient departments are required to use the "PO" claim modifier to identify services furnished in off-campus provider-based departments (PBDs). CMS proposes that hospitals will be required to report any new services that are provided in PBDs of which would then need to be billed differently at the Medicare Physician Fee Schedule (MPFS) rate.

CMS does not have sufficient time before January 1, 2017 to develop a mechanism for off-campus PBDs to bill for non-excepted items and services under a payment system other than the OPPS (*i.e.*, PFS) because it would require significant changes to enrollment forms, claim forms, hospital cost reports, etc. Therefore CMS proposes a temporary solution for one year (CY 2017) where payment will be made to a billing physician or non-physician practitioner (NPP) under the PFS at the non-facility rate. CMS does not believe that under current systems, off-campus PBDs can be paid for its facility services under the PFS, but it is exploring options for CY 2018. Alternatively, if an off-campus PBD wishes to bill Medicare for those services, it could enroll as another provider type (ASC or physician group practice).

CMS estimates that this policy will reduce net OPPS payments by $500 million in CY 2017. It will also increase payments to physicians under the MPFS by $170 million in CY 2017, resulting in a net Medicare Part B impact from the provision of reducing CY 2017 Part B expenditures by $330 million. This also offers lower beneficiary cost-sharing which would be same as in the office setting. Below is a list of the clinical families and APC which would be affected by this policy:

Clinical Families	APCs
Advanced Imaging	5523-25, 5571-73, 5593-4
Blood Product Exchange	5241-44
Cardiac/Pulmonary Rehabilitation	5771, 5791
Clinical Oncology	5691-94
Diagnostic tests	5721-24, 5731-35, 5741-43
Ear, Nose, Throat (ENT)	5161-66
General Surgery	5051-55, 5061, 5071-73, 5091-94, 5361-62
Gastrointestinal (GI)	5301-03, 5311-13, 5331, 5341
Gynecology	5411-16
Minor Imaging	5521-22, 5591-2
Musculoskeletal Surgery	5111-16, 5101-02
Nervous System Procedures	5431-32, 5441-43, 5461-64, 5471
Ophthalmology	5481, 5491-95, 5501-04
Pathology	5671-74
Radiation Oncology	5611-13, 5621-27, 5661
Urology	5371-77
Vascular/Endovascular/Cardiovascular	5181-83, 5191-94, 5211-13, 5221-24, 5231-32
Visits and Related Services	5012, 5021-25, 5031-35, 5041, 5045, 5821-22, 5841

Changes for Payment for Film X-Ray

The Consolidated Appropriations Act mandates that, effective for services furnished during 2017, the payment under the OPPS for imaging services that are X-rays taken using film shall be reduced by 20 percent. This is an incentive for hospitals to stop using outdated X-ray equipment and to make the transition over to digital technology. CMS is proposing the development of a new modifier to be used by hospitals to be appended to film-based X-ray services billed to Medicare for payment. Effective January 1, the use of this proposed modifier would result in a 20 percent payment reduction for the film-based X-ray services. CMS states that they will make proposals on the reduction of imaging services for X-rays taken using computed radiography technology in future rulemaking.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Section 218(b) of the Protecting Access of Medicare Act of 2014 directs the Secretary to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services through clinical decision support mechanisms (CDSMs). This new program is due to be implemented for all outpatient settings including the office, hospital outpatient and ambulatory surgery centers. Ordering practitioners will be required to consult AUC at the time of ordering advanced diagnostic imaging, and imaging suppliers will be required to report information related to such consultations on claims for all applicable advanced diagnostic imaging services paid under the MPFS, the OPPS, and the ASC payment systems. The 2016 MPFS final rule took the first step in specifying applicable AUC and establishing CMS authority to identify clinical priority areas for making outlier determinations.

The CY 2017 MPFS proposed rule includes proposed requirements and processes for the second component of the Medicare AUC program, which is the specification of qualified clinical decision support mechanisms (CDSMs), the electronic tool through which the ordering practitioners consult AUC. It also proposes specific clinical priority areas and exceptions to the AUC consultation and reporting requirements. CMS refers readers to the CY 2017 MPFS proposed rule for further information.

The ACR staff and HOPPS Committee are currently reviewing the provisions in this proposed rule and will prepare comments to CMS by close of the comment period on September 6, 2016.