Medicare Physician Fee Schedule Proposed Rule for Calendar Year 2018
Detailed Summary of the Payment Provisions

The American College of Radiology (ACR) has prepared this detailed analysis of proposed changes to the payment provisions of the Medicare Physician Fee Schedule (PFS) in calendar year (CY) 2018. The proposed rule has a 60-day comment period closing on Sept. 11, 2017. The ACR will provide detailed comments. If finalized, the rule changes will be effective Jan. 1, 2018.

Conversion Factor (Page 719)

CMS estimates a CY 2018 conversion factor of $35.9903, which reflects the 0.5 percent update specified by the Medicare Access and CHIP Reauthorization Act (MACRA) a budget neutrality adjustment and a target recapture amount mandated by the Protecting Access to Medicare Act of 2014 (PAMA). Overall, this is a slight increase from the current conversion factor of $35.8887.

TABLE 38: Calculation of the Proposed CY 2018 PFS Conversion Factor

Conversion Factor in effect in CY 2017		35.8887
Update Factor	0.50 percent (1.0050)	
CY 2018 RVU Budget Neutrality Adjustment	-0.03 percent (0.9997)	
CY 2018 Target Recapture Amount	-0.19 percent (0.9981)	
CY 2018 Conversion Factor		35.9903

CMS estimates the CY 2018 net reduction in expenditures resulting from proposed adjustments to relative values of misvalued codes to be 0.31 percent. Since, if finalized, this amount would not meet the 0.5 percent target established by the Achieving a Better Life Experience Act of 2014 (ABLE), payments under the fee schedule 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. The estimated target recapture amount for 2018 will result in a 0.19% reduction to the conversion factor.

The Act requires that increases or decreases in relative value units (RVUs) may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS must make adjustments to preserve budget neutrality.

CMS estimates an overall impact of the physician fee schedule (PFS) proposed changes to radiology to be a 1 percent decrease, while interventional radiology would see an aggregate decrease of 1 percent and nuclear medicine a 0 percent change if the provisions within the proposed rule are finalized. Radiation oncology and radiation therapy centers are looking at an overall impact of a 1 percent increase. Diagnostic testing facilities are facing an overall impact of a negative 6 percent due to practice expense (PE) RVU changes.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services (Page 418)

Background and Overview

PAMA included a provision for the mandatory use of appropriate use criteria (AUC) for advanced diagnostic imaging services. Through the CY 2016 rulemaking process, CMS addressed the initial component of the AUC program, specifying applicable AUC. CMS established a process for the development of AUC, defined provider-led entities (PLEs), and established the process by which PLEs may become qualified to develop AUC. The first list of qualified PLEs was posted on the CMS website in late June 2016.

The CY 2017 PFS final rule identified the requirements clinical decision support mechanisms (CDSMs) must meet for qualification, including an opportunity for preliminary qualification for mechanisms still working toward full adherence. It also established a process by which CDSMs may become qualified. The first list of qualified CDSMs was posted to the CMS website in conjunction with this proposed rule.

In addition, CMS defined applicable payment systems under this program (PFS, Hospital Outpatient Prospective Payment System (HOPPS), and Ambulatory Surgical Center (ASC) payment system). It specified the first list of priority clinical areas for the identification of outlier ordering professionals and identified exceptions to the requirements that ordering professionals consult specified applicable AUC when ordering applicable imaging services.

This rule includes proposals for the start date of the Medicare AUC program, modification of policies related to significant hardship exceptions and details regarding how AUC consultation information must be included on the Medicare claim.

Program Implementation Date

CMS is proposing that ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2019. The Agency states that this proposed effective date is necessary to allow time for ordering practitioners, not already aligned with a qualified CDSM, to research and evaluate the CDSMs so they may make an informed choice among available options.

CMS believes it is allowing needed time for education and outreach, practitioner and stakeholder preparation, and enhancements making CDSMs more user-friendly and less burdensome. CMS notes that the proposed implementation date substantially lags the statutory requirement of January 1, 2017. The Agency also indicates that unless a statutory exception applies, an AUC consultation must take place for ***every*** order for an applicable imaging service furnished in an applicable setting and under an applicable payment system.

Given the proposed program start date of January 1, 2019, CMS anticipates that implementation of the prior authorization component for outlier ordering professionals would also be delayed

beyond January 1, 2020. The Agency will outline details around outlier calculations and prior authorization in the CY 2019 proposed rule.

Claims Processing

CMS notes that furnishing professionals are required to report the following information on Medicare claims for applicable imaging services:

1. Which qualified CDSM was consulted by the ordering professional;
2. Whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC or whether specified applicable AUC were not applicable to the service ordered;
3. The National Provider Identifier (NPI) of the ordering professional (if different from the furnishing professional).

This information is required for both the technical and professional component claims for applicable advanced diagnostic imaging services in all three applicable payment systems (PFS, HOPPS and ASC).

The rule acknowledges the possibility that AUC may not be available in a particular qualified CDSM to address every applicable imaging service that might be ordered. As such, the furnishing professional can meet the requirement to report information on the ordering professional's AUC consultation by indicating that AUC are not applicable to the service ordered.
CMS points out that qualified CDSMs must make available, at a minimum, AUC that reasonably address common and important clinical scenarios within all priority clinical areas, which represent about 40 percent of advanced diagnostic imaging services paid for by Medicare in 2014. Additionally, the Agency notes that they expect the "not applicable" situations to be limited in scope and their frequency to decrease over time as qualified PLEs continue to build out their AUC libraries and qualified CDSMs update their content and collaborate with more PLEs.

To implement the reporting requirement, CMS proposes to establish a series of HCPCS level 3 codes. These G-codes would describe the specific CDSM that was used by the ordering professional. Ultimately, there would be one G-code for every qualified CDSM with the code description including the name of the CDSM. However, because the claims processing system can only recognize new codes quarterly and new qualified CDSMs are expected to be announced in June of each year, CMS proposes to establish a generic G-code that would be used to report that a qualified CDSM was consulted, but would not identify a specific qualified CDSM. Clinicians would only be permitted to use this code if a more specific named code did not yet exist for that clinician's CDSM. Furnishing professionals would report this code temporarily until a specific G-code describing the newly qualified CDSM by name becomes available. CMS also proposes to establish a G-code to identify circumstances where there was no AUC consultation through a qualified CDSM. The description of this code would indicate that a qualified CDSM was not consulted by the ordering professional.

These G-codes would be a line-item on both practitioner and facility claims. CMS would expect that one AUC consultation G-code would be reported for every advanced diagnostic imaging service on the claim. Each G-code would be expected, on the same claim line, to contain at least one new HCPCS modifier. CMS proposes to develop a series of modifiers to provide necessary information, including:

1. Whether the imaging service would adhere to the applicable AUC;
2. Whether the imaging service would not adhere to the applicable AUC;
3. Whether such criteria were not applicable to the imaging service ordered;
4. Whether the imaging service was ordered for a patient with an emergency medical condition;
5. Whether the ordering professional has a hardship exception.

CMS is seeking comment on any additional HCPCS modifiers that might be needed to separately identify allowable scenarios for which a qualified CDSM was not consulted by the ordering professional.

The proposed AUC consultation and reporting start date of January 1, 2019 allows CMS adequate time to operationalize the claims-based procedures and systems changes needed to accomplish the processing of these Medicare claims. Due to the complex nature of the program, CMS is proposing an "educational and operations testing period" of one year, beginning January 1, 2019. During this period, ordering professionals would consult AUC. Furnishing professionals would report AUC consultation information on the claim, but CMS would continue to pay claims whether or not they correctly include the information.

This educational period allows providers to actively participate in the program while avoiding claims denials during the learning curve. It also gives CMS the opportunity to make any needed claims processing adjustments before payments are impacted.

CMS is seeking comment on whether the program should be delayed beyond the proposed start date of January 1, 2019 and/or whether the educational and operations testing period should be longer than one year.

The Agency expects a voluntary reporting period to begin prior to January 1, 2019, possibly in July 2018, depending on the readiness of the Medicare claims system to accept and process claims that include AUC consultation information. CMS will make announcements through their website and listservs when the voluntary reporting becomes available.

Alignment with Other Medicare Quality Programs

CMS points out that the CY 2018 Quality Payment Program proposed rule included a proposal to give Merit-based Incentive Payment System (MIPS) credit to ordering professionals for consulting AUC using a qualified CDSM as a high-weight improvement activity for the performance period beginning January 1, 2018. The Agency believes this will incentivize early use of qualified CDSMs to consult AUC by motivated eligible clinicians who are looking to improve patient care and better prepare themselves for the AUC program. **CMS is also**

considering how the AUC program could serve to support a quality measure under the MIPS quality performance category, and they seek feedback from the public regarding the feasibility and value of pursuing this idea further.

Significant Hardship Exceptions to Consulting and Reporting Requirements

CMS is proposing to modify the significant hardship exceptions to reflect the sunsetting of the payment adjustments under the Medicare Electronic Health Record (EHR) Incentive Program and to substitute an alignment with the advancing care information performance category of MIPS. The Agency is proposing the following categories for the AUC program significant hardship exceptions:

- Insufficient Internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of Certified Electronic Health Record Technology (CEHRT)
- Lack of face-to-face patient interaction

The Agency proposes to remove the hardship exception for ordering professionals who have been practicing for less than two years. CMS notes that only ordering professionals are allowed to seek a significant hardship exception. This option is not available to furnishing professionals.

CMS proposes to establish a process for identifying ordering professionals in need of a significant hardship exception to the Medicare AUC requirements that is outside of the MIPS re-weighting process. A significant hardship exception for this program would be granted for no longer than 12 months, with the option to establish an exception for a shorter period where warranted by the circumstances. Further information on this process will be provided in future rulemaking. **CMS invites public comment on additional circumstances for which it may be appropriate for an ordering professional to be granted a significant hardship exception under the AUC program.**

Summary

CMS notes that some stakeholders have expressed concern that AUC program requirements may inadvertently encourage physicians to order imaging services that they do not believe are right for their patients. The goal of the evidence-based AUC is to assist clinicians in ordering the most appropriate imaging services for their patients' specific clinical scenarios. **To ensure the program is implemented effectively, CMS is asking for public comment on such potential unintended consequences. The Agency also seeks comments on how it can continue to engage interested participants in developing AUC in a transparent and scientifically robust manner. CMS is particularly interested in how qualified PLEs develop or modify AUC in collaboration with non-PLE entities and what additional challenges such entities might face.**

Mammography Services

In the 2017 rulemaking cycle, CMS discussed potential 50 percent reduction to the technical component (TC) payment for the mammography services. The ACR submitted extensive comments to CMS on this issue. In addition, the ACR met with CMS and reiterated our concerns and recommended that CMS not move forward with the 50 percent reduction and that the current payment rates are maintained. Based on the information presented in the addendum, the proposed payment rates for the mammography services in the proposed MPFS rule are the same as the current payment rate.

Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services (Page 109)

The Consolidated Appropriations Act of 2016 provides for a 7 percent reduction in payments for the TC of imaging service made under the PFS that are X-rays taken using computed radiography technology furnished during Calendar Years 2018-2022 and a 10 percent reduction for such services furnished during CY 2023 and beyond. Computed radiography technology is defined as cassette-based imaging that uses an imaging plate to create the image involved.

To implement this provision, CMS is proposing the development of a new modifier (to be specified in the final rule) to be used on claims for these services beginning on January 1, 2018. The modifier would be required on claims for the technical component of the X-ray service, including when the service is billed globally because the PFS payment adjustment is made to the technical component regardless of whether it is billed globally or billed separately using the –TC modifier. The modifier must be used to report the specific services that are subject to the payment reduction. Its accurate use is subject to audit.

Potentially Misvalued Services (Page 99)

CMS is not proposing any new screens for CY 2018; however, the Agency is seeking comment on the best approach for developing new screens as well as what particular new screens it may consider.

Proposed Valuation of Specific Codes (Page 132)

CMS has indicated a shift in its approach to reviewing RUC recommendations, and it is relying more heavily on RUC-recommended values for CY2018. However, CMS also includes potential alternative methods of valuation for consideration and are seeking comment on both the RUC-recommended values and the alternative values proposed.

Cryoablation of Pulmonary Tumor (CPT codes 32998 and 32X99) (Page 164)

For CY2018, the CPT Editorial Panel has created a new code (32X99) to report cryoablation of pulmonary tumors and revised the descriptor for CPT code 32998 to include imaging for ablation of tumor. Cat III code 0340T will be deleted. CMS is proposing to accept the RUC-recommended values at 9.03 RVUs for both CPT codes 32998 and 32X99.

However, CMS expressed concerns that the new codes, 32998 and 32X99 bundle in imaging, as it analysis of 2014 data indicates that imaging is reported less than 50% of the time with CPT code 32998. Given this, CMS is considering a work RVU of 7.69 for both 32998 and 32X99 based on the sum of the current work RVU for CPT code 32998 and half of the work RVU of 77013, which is the imaging guidance code with which 32998 is most often reported).

Endovascular Repair Procedures (CPT codes 34X01, 34X02, 34X03, 34X04, 34X05, 34X06, 34X07, 34X08, 34X09, 34X10, 34X11, 34X12, 34X13, 34812, 34X15, 34820, 34833, 34834, 34X19, and 34X20) (Page 165)

The CPT Editorial Panel bundled endovascular abdominal aortic aneurysm repair (EVAR) codes with radiologic supervision and interpretation codes to create 16 new codes and revise four existing codes for a total of 20 EVAR codes. Fourteen other codes related to endovascular repair procedures were also deleted through this process.

CMS is proposing to accept the RUC-recommended values at of 23.71 RVUs for CPT code 34X01, 36.00 RVUs for CPT code 34X02, 26.52 RVUs for CPT code 34X03, 45.00 RVUs for CPT code 34X04, 29.58 RVUs for CPT code 34X05, 45.00 RVUs for CPT code 34X06, 22.28 RVUs for CPT code 34X07, 36.50 RVUs for CPT code 34X08, 6.50 RVUs for CPT code 34X09, 15.00 RVUs for CPT code 34X10, 6.00 RVUs for CPT code 34X11, 12.00 RVUs for CPT code 34X12, 2.50 RVUs for CPT code 34X13, 4.13 RVUs for CPT code 34812, 5.25 RVUs for CPT code 34X15, 7.00 RVUs for CPT code 34820, 8.16 RVUs for CPT code 34833, 2.65 RVUs for CPT code 34834, 6.00 RVUs for CPT code 34X19, and 7.19 RVUs for CPT code 34X20.

CMS is not proposing any refinements to the RUC-recommended practice expense inputs.

However, CMS did consider crosswalking some codes based on the survey 25th percentile values in the family due to concerns about rank order anomalies, specifically involving CPT codes 34X02, 34X04, 34X06, and 34X08. CMS is seeking comment on whether the relativity between codes in the family would be improved by refining the RVUs as follows: 32.00 RVUs for CPT code 34X02 (crosswalk to 48000), 40.00 RVUs for CPT code 34X04 (crosswalk to 33534), 49.00 RVUs for CPT code 34X06, and 30.00 RVUs for CPT code 34X08.

For eight of the ZZZ global period codes that describe endovascular access, CMS considered changing them to 0-day global codes and adding back the preservice and immediate post-service times and using the building block methodology to increase the work RVUs accordingly. There is concern that, as add-on procedures, the codes would not be subject to the multiple procedure payment discount.

Selective Catheter Placement (CPT codes 36215, 36216, 36217, and 36218) (Page 169)

CPT code 36215 was identified as potentially misvalued on a screen of Harvard-valued codes with utilization over 30,000, as well as by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT codes 36216, 36217, and 36218. CMS is proposing to

accept the RUC-recommended values at 4.17 RVUs for CPT code 36215, 5.27 RVUs for CPT code 36216, 6.29 RVUs for CPT code 36217, and 1.01 RVUs for CPT code 36218.

CMS has some concerns about the RUC's recommendation to use the survey 75% intraservice work time for CPT code 36217, which may be clinically inappropriate, as the survey 75% time was identical for both 36216 and 36217. CMS considered reducing the intraservice time for 36217 by 10 minutes (to the survey median time) to preserve the incremental, linear consistency between the work RVU and intraservice time within the family.

CMS is also proposing the following refinements to the practice expense recommendations:

- Remove the equipment time for mobile instrument table (EF027) from CPT code 36315, 36216, and 36217, as CMS believes this equipment would be used for moderate sedation, which was removed from these procedures in CY2017.

Treatment of Incompetent Veins (CPT codes 36470, 36471, 364X3, 364X4, 364X5, and 364X6) (Page 170)

The CPT Editorial Panel created four new codes (364X3-364X8) and revised two existing codes (36470 and 36471) for a total of 6 codes pertaining to the treatment of incompetent veins. CMS is proposing to accept the RUC-recommended values at 0.75 RVUs for CPT code 36470, 1.50 RVUs for CPT code 36471, 3.50 RVUs for CPT code 364X3, 1.75 RVUs for CPT code 364X4, 2.35 RVUs for CPT code 364X5, and 3.00 RVUs for CPT code 364X6.

CMS did consider "bundling" 364X3 and 364X4, as it noted that 364X4 was estimated to be billed 50% of the time with 364X3. To accomplish this, CMS considered a value of 4.38 RVUs for 364X3, equal to the recommended 3.50 RVUs plus half the value of 364X4 at 0.88 RVU.

CMS is also proposing the following refinements to the practice expense recommendations:

- Reallocate the 2 minutes from clinical labor activity *"Setup scope"* (CA015) to clinical labor activity "*Prepare room, equipment and supplies"* (CA013) for CPT codes 364X3, 364X5, and 364X6.
- Refine clinical labor activity "*Check dressings, catheters, wounds*" (CA029) activity for CPT codes 36470, 36471, 364X3, 364X5, and 364X6, consistent with the standard times for this clinical labor activity.
- Remove the six individual 4x4 sterile gauze (SG055) supplies and replace them with a 4x4 sterile gauze pack of 10 (SG056) for CPT codes 36470, 36471, 364X3, 364X5, and 364X6.
- Adjust the equipment times for the surgical light (EF014), the power table (EF031), and the portable ultrasound unit (EQ250) for CPT codes 364X3, 364X5, and 364X6 consistent with the standards for non-highly technical equipment

Insertion of Catheter (CPT codes 36555, 36556, 36620, and 93503) (Page 173)

CPT code 36556 was identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. The family was expanded to include CPT codes 36555, 36620, and 93503. CMS is proposing to

accept the RUC-recommended values at 1.93 RVUs for CPT code 36555, 1.75 RVUs for CPT code 36556, 1.00 RVUs for 36220, and 2.00 RVUs for CPT code 93503

CMS is also proposing the following refinements to the practice expense recommendations:

- Remove the clinical labor time activity for *"Monitor pt. following procedure"* and the equipment time for the 3-channel ECG (EQ011) for CPT code 36555, since moderate sedation inputs are not included as part of the procedure.
- Refine the equipment times for the exam table (EF023) and the exam light (EQ168) to reflect changes in the clinical labor time.

Insertion of PICC Catheter (CPT code 36569) (Page 174)

CPT code 36569 was identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. CMS is proposing to accept the RUC-recommended value at 1.70 RVUs for CPT code 36569.

CMS is also proposing the following refinements to the practice expense recommendations:

- Remove the equipment time for the exam table (EF023) since it is part of the radiographic-fluoroscopic room (EL014) included in fluoroscopic guidance code 77001, with which it is typically billed.

Bone Marrow Aspiration (CPT codes 38220, 38221, 382X3, and 2093X) (Page 174)

CPT code 38221 was identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. CPT codes 38220 and 38221 were revised, and two new CPT codes were created to describe bone marrow aspiration. CMS is proposing to accept the RUC-recommended values at 1.20 RVUs for CPT code 38220, 1.28 RVUs for CPT code 38221, 1.44 RVUs for CPT code 382X3, and 1.16 RVUs for CPT code 2093X.

CMS is proposing to change the global period for codes 38220, 38221, and 382X3 from XXX to 000 and have proposed refinements to the physician pre-service times to align with the pre-service times of other recently reviewed 0-day global codes such as CPT code 30903. With the valuation of CPT code 382X3, CMS is proposing to eliminate payment using HCPCS code G0384. To maintain relativity among physician fee schedule services, CMS also considered a crosswalk of CPT code 2093X to CPT code 64494 at 1.00 RVU. CMS is seeking comment on the appropriateness of the alternative values.

CMS is also proposing the following refinements to the practice expense recommendations:

- Refine the clinical labor for "Lab Tech activities" from 12 minutes to 9 minutes for CPT code 38220, from 7.5 minutes to 7 minutes for CPT code 38221, and from 12.5 minutes to 10 minutes for CPT code 382X3. CMS is proposing to remove the individual lines breaking out the lab activities, as they feel that this may inflate the total time assigned.
- Refine the clinical labor for "Provide preservice education/obtain consent" from 12 minutes to 6 minutes.

CT Soft Tissue Neck (CPT codes 70490, 70491, and 70492) (Page 185)

CPT codes 70490 and 70492 were identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. The family was expanded to include CPT code 70491. CMS is proposing to accept the RUC-recommended values at 1.28 RVUs for CPT code 70490, 1.38 RVUs for CPT code 70491, and 1.62 RVUs for CPT code 70492.

CMS also considered crosswalking CPT code 70490 to 72125 at 1.07 RVUs, which is a similar service with identical intraservice and total times. CMS considered 1.17 RVUs for CPT code 70491 and 1.41 for CPT code 70492, and is seeking comment on how these recommendations may affect relativity among other CT services.

Magnetic Resonance Angiography (MRA) Head (CPT codes 70544, 70545, and 70546) (Page 186)

CPT code 70544 was identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. The family was expanded to include CPT codes 70545 and 70546. CMS is proposing to accept the RUC-recommended values at 1.20 RVUs for CPT code 70544, 1.20 RVUs for CPT code 70545, and 1.48 RVUs for CPT code 70546.

CMS is also proposing the following refinements to the practice expense recommendations:

- For service period clinical labor activity: "Provide preservice education/obtain consent": 5 minutes 5 minutes for CPT code 70544, 7 minutes for CPT code 70545, and 7 minutes for CPT code 70546.
- CMS is seeking comment concerning the appropriate minutes for intraservice clinical labor activity "acquire images" and proposes 20 minutes of clinical time to maintain relativity among the codes in the family as well as other MRA and MRI codes.

Magnetic Resonance Angiography (MRA) Neck (CPT codes 70547, 70548, and 70549) (Page 187)

CPT code 70549 was identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT codes 70547 and 70549. CMS is proposing to accept the RUC-recommended values at 1.20 RVUs for CPT code 70547, 1.50 RVUs for CPT code 70548, and 1.80 RVUs for CPT code 70549.

CMS is also proposing the following refinements to the practice expense recommendations:

- For service period clinical labor activity "Provide preservice education/obtain consent": 5 minutes 5 minutes for CPT code 70547, 7 minutes for CPT code 70548, and 7 minutes for CPT code 70549.
- CMS is seeking comment concerning the appropriate minutes for intraservice clinical labor activity "acquire images" and expressed concern that the RUC-recommended 26 minutes for non-contrast MRA is longer than the 20 minutes recommended for MRA with contrast.

CT Chest (CPT Codes 71250, 71260, and 71270) (Page 187)

CPT codes 71260 and 71270 were identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT code 71250. CMS is proposing to accept the RUC-recommended values at 1.16 RVUs for CPT code 71250, 1.24 RVUs for CPT code 71260, and 1.38 RVUs for CPT code 71270.

CMS considered maintaining the 1.02 RVUs for CPT code 71250, indicating concern about lack of evidence supporting the increased time or intensity since its last valuation. It also cited other similar CT services that indicated the RUC-recommended values could be overvalued. If CMS implements 1.02 RVUs for CPT code 71250, it proposes incremental increases that would yield 1.10 RVUs for 71260 and 1.24 RVUs for 71270. CMS is requesting comments on whether the alternative values would improve relativity among other CT services.

MRI of Abdomen and Pelvis (CPT codes 72195, 72196, 72197, 74181, 74182, and 74183) (Page 188)

CPT codes 74182 and 72196 were identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. The family was expanded to include CPT codes 74181, 74183, 72195, and 72197. CMS is proposing to accept the RUC-recommended values at 1.46 RVUs for CPT code 72195, 1.73 RVUs for CPT code 72196, 2.20 RVUs for CPT code 72197, 1.46 RVUs for CPT code 74181, 1.73 RVUs for CPT code 74182, and 2.20 RVUs for CPT code 74183.

CMS is also proposing the following refinements to the practice expense recommendations:

- For clinical labor activity “acquire images” for CPT codes 74181 and 74182, CMS considered 30 minutes which it feels is more consistent with other MR codes. Current recommendations for 74181 and 74182 are 20 minutes and 40 minutes, respectively, which was determined over 15 years ago through a consensus panel, and CMS is seeking comments on the appropriate values.

MRI Lower Extremity (CPT codes 73718, 73719, 73720) (Page 189)

CPT codes 73718 and 73720 were identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT code 73719. CMS is proposing to accept the RUC-recommended values at 1.35 RVUs for CPT code 73718, 1.62 RVUs for CPT code 73719, and 2.15 RVUs for CPT code 73720.

CMS is also proposing the following refinements to the practice expense recommendations to maintain consistency with other MR services:

- For service period clinical labor activity “Provide preservice education/obtain consent”: 5 minutes 5 minutes for CPT code 73718, 7 minutes for CPT code 73719, and 7 minutes for CPT code 73720.
- For service period task “Prepare room, equipment, supplies”: 3 minutes for CPT code 73718, 5 minutes for CPT code 73719, and 5 minutes for CPT code 73720.

Abdominal X-Ray (CPT Codes 74022, 740X1, 740X2, and 740X3) (Page 189)

CPT codes 74000 and 74022 were identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The CPT Editorial Panel then created CPT codes 740X1, 740X2, and 740X3 to replace CPT codes 74000, 74010, and 74020, and retained CPT code 74022. CMS is proposing to accept the RUC-recommended work values for these codes, at 0.18 RVU for CPT code 740X1, 0.23 RVU for CPT code 740X2, 0.27 RVU for CPT code 740X3, and 0.32 for CPT code 74022.

However, CMS is also seeking comment on utilization for each of the new codes, 740X1-740X3. The RUC's utilization crosswalks suggest that 25 percent of services currently reported with CPT code 74010 will be reported with CPT code 740X2, and 75 percent will be reported with CPT code 740X3.Seventy-five percent of services currently reported with CPT code 74020 will be reported with CPT code 740X2, and 25 percent will be reported with CPT code 740X3. Since a rationale was not provided for these assumptions, CMS used an even distribution of services previously reported as CPT codes 74010 and 74020 to CPT codes 740X2 and 740X3. CMS believes the services previously reported with codes 74010 and 74020 will be reported in equal volume between the code representing two views and the code representing three views.

Angiography of Extremities (CPT codes 75710 and 75716) (Page 190)

CPT code 75710 was identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT code 75716. CMS is proposing to accept the RUC-recommended values at 1.75 RVUs for CPT code 75710 and 1.97 RVUs for CPT code 75716.
CMS is also proposing the following refinements to the practice expense recommendations:

- Remove the 2 minutes associated with clinical labor activity *"prepare room, equipment, and supplies."* CPT codes 75710 and 75716, which represent radiological supervision and interpretation, are billed with codes that include activities, such as needle placement and imaging. The "prepare room, equipment, supplies," activity will be accounted for with the codes that are billed with these interpretation codes.
- Refine the minutes associated with *"Technologist QC's images in PACS, checking for all images, reformats, and dose page"* consistent with the standard clinical labor times for tasks associated with the PACS workstation.

Ultrasound of Extremity (CPT codes 76881 and 76882) (Page 191)

The RUC identified CPT codes 76881 and 76882 for review of practice expense (PE) inputs.

CMS is proposing the following refinements to the practice expense recommendations:

- For 76881, remove 1 minute from the clinical labor task *"Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue,"* because this code does not include any equipment time for the PACS workstation proxy or professional PACS workstation.

- Accept the RUC-recommended shift of the general ultrasound room from the PE inputs for CPT code 76881 to the PE inputs for CPT code 76882. CMS is seeking comment on whether a portable ultrasound unit would be a more accurate PE input for both codes, given that the dominant specialty for both services is podiatry based on available 2016 Medicare claims data. They are also proposing that these codes would not be subject to the phase-in of significant RVU reductions given the significance of this shift of resource costs between codes in the same family.

Radiation Therapy Planning (CPT codes 77261, 77262, and 77263) (Page 192)

CPT code77263 was identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT codes 77261 and 77262. CMS is proposing to accept the RUC-recommended values at 1.30 RVUs for CPT code 77261, 2.00 RVUs for CPT code 77262, and 3.14 RVUs for CPT code 77263.

However, CMS is concerned about the RUC-recommended work RVUs given the decreases in service times compared to the current values, specifically for CPT code 77263, which constitutes the majority of the utilization for codes in the family. For CPT code 77263, CMS considered a work RVU of 2.60 based on a crosswalk to CPT code 96111 (Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report), which has an identical intraservice time, and similar total time to the RUC-recommended time values for CPT code 77263. As a possible alternative method of valuation, CMS considered applying a ratio methodology (based on the RUC-recommended RVU and the crosswalked RVU to 96111 of 2.60) to determine the RVUs for 77261 and 77263 at 1.08 RVUs and 1.66 RVUs, respectively. CMS is requesting comment on the appropriateness of this methodology as applied to these codes.

Practice Expense Inputs for Digital Imaging Services (Page 42)

In the CY 2017 PFS final rule, CMS finalized their proposal to add a professional PACS workstation used for interpretation of digital images to a series of CPT codes and to address costs related to the use of film that had previously been incorporated as direct PE inputs for these services.

Following the publication of the CY 2017 PFS final rule, CMS received comments from stakeholders requesting that the professional PACS workstation be included for the below series of vascular ultrasound codes that use the technical PACS workstation.

CPT Code	Short Descriptor
76706	US ABDL AORTA SCREEN AAA
93880	EXTRACRANIAL BILAT STUDY
93882	EXTRACRANIAL UNI/LTD STUDY
93886	INTRACRANIAL COMPLETE STUDY
93888	INTRACRANIAL LIMITED STUDY

93890	TCD VASOREACTIVITY STUDY
93892	TCD EMBOLI DETECT W/O INJ
93893	TCD EMBOLI DETECT W/INJ
93922	UPR/L XTREMITY ART 2 LEVELS
93923	UPR/LXTR ART STDY 3+ LVLS
93924	LWR XTR VASC STDY BILAT
93925	LOWER EXTREMITY STUDY
93926	LOWER EXTREMITY STUDY
93930	UPPER EXTREMITY STUDY
93931	UPPER EXTREMITY STUDY
93965	*NONINVASIVE PHYSIOLOGIC STUDIES OF EXTREMITY VEINS, COMPLETE BILATERAL STUDY
93970	EXTREMITY STUDY
93971	EXTREMITY STUDY
93975	VASCULAR STUDY
93976	VASCULAR STUDY
93978	VASCULAR STUDY
93979	VASCULAR STUDY
93980	PENILE VASCULAR STUDY
93981	PENILE VASCULAR STUDY
93990	DOPPLER FLOW TESTING
G0365	VESSEL MAPPING HEMO ACCESS

* Deleted Code

CMS is seeking comment on whether the use of the professional PACS workstation would be typical in the above list of CPT codes. The Agency will consider information submitted in comments to determine whether the professional PACS workstation should be included as a direct PE input for these codes.

<u>Preservice Clinical Labor for 0-Day and 10-Day Global Services</u> (Page 45)

Several years ago, the RUC's PE Subcommittee reviewed the preservice clinical labor times for CPT codes with 0-day and 10-day global period and concluded that these codes are assumed to have no preservice clinical staff time unless the specialty can provide evidence that the preservice time is appropriate. CMS notes that for CY 2018, 41 of the 53 reviewed codes with 0-day or 10-day global periods include preservice clinical labor of some kind. **Because 77 percent of the reviewed codes for the current calendar year deviate from the "standard", CMS is seeking comment on the value and appropriate application of the standard in their review of RUC recommendations in future rulemaking. CMS would specifically like comment on whether the standard preservice clinical labor time of 0 minutes should be consistently applied for 0-day and 10-day global codes in future rulemaking.**

<u>Obtain Vital Signs Clinical Labor</u> (Page 46)

CMS has traditionally assigned a clinical labor time of 3 minutes for the "Obtain vital signs" clinical labor activity, based on the amount of time typically required to check a patient's vitals. Over time, that number of minutes has increased as codes are reviewed. Many of the reviewed codes for the current CY 2018 rulemaking cycle have a recommended clinical labor time of 5 minutes for "Obtain vital signs" because of the measuring of two additional vital signs: the patient's height and weight.

To preserve relativity among the PFS codes, CMS is proposing to assign 5 minutes of clinical labor time for all codes that include the "Obtain vital signs" task, regardless of the date of last review. CMS is also proposing to update the equipment times of the codes with this clinical labor task accordingly to match the changes in clinical labor time. The proposed list of all codes affected by these proposed vital signs changes to direct PE inputs is available on the CMS website.

Establishment of Clinical Labor Activity Codes (Page 47)

Variations in the format of the "PE worksheet" historically used to detail the recommended direct PE inputs for use in developing PE RVUs have made it difficult for both the RUC's development and CMS' review of code values for individual codes. CMS understands that beginning with the CY 2019 PFS rulemaking cycle, the RUC intends to mandate the use of a new PE worksheet for purposes of their recommendation development process to standardize the clinical labor tasks and assign them a clinical labor activity code. The Agency believes the use of the new spreadsheet will help it simplify and standardize hundreds of different clinical labor tasks currently listed in the direct PE database.

To help facilitate this transition to the new clinical labor activity codes, CMS has developed a crosswalk to link the old clinical labor tasks with the new clinical labor activity codes. The crosswalk is informational only and will not change either the direct PE input values or the PE RVUs for codes.

For CY 2018 rulemaking, CMS is displaying two versions of the Labor Task Detail public use file. One version is the old listing of clinical labor tasks. The other covers the same tasks as described by the new listing of clinical labor activity codes. These lists are available on the CMS website under downloads for the CY 2018 PFS proposed rule.

Equipment Recommendations for Scope Systems (Page 48)

CMS has found unexplained inconsistencies with the use of scopes and the video systems associated with them during its routine reviews of direct PE input recommendations. Some of the scopes include video systems bundled into the equipment item. Some include scope accessories as part of their price, and some are standalone scopes with no other equipment included. The variations do not appear to be consistent with the different code descriptions.

In the CY 2017 PFS proposed rule, CMS proposed a structure that separates the scope and the associated video system as distinct equipment items for each code. The Agency proposed to define the scope video system as including a monitor, a processor, a form of digital capture, a

cart and a printer, which they believe represents the typical case for a scope video system. CMS proposed to separately price any scope accessories and individually evaluate their inclusion or exclusion as direct PE inputs for particular codes under the current policy, based on whether they are typically used in furnishing the services described by the particular codes.

CMS also proposed standardizing refinements to the way scopes have been defined in the direct PE input database and classified the existing scopes in the direct PE database under a new classification system. The Agency indicated in last year's rule that proposed input prices for these equipment items would be included in future rulemaking.

In this proposed rule, CMS is making further proposals to continue to clarify scope equipment inputs. Itis seeking comments regarding the new set of proposals.

The Agency is considering creating a single scope equipment code for each of the five categories detailed in the proposed rule: (1) a rigid scope; (2) a semi-rigid scope; (3) a non-video flexible scope; (4) a non-channeled flexible video scope; and (5) a channeled flexible video scope. Under the current classification system, there are many different scopes in each category depending on the medical specialty furnishing the service and the affected part of the body. CMS believes the variation between these scopes is not significant enough to warrant maintaining these distinctions, and it believes creating and pricing a single scope equipment code for each category would help provide additional clarity**. CMS is seeking public comment on the merits of this potential scope organization, as well as any pricing information regarding these five new scope categories.**

For CY 2018, CMS is proposing two minor changes to PE inputs related to scopes. They are proposing to add an LED light source into the cost of the scope video system (ES031), which would remove the need for a separate light source in these procedures. If this proposal were to be finalized, the equipment time for the separate light source from CPT codes that include the scope video system would be removed. CMS is also proposing an increase to the price of the scope video system of $1000 to cover the expense of miscellaneous small equipment associated with the system that falls below the threshold of individual equipment pricing as scope accessories (such as cables, microphones, foot pedals, etc.). **The Agency seeks comments on the inclusion of the LED light in the scope video system and the appropriate pricing of the system with the inclusion of these additional equipment items.**

CMS anticipates adopting detailed changes to scope systems at the code level through rulemaking for CY 2019, because additional feedback from expert stakeholders will improve the details of the proposed changes. CMS is not proposing any additional pricing changes to scope equipment for CY 2018 due to the proposed reorganization into a single type of scope equipment for each of the five scope categories. However, the Agency would consider updating prices for these equipment items through the public request process for price updates or based on information submitted as part of RUC recommendations.

<u>Clarivein Kit for Mechanochemical Vein Ablation</u> (Page 52)

In the CY 2017 PFS final rule, CMS finalized work RVUs and direct PE inputs for two new codes related to mechanochemical vein ablation, CPT codes 36473 and 36474. Following the publication of the final rule, stakeholders contacted CMS and requested that a Clarivein kit supply item (SA122) be added to the direct PE inputs for CPT code 36474, the add-on code for ablation of subsequent veins. The Agency stated that the Clarivein kit was accidentally omitted from the RUC recommendations and that an additional kit is necessary to perform the service described by the add-on procedure. **CMS is soliciting comment regarding the use of multiple kits during procedures described by the base and add-on codes to determine whether this supply should be included as a direct PE input for CPT code 36474 for CY 2018.**

Updates to Prices for Existing Direct PE Inputs (Page 56)

CMS is proposing to change the name of the ED050 equipment from "PACS Workstation Proxy" to the "Technologist PACS workstation" to avoid confusion between the technical PACS workstation and the professional PACS workstation.

The Agency notes that to be included in a given year's proposed rule, CMS needs to receive invoices by the February 10th deadline established for code valuation recommendations. CMS would consider any invoices submitted as public comments during the comment period following the publication of the proposed rule and would consider any invoices received after February or outside of the public comment process as part of the established annual process for requests to update supply and equipment prices.

Adjustment to Allocation of Indirect PE for Some Office-Based Services (Page 58)

CMS describes the current process for allocating indirect costs for each code on the basis of the direct costs specifically associated with a code and the greater of either the clinical labor costs or the work RVUs. For PFS services prices in both the facility and non-facility settings, the difference in indirect PE RVUs between settings is driven by differences in direct PE inputs for those settings since the other allocator of indirect PE, the work RVU, does not differ between settings. For most services, the direct PE input costs are higher in the nonfacility setting than in the facility setting. As a result, indirect PE RVUs allocated to these services are higher in the nonfacility setting than in the facility setting. When direct PE inputs for a service are very low, however, the allocation of indirect PE RVUs is almost exclusively based on work RVUs, which results in a very small (or no) site of service differential between the total PE RVUs in the facility and nonfacility setting.

Primary therapy and counseling services are among the services most affected by this anomaly. CMS identified codes that describe face-to-face services, have work RVUs greater than zero and are priced in both facility and nonfacility settings. From among these codes, the Agency identified approximately 50 codes with a ratio between nonfacility PE RVUs and work RVUs of less than 0.4, most of which are primarily furnished by behavioral health professionals, for a potential modification to the indirect PE allocation methodology.

CMS believes it would be appropriate to establish a minimum nonfacility indirect PE RVU that would better reflect the resources involved in furnishing these services. The Agency proposes to set the nonfacility indirect PE RVUs for these codes using the indirect PE RVU to work RVU ratio for the most commonly furnished office-based, face-to-face service as a marker. The CPT code is 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

For each of the identified outlier codes, CMS proposes to compare the ratio between indirect PE RVUs and work RVUs that result from the preliminary application of the standard methodology to the ratio for the marker code, CPT code 99213. The proposed change in the methodology would then increase the allocation of indirect PE RVUs to the outlier codes to at least one quarter of the difference between the two ratios. Recognizing that this change in the PE methodology could have a significant impact on the allocation of indirect PE RVUs across all of the PFS, the Agency proposes to implement only one quarter of this proposed minimum value for nonfacility indirect PE for the outlier codes in 2018. CMS would implement the change over a 4-year transition period, consistent with previous significant changes to PE methodology. The Agency estimates that approximately $40 million or 0.04 percent of the total PFS allowed charges would shift within the PE methodology for each year of the proposed 4-year transition. The PE RVUs in Addendum B of this rule were calculated with the proposed methodology.

Interest Rates (Page 41)

CMS is not proposing any changes to the interest rates used in developing the equipment cost per minute calculations for CY 2018.

Equipment Maintenance (Page 44)

CMS states that it continues to investigate potential options for determining equipment maintenance costs for a broad range of equipment items; however, no proposals were included in the rule.

Determination of Malpractice Relative Value Units (Page 62)

In the CY 2016 PFS final rule, CMS finalized a policy to begin conducting annual malpractice (MP) RVU updates to reflect changes in the mix of practitioners providing services and to adjust MP RVUs for risk, intensity and complexity. CMS also finalized a policy to modify the specialty mix assignment methodology to use an average of the 3 most recent years of data instead of a single year of data.

In this proposed rule, CMS proposes to use the most recent data for the proposed MP RVUs for CY 2018 and to align the update of MP premium data and MP GPCIs to once every 3 years. **CMS is seeking comment on these proposals and are also seeking comment on methodologies and sources that we might use to improve the next update of MP premium data.**

For this year's update, CMS included premium information for all physician and non-physician provider (NPP) specialties, and all risk classifications available in the collected rate filings. Although premium data was collected from all states, the District of Columbia, and Puerto Rico, not all specialties had distinct premium data in the rate filings from all states. Additionally, for some specialties, MP premiums were not available from the rate filings in any state. Therefore, for specialties for which there were not premium data for at least 35 states, and specialties for which there were not distinct premium data in the rate filings, CMS crosswalked the specialty to a similar specialty, either conceptually or by available premium data, for which there was sufficient and reliable data. These specialties and the specialty data that we propose to use are shown in Table 6 on page 67 of the display copy of the proposed rule. Nuclear medicine, radiation oncology and interventional radiology were all crosswalked to diagnostic radiology. **CMS is seeking comment as to the appropriateness of the crosswalks used in developing MP RVUs.**

CMS notes that for determining the risk factor for suppliers of TC-only services in the CY 2015 update, they updated the premium data for independent diagnostic testing facilities (IDTFs) that were used in the CY 2010 update. These data were obtained from a survey conducted by the Radiology Business Management Association (RBMA) in 2009. The Agency ultimately used these data to calculate an updated TC specialty risk factor.

CMS applied the updated TC specialty risk factor to suppliers of TC-only services. In the CY 2015 final rule with comment period, RBMA voluntarily submitted updated MP premium information collected from independent diagnostic testing facilities (IDTFs) in 2014 and requested that CMS use the data for calculating the CY 2015 MP RVUs for TC services. The Agency declined to use the data after concluding further study was necessary. CMS planned to reconsider the matter and propose possible changes through future rulemaking. **CMS believes that data for a broader set of technical component services are needed and seeks comment on appropriate, comparable data sources for such information. The Agency also seeks comment on whether the data for IDTFs are comparable and appropriate as a proxy for the broader set of TC services**.

In the next update of specialty risk factors, CMS will make efforts to collect more data across a broader set of the technical component services, not just for radiology (as is currently reflected in the RBMA data), but also data for services performed by other non-physician practitioners including cytotechnologists, and cardiovascular technologists. In the interim, for CY 2018, CMS proposes to assign a TC risk factor of 1.0, which corresponds to the lowest physician specialty risk factor.

The Agency assigned the risk factor of 1.0 to the TC services because they do not have comparable professional liability premium data for the full range of clinicians that furnish these

services. In lieu of comprehensive, comparable data, CMS used 1.0 as the default minimum risk factor, though the Agency seeks information on the best available data sources for use in the next update, as well as empirical information that would support assignment of an alternative risk factor for these services. Table 8, beginning on page 71 of the display copy of the proposed rule, shows the proposed risk factors by specialty type.

The proposed MP RVUs are shown in Addendum B of this proposed rule.

Medicare Telehealth Services (Page 77)

The conditions for Medicare to make payments for telehealth services under the PFS are as follows:

- The service must be furnished via an interactive telecommunications system.
- The service must be furnished by a physician or other authorized practitioner.
- The service must be furnished to an eligible telehealth individual.
- The individual receiving the service must be located in a telehealth originating site.

The service must be on the list of Medicare telehealth services in additional to meeting the above criteria.

CMS is proposing to add HCPCS code G0296 (Counseling visit to discuss need for lung cancer screening using low dose CT scan). The Agency believes that this service is similar to office visits currently on the telehealth list and that all components of this service can be furnished via interactive telecommunications technology.

Due to Medicare's use of a new Place of Service (POS) Code describing services furnished via telehealth, CMS is proposing to eliminate the required use of the GT modifier on professional claims for these services. Because institutional claims do not use a POS code, the Agency proposes for distant site practitioners billing under Critical Access Hospital (CAH) Method II to continue to use the GT modifier on their claims. CMS proposes to maintain the GQ modifier for the federal telemedicine demonstration programs in Alaska or Hawaii.

CMS is seeking comment on ways that it may further expand access to telehealth services within the current statutory authority and pay appropriately for services that take full advantage of communication technology. The Agency is also seeking comment on whether to make separate payment for CPT codes that describe remote patient monitoring.

Proposed Payment Rates under the PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital (Page 111)

Sections 1833(t)(1)(B)(v) and (t)(21) of the Act require that certain items and services furnished by certain off-campus provider-based departments (PBDs) (collectively referenced in this rule as nonexcepted items and services furnished by nonexcepted off-campus PBDs) shall not be considered covered OPD services for purposes of payment under the OPPS. Payment for these nonexcepted items and services furnished on or after January 1, 2017 shall be made under the

applicable payment system. In the CY 2017 OPPS/ASC final rule with comment period, CMS finalized the PFS as the "applicable payment system" for most nonexcepted items and services furnished by off-campus PBDs.

As part of that discussion and in response to public comments, CMS indicated it would issue an interim final rule with comment period (the CY 2017 interim final rule) to establish payment policies under the PFS for nonexcepted items and services furnished on or after January 1, 2017. In this proposed rule, the Agency proposes the payment policies under the PFS for nonexcepted items and services furnished during CY 2018. The CY 2017 interim final rule can be found online at https://www.gpo.gov/fdsys/pkg/FR-2016-11-14/pdf/2016-26515.pdf. CMS anticipates responding to public comments and finalizing the CY 2017 interim final rule in future PFS rulemaking.

Payment Mechanism

For CY 2017, CMS established a new set of payment rates under the PFS that reflected the relative resource costs of furnishing the technical component of a broad range of services to be paid under the PFS specific to the off-campus PBD of a hospital with packaging (bundling) rules that are unique to the hospital outpatient setting under the OPPS.

In principle, the coding and billing mechanisms required to make appropriate payment to hospitals for nonexcepted items and services furnished by nonexcepted off-campus PBDs are parallel to those used to make payment for the technical component services for a range of supplier types paid under the PFS. CMS is proposing to maintain this mechanism for CY 2018.

Establishment of Payment Rates

In the CY 2017 interim final rule, CMS estimated that for CY 2017 scaling the OPPS payment rates by 50 percent would strike an appropriate balance that avoided potentially underestimating the relative resources involved in furnishing services in nonexcepted off-campus PBDs as compared to the services furnished in other settings for which payment was made under the PFS. Specifically, the Agency established site-specific rates under the PFS for the technical component of the broad range of nonexcepted items and services furnished by nonexcepted off-campus PBDs to be paid under the PFS that was based on the OPPS payment amount for the same items and services, scaled downward by 50 percent. CMS called this adjustment the "PFS Relativity Adjuster." The PFS Relativity Adjuster refers to the percentage of the OPPS payment amount paid under the PFS for a nonexcepted item or service to the non-excepted off-campus PBD under this policy.

CMS was concerned, however, that the 50 percent PFS Relativity Adjuster might overestimate PFS nonfacility payments relative to OPPS payments. For example, if CMS was able at the time to sufficiently estimate the effect of the packaging differences between the OPPS and PFS, the Agency suspected that the equivalent portion of PFS payments for evaluation and management codes, and for PFS services on average, would likely have been less than 50 percent for the same services. CMS considered the 50 percent PFS Relativity Adjuster for CY 2017 to be a

transitional policy until more precise data would be available to better identify and value nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by hospitals.

All nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by a hospital on an institutional claim with modifier "PN" (Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital) are currently paid under the PFS at the rate established in the CY 2017 interim final rule. Specifically, nonexcepted off-campus PBDs must report modifier "PN" on each UB-04 claim line to indicate a nonexcepted item or service, and otherwise continue to bill as they currently do.

In considering the appropriate PFS Relativity Adjuster for CY 2018, CMS continues to believe that claims data from CY 2017, which are not yet available, are needed to guide potential changes to the general approach. In the absence of such data, however, the Agency has continued to consider the appropriate PFS Relativity Adjuster based on the information that is available. In the analysis establishing the PFS Relativity Adjuster for CY 2017, CMS attempted to identify the appropriate value by comparing OPPS and PFS payment rates for services frequently reported in PBDs and described by the same codes under the two payment systems.

Consistent with our previously stated concern that the PFS Relativity Adjuster for CY 2017 might be too small, generally resulting in greater overall payments to hospitals for services furnished by nonexcepted off-campus PBDs than would otherwise be paid under the PFS in the non-facility setting, CMS believes it is appropriate to propose changing the PFS Relativity Adjuster to ensure that payment made to these nonexcepted PBDs better aligns with these services that are the most frequently furnished in this setting.

For CY 2018, CMS proposes to revise the PFS Relativity Adjuster for nonexcepted items and services furnished by nonexcepted off-campus PBDs to be 25 percent of the OPPS payment rate. The Agency arrived at this proposed PFS Relativity Adjuster by making a code-level comparison for the service most commonly billed in the off-campus PBD setting under the OPPS: a clinic visit reported using HCPCS code G0463. To determine the analogous payment for the technical aspects of this service under the PFS in nonfacility settings, CMS compared the CY 2017 OPPS national payment rate for HCPCS code G0463 ($102.12) with the difference between the nonfacility and facility PFS payment amounts under the PFS using CY 2017 rates for the weighted average of outpatient visits (CPT codes 99201-99205 and CPT codes 99211-99215) billed by physicians and other professionals in an outpatient hospital place of service.

CMS continues to recognize that the comparison between the OPPS and PFS rates for other services varies greatly and that there are other factors that contribute to the differences in aggregate payment amounts for a broader range of services. They include the specific mix of services furnished by non-excepted PBDs, policies related to packaging of codes under OPPS and payment adjustments, such as Multiple Procedure Payment Reductions (MPPRs) and bundling under the PFS that rely on empirical information about whether or not codes are billed on the same day.

However, like for CY 2017, for CY 2018, CMS must also set the PFS Relativity Adjuster prior to studying the CY 2017 claims data that might allow consideration and incorporation of many more factors. Until CMS can study claims data, it believes the comparison between PFS and OPPS payment for the most common services furnished in off-campus PBDs is a better proxy than the previous approach. **CMS requests comments on this proposal and also on whether it should adopt a different PFS Relativity Adjuster that represents a middle ground between the CY 2017 PFS Relativity Adjuster and the proposed CY 2018 PFS Relativity Adjuster.**

Coding Consistency

CMS notes that a set of radiation treatment delivery and imaging guidance services are reported using different codes under the PFS and the OPPS. CMS established HCPCS Level II G codes to describe radiation treatment delivery services when furnished in the physician office setting. However, these HCPCS G codes are not recognized under the OPPS; rather, CPT codes are used to describe these services when furnished in the HOPD. Under the PFS, CMS is obligated by statute to require maintenance of the CY 2016 coding and payment inputs for these services for CY 2017 and CY 2018.

Because nonexcepted items and services furnished by a nonexcepted off-campus PBD are paid under the PFS, and CMS is required to maintain the CY 2016 coding and payment inputs for these services under the CY 2018 PFS, the Agency is proposing to maintain payment amounts for nonexcepted items and services furnished by a nonexcepted off-campus PBD consistent with the payments that would be made to other facilities under the PFS. That is, nonexcepted off-campus PBDs submitting claims for these nonexcepted items and services will continue to bill the HCPCS G-codes established under the PFS to describe radiation treatment delivery services. Under this proposal, the nonexcepted off-campus PBD must append modifier PN to each applicable claim line for these nonexcepted items and services, even though the PFS Relativity Adjuster will not apply. The payment amount for these services would be set to reflect the technical component rate for the code under the PFS.

OPPS Payment Adjustments

In the CY 2017 interim final rule, CMS adopted the packaging payment rates and MPPR percentage that applied under the OPPS to establish the PFS payment rates for nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by hospitals. That is, the claims processing logic that was used for payments under the OPPS for comprehensive APCs (C-APCs), conditionally and unconditionally packaged items and services and major procedures that was incorporated into the newly established PFS rates. CMS continues to believe it is necessary to incorporate the OPPS payment policies for C-APCs, packaged items and services, and MPPRs to maintain the integrity of the PFS Relativity Adjuster because the adjuster is intended, in part, to account for the methodological differences between the OPPS and the PFS rates that would otherwise apply. **CMS is soliciting comments on the applicability of particular prospective OPPS adjustments to nonexcepted items and services.**

Supervision Rules

The supervision rules that apply for hospitals continue to apply for nonexcepted off-campus PBDs that furnish nonexcepted items and services.

CY 2019 and Future Years

For CY 2019 and for future years, CMS intends to examine the claims data to determine not only the appropriate PFS Relativity Adjuster(s), but also whether additional adjustments to the methodology are appropriate. The goal here is to attain site neutral payments to promote a level playing field under Medicare between physician office settings and nonexcepted off-campus PBD settings, without regard to the kinds of services furnished by particular off-campus PBDs. **CMS requests comments on potential changes to the methodology that would better account for these specialty-specific patterns.**

MACRA Patient Relationship Categories and Codes (Page 550)

The proposed rule provides background information on the Quality Payment Program (QPP) mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). To facilitate the attribution of patients and episodes to one or more clinicians, MACRA requires the development of patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service.

CMS posted the operational list of patient relationship categories on May 17, 2017 on its website. The list is based on the public comments and consultations with stakeholders and experts on a draft list of patient relationship categories posted in April 2016 and a list of modified patient relationship categories posted in December 2016,

The patient relationship categories on the operational list include the following:

- Continuous/Broad Services
- Continuous/Focused Services
- Episodic/Broad Services
- Episodic/Focused Services
- Only as Ordered by Another Clinician

CMS is required to make annual revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate using the rulemaking process. In preparation for potential revisions by November 1, 2018, the Agency is seeking comment on the operational list of patient relationship categories available on the CMS website.

Reporting of Patient Relationship Codes Using Modifiers

Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, must include the applicable codes established for care episode groups, patient condition groups, and patient relationship categories, as well as the NPI of the ordering physician or applicable practitioner.

CMS worked with the American Medical Association's (AMA) CPT Editorial Panel and submitted an application for the CPT modifiers for reporting of the patient relationship codes. At its June 2017 meeting the CPT Editorial Panel, determined that AMA would not include the modifiers in the CPT code set, pending future finalization of the modifiers by CMS, whereby CMS publishes the modifiers as Level II HCPCS Modifiers. Therefore, the Agency is proposing the Level II HCPCS Modifiers in Table 26 (below) as the patient relationship codes, which would be added to the operational list if adopted in the final rule.

TABLE 26: Proposed Patient Relationship HCPCS Modifiers and Categories

No.	Proposed HCPCS Modifier	Patient Relationship Categories
1x	X1	Continuous/broad services
2x	X2	Continuous/focused services
3x	X3	Episodic/broad services
4x	X4	Episodic/focused services
5x	X5	Only as ordered by another clinician

CMS is proposing that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include the applicable HCPCS modifiers in Table 26, as well as the NPI of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner). To give clinicians time to gain familiarity with the modifiers to report patient relationships, the Agency is proposing to initially permit voluntary reporting of the HCPCS modifiers on Medicare claims. The uses and selection of the modifiers would not be a condition of payment. Claims would be paid regardless of whether and how the modifiers are included. CMS would work with clinicians to educate them about the proper use of the modifiers.

CMS notes that, while it may work with clinicians to explore incorporating these codes into the QPP in future years, the measures proposed and finalized to date, those proposed for 2018, and those currently under development for future rulemaking for the MIPS performance categories do not require patient relationship codes to properly measure clinicians' quality and resource use in the Medicare program.

CMS solicits comment on the proposal for voluntary reporting of the proposed HCPCS modifiers on claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018 and on the proposed list of HCPCS modifiers in Table 26. The Agency seeks comments on their intention to resubmit these patient relationship modifiers to AMA for future consideration into the CPT modifier code set.

<u>Request for Information on CMS Flexibilities and Efficiencies</u> (Page 709)
To reduce burdens for hospitals, physicians and patients, to improve the quality of care, decrease costs, and ensure that patients and their providers are making the best health care choices possible, CMS is including a Request for Information in this proposed rule.

CMS would like to start a national conversation about improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families. The Agency aims to increase quality of care, lower costs, improve program integrity and make the health care system more effective, simple and accessible.

The Agency invites the public to submit their ideas for regulatory, subregulatory, policy, practice, and procedural changes to better accomplish these goals. Ideas to shape comments include:

- Payment system redesign
- Elimination or streamlining of reporting, monitoring, and documentation requirements
- Aligning Medicare requirements and processes with those from Medicaid and other payers
- Operational flexibility
- Feedback mechanisms and data sharing that would enhance patient care
- Support of the physician-patient relationship in care delivery
- Facilitation of individual preferences
- Recommendations regarding when and how CMS issues regulations and policies
- How CMS can simplify rules and policies for beneficiaries, clinicians, physicians, providers and suppliers

CMS notes that data and specific examples would be helpful when possible. The Agency will not respond to comment submission in the final rule, but will actively consider all input as future regulatory proposals are developed. Respondents should not include any information that might be considered proprietary or confidential.