The Centers for Medicare and Medicaid Services (CMS) released the review copy of the 2016 Medicare Physician Fee Schedule (MPFS) final rule on October 30, 2015. The American College of Radiology (ACR) will be submitting comments to CMS addressing issues of concern by the deadline on December 29, 2015. Following are highlights of the payment provisions of the final rule.

Conversion Factor and Impacts (page 1248)

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 established the update factor for calendar years 2015 through 2025. The Protecting Access to Medicare Act (PAMA) legislation established an annual target for reductions in MPFS expenditures resulting from adjustments to RVUs of misvalued codes. The Achieving a Better Life Experience Act of 2014 (ABLE) Act accelerated the application of this target and set a 1 percent target for CY 2016. CMS estimates the CY 2016 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.23 percent. Since this does not meet the 1 percent target established by the ABLE Act, payments under the fee schedule must be reduced by the difference between the target for the year and the estimated net reduction in expenditures. As a result, CMS estimates that the CY 2016 Target Recapture Amount will produce a reduction to the CF of -0.77 percent.

The estimated conversion factor for CY 2016 is $35.8279, which reflects the budget neutrality adjustment, the 0.5 percent update adjustment factor specified under the Medicare Access and CHIP Reauthorization Act (MACRA), and the 0.77 percent target recapture amount required under the Act as described above.

<table>
<thead>
<tr>
<th>TABLE 60: Calculation of the CY 2016 PFS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversion Factor in effect in CY 2015</td>
</tr>
<tr>
<td>Update Factor</td>
</tr>
<tr>
<td>CY 2016 RVU Budget Neutrality Adjustment</td>
</tr>
<tr>
<td>CY 2016 Target Recapture Amount</td>
</tr>
<tr>
<td><strong>CY 2016 Conversion Factor</strong></td>
</tr>
</tbody>
</table>
Below is an excerpt from Table 62 on page 1250: CY 2016 MPFS Estimated Impact on Total Allowed Charges by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charged (mil)</th>
<th>Impact of Work of RVU Changes</th>
<th>Impact of PE RVU Changes</th>
<th>Impact of MP RVU Changes</th>
<th>Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIAGNOSTIC TESTING FACILITY</td>
<td>$725</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>INTERVENTIONAL RADIOLOGY</td>
<td>$298</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>NUCLEAR MEDICINE</td>
<td>$46</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>PORTABLE X-RAY SUPPLIER</td>
<td>$103</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>RADIATION ONCOLOGY</td>
<td>$1,776</td>
<td>0%</td>
<td>-2%</td>
<td>0%</td>
<td>-2%</td>
</tr>
<tr>
<td>RADIATION THERAPY CENTERS</td>
<td>$52</td>
<td>0%</td>
<td>-2%</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>RADIOLOGY</td>
<td>$4,494</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Practice Expense Inputs for Digital Imaging Services (Page 50)**

CMS finalized the proposal to update the price for the PACS workstation to $5,557 from the current price of $2,501 since the latter price was based on the proxy item and the former based on submitted invoices.

In addition to the workstation used by the clinical staff acquiring the images and furnishing the technical component of the services, CMS indicated in the proposed rule that a stakeholder also submitted more detailed information regarding a workstation used by the practitioner interpreting the image in furnishing the professional component of many of these services. CMS stated that they generally believe that workstations used by these practitioners are more accurately considered indirect costs associated with the professional component of the service. However, they understand that the professional workstations for interpretation of digital images are similar in principle to some of the previous film inputs incorporated into the global and technical components of the codes. Given that many of these services are reported globally in the nonfacility setting, CMS believes it may be appropriate to include these costs as direct inputs for the associated HCPCS codes. Based on established methodology, these costs would be incorporated into the PE RVUs of the global and technical component of the HCPCS code.

CMS sought comment in the proposed rule on whether including the professional workstation as a direct PE input for these codes would be appropriate, given that the resulting PE RVUs would be assigned to the global and technical components of the codes. In the final rule, CMS indicated
that many commenters, including the RUC, stated that the proposed price did not capture the appropriate pricing for the PC of the PACS workstation. Several commenters indicated that the professional workstation was a direct PE item due to the fact that it is used for individual studies (one at a time) in the non-facility setting, and its use involves a bi-directional exchange between a technologist and a radiologist while the TC is being provided. These commenters also suggested that the professional PACS workstation was a direct proxy for the film alternators, film processors, and view-boxes previously considered direct PE inputs for many of these services prior to the film to digital conversion. Several commenters suggested that the true cost of the PACS workstation was significantly higher than the proposed $5,557 due to these professional expenses.

CMS responded that they agree that the costs of the professional workstation may be analogous to costs previously incorporated as direct PE inputs for these services. Therefore, CMS is seeking comments and recommendations from stakeholders, including the RUC, regarding which codes would require the professional PACS workstation and for how many minutes the professional equipment workstation would be used relative to the work time or clinical labor tasks associated with individual codes. Any such recommendations will be addressed in future rulemaking.

CMS indicated that a stakeholder expressed concern about the changes in direct PE inputs for Current Procedural Terminology® (CPT) code 76377, (3D radiographic procedure with computerized image post-processing), that were proposed and finalized in CY 2015 rulemaking as part of the film to digital change. Based on a recommendation from the RUC, CMS removed the input called “computer workstation, 3D reconstruction CT-MR” from the direct PE input database and assigned the associated minutes to the proxy for the PACS workstation. CMS sought comment from stakeholders about whether or not the PACS workstation used in imaging codes is the same workstation that is used in the postprocessing described by CPT code 76377, or if more specific workstation should be incorporated in the direct PE input database.

After consideration of comments received, CMS agreed that the “computer workstation, 3D reconstruction CT-MR” equipment (ED014) should be restored to the equipment list and assigned to CPT code 76377 with an equipment time of 38 minutes. However, CMS does not believe that the typical service for CPT code 76377 would also use the PACS workstation. Therefore, CMS substituted ED014 in place of the PACS workstation.

**Appropriate Use Criteria for Advanced Diagnostic Imaging Services (Page 627)**

CMS stated that the goal of this statutory appropriate use criteria (AUC) program is to promote the evidence-based use of advanced diagnostic imaging to improve quality of care and reduce inappropriate imaging. CMS also acknowledged the consensus that AUC programs are preferable to across the board payment reductions that do not differentiate interventions that add value from those that cause harm or add no value.

CMS discussed their experiences and lessons learned from the Medicare Imaging Demonstration (MID) which was a 2-year program that began in October 2011. CMS believes that a successful
program would allow flexibility, and they foresee competing sets of AUC developed by different provider-led entities, and competing CDS mechanisms from which providers may choose.

CMS stated that given the timing of the MPFS rulemaking process, they were not able to include proposals in the MPFS proposed rule to begin implementation in the same year the PAMA was enacted. They state that in the time since the legislation was enacted, they have met extensively with stakeholders to gain insight and hear their comments and concerns about the AUC program.

The Act specifies that the Secretary must publish an initial list of specified CDS mechanisms no later than April 1, 2016, and that the Secretary must identify on an annual basis the list of specified qualified CDS mechanisms. CMS stated that they intend to provide clarifications, develop definitions, and establish the process by which they will specify qualified CDS mechanisms during the rulemaking for CY 2017. They anticipate that the initial list of specified applicable CDS mechanisms will be published sometime after the CY 2017 MPFS final rule. If they were to follow a similar process for CDS as they have for specifying AUC, the initial list of CDS mechanisms would be available in the summer of 2017.

CMS also acknowledges that January 1, 2017, is the statutory deadline for the requirement for an ordering professional to consult with a listed qualified CDS mechanism when ordering an applicable imaging service that would be furnished in an applicable setting and paid for under an applicable payment system; and for the furnishing professional to include on the Medicare claim information about the ordering professional’s consultation with a qualified CDS mechanism. CMS stated that it is important that they first establish through notice and comment rulemaking the process by which applicable AUC will be specified as well as the CDS mechanisms through which ordering providers would access them. They anticipate including further discussion and adopting policies regarding claims-based reporting requirements in the CY 2017 and CY 2018 rulemaking cycles. Therefore, CMS does not intend to require that ordering professionals meet this requirement by January 1, 2017.

Definitions (Page 636)

The Act defines appropriate use criteria as only those criteria developed or endorsed by national professional medical societies or other PLEs, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition for an individual. CMS proposed to add the following language to the definition of AUC: AUC are a collection of individual appropriate use criteria. Individual criteria are information presented in a manner that links: a specific clinical condition or presentation; one or more services; and, an assessment of the appropriateness of the service(s).

A provider-led entity would include national professional medical specialty societies (for example the American College of Radiology and the American Academy of Family Physicians) or an organization that is comprised primarily of providers and is actively engaged in the practice and delivery of healthcare (for example hospitals and health systems). Applicable AUC become specified when they are developed, modified or endorsed by a qualified provider-led entity. A provider-led entity is not considered qualified until CMS makes a determination via
the qualification process finalized in the rule. CMS introduced priority clinical areas to inform ordering professionals and furnishing professionals of the clinical topics, clinical topics and imaging modalities or imaging modalities that may be identified by the agency through annual rulemaking and in consultation with stakeholders which may be used in the identification of outlier ordering professionals.

_AUC Development by Provider-Led Entities_ (Page 638)

CMS recognizes that it is not feasible for them to review every individual criterion. Therefore, they proposed to establish a qualification process and requirements for qualified provider-led entities in order to ensure that the AUC development or endorsement processes used by a provider-led entity result in high quality, evidence-based AUC in accordance with section 1834(q)(2)(B).

The cornerstone of the process by which PLEs become qualified by Medicare to develop AUC is for PLEs to demonstrate that they engage in a rigorous evidence-based process for developing, modifying, or endorsing AUC. It is through this demonstration that CMS proposed to meet the requirements of the Act to take into account certain considerations for specifying AUC.

The first proposed requirement is related to the evidentiary review process for individual criteria. Entities must engage in a systematic literature review of the clinical topic and relevant imaging studies. CMS would expect the literature review to include evidence on analytical validity, clinical validity, and clinical utility of the specific imaging study. In addition, the provider-led entity must assess the evidence using a formal, published, and widely recognized methodology for grading evidence. Consideration of relevant published evidence-based guidelines and consensus statements by professional medical specialty societies must be part of the evidence assessment. Published consensus statements may form part of the evidence base of AUC and would be subject to the evidentiary grading methodology as any other evidence identified as part of a systematic review.

In addition, CMS proposed that the provider-led entity’s AUC development process must be led by at least one multidisciplinary team with autonomous governance that is accountable for developing, modifying, or endorsing AUC. At a minimum, the team must be composed of three members including one with expertise in the clinical topic related to the criterion and one with expertise in imaging studies related to the criterion. CMS encourages such teams to be larger, and include experts in each of the following domains: statistical analysis (such as biostatics, epidemiology, and applied mathematics); clinical trial design; medical informatics; and quality improvement. A given team member may be the team’s expert in more than one domain. These experts should contribute substantial work to the development of the criterion, not simply review the team’s work.

CMS also proposed that the provider-led entity must have a publicly transparent process for identifying and disclosing potential conflicts of interest of members on the multidisciplinary AUC development team. The provider-led entity must disclose any direct or indirect relationships, as well as ownership or investment interests, among the multidisciplinary team
members or immediate family members and organizations that may financially benefit from the AUC that are being considered for development, modification or endorsement.

For individual criteria to be available for practitioners to review prior to incorporation into a CDS mechanism, CMS proposed that the provider-led entity must maintain on its website each criterion that is part of the AUC that the entity has considered or is considering for development, modification, or endorsement. This public transparency of individual criteria is critical not only to ordering and furnishing professionals, but also to patients and other health care providers who may wish to view all available AUC.

CMS recognized that not all aspects of a criterion will be evidence-based, and that a criterion does not exist for every clinical scenario. They believe it is important for AUC users to understand which aspects of a criterion are evidence-based and which are consensus based. Therefore, CMS proposed that key decision points in individual criteria be graded in terms of strength of evidence using a formal, published, and widely recognized methodology. This level of detail must be part of each AUC posted to the entity’s website.

Finally, CMS proposed that a provider-led entity’s process for developing, modifying, or endorsing AUC (which would be inclusive of the requirements being proposed in this rule) must be publicly posted on the entity’s website.

*Process for Provider-Led Entities to Become Qualified to Develop, Endorse, or Modify AUC (Page 641)*

CMS proposed that provider-led entities must apply to CMS to become qualified. They proposed that entities that believe they meet the definition of provider-led submit applications to us that document adherence to each of the qualification requirements. The application must include a statement as to how the entity meets the definition of a provider-led entity. Applications will be accepted each year but must be received by January 1. A list of all applicants that CMS determines to be qualified provider-led entities will be posted on the CMS website by the following June 30 at which time all AUC developed or endorsed by that provider-led entity will be considered to be specified AUC. All qualified provider-led entities must re-apply every 6 years and their applications must be received by January 1 during the 5th year of their approval. CMS noted that the application is not a CMS form; rather it is created by the applicant entity.

*Identifying Priority Clinical Areas (Page 641)*

CMS proposed to identify priority clinical areas of AUC that they will use in identifying outlier ordering professionals. Although there is no consequence to being identified as an outlier ordering professional until January 2020, it is important to allow ordering and furnishing professionals as much time as possible to use and familiarize themselves with the specified applicable AUC that will eventually become the basis for identifying outlier ordering professionals.

To identify these priority clinical areas, CMS may consider incidence and prevalence of diseases, as well as the volume, variability of utilization, and strength of evidence for imaging services.

6
They may also consider applicability of the clinical area to a variety of care settings, and to the Medicare population. CMS proposed to annually solicit public comment and finalize clinical priority areas through the MPFS rulemaking process beginning in CY 2017. To further assist in developing the list of proposed priority clinical areas, CMS also proposed to convene the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC), a CMS FACA compliant committee, as needed to examine the evidence surrounding certain clinical areas. Future rulemaking will address additional details.

Identification of Non-Evidence-Based AUC (Page 642)

In order to address the concern that some of the AUC developed by qualified provider-led entities may not be evidence-based, CMS proposed a process by which they would identify and review potentially non-evidence-based criteria that fall within one of the identified priority clinical areas. CMS proposed to accept public comment through annual MPFS rulemaking so that the public can assist in identifying AUC that potentially are not evidence-based. CMS foresees this being a standing request for comments in all future rules regarding AUC. CMS also proposed to use the MEDCAC to further review the evidentiary basis of these identified AUC, as needed. If a number of criteria from an AUC library are identified as being insufficiently evidence-based, and the provider-led entity that produced the library does not make a good faith effort to attempt to correct these in a timely fashion, this information could be considered when the provider-led entity applies for re-qualification.

Comments and CMS Response (Page 644)

There was disagreement among commenters regarding the proposed definition for PLE. Some commenters requested that the definition of PLE be expanded to include radiology benefit management (RBM) or similar companies, health plans, and manufacturers. Commenters in support of RBMs stated that national professional medical societies had potential conflicts of interest when developing AUC for use by their own medical specialty as some specialties are paid by performing imaging services. Commenters in support of national professional medical specialty societies state that RBMs had potential conflicts of interest and were incentivized to control costs.

CMS responded that they are modifying the proposed definition of PLE to finalize a definition that focuses on the practitioners and providers that comprise an organization and not on whether the organization, as an entity, delivers care. This approach subsumes national professional medical specialty societies whose members are actively engaged in delivering care in the community and eliminates the need to establish a separate definition as they are now an example of a PLE. This will also include alliances and collaboratives of hospitals and hospital system. CMS does not believe the modified definition of PLE that they finalized will limit the AUC market or the participation of third parties (such as RBMs) in the AUC development process. There may be opportunity for third parties to collaborate with PLEs to develop AUC.

Some commenters requested that the PLE’s multidisciplinary team should include more than the minimum three members proposed by CMS, with some commenters suggesting upwards of 15
members. CMS responded by modifying their proposal to instead require that the multidisciplinary team must have at least seven members including a primary care practitioner. They are also modifying the requirements to clearly state that the required expertise in the clinical topic and imaging service related to the AUC that are being developed must be provided by practicing physicians. In addition to primary care, CMS is also modifying their proposal to require that experts in clinical trial design and statistical analysis be required members of the team. A given team member may be the team’s expert in more than one domain. While CMS does not agree that involvement from industry or patient advocates should be required on the team, they do believe that teams could benefit from dialogue with such stakeholders. CMS encourages the teams to be larger where appropriate and to include experts in medical informatics and quality improvement.

CMS added language to the rule to require at least annual review of AUC by qualified PLEs. One commenter recommended that the cost of systematic reviews and the costs associated with AUC development should be at least partially mitigated by government organizations like CMS, and tax incentives or grant money should be available to medical specialty societies to help offset costs. CMS responded by indicating that PAMA included no provisions authorizing funding tax incentives, grants, or other financial assistance to PLEs developing AUC.

The ACR recommended that CMS include processes approved by the National Guidelines Clearinghouse (NGC) as examples of a rigorous evidence-based process, and that they grant provisional approval as qualified to PLEs that have met the NGC inclusion criteria and whose AUC are posted to the NGC. CMS responded that while the NGC serves as an important repository for clinical practice guidelines, they believe that the CMS application process for qualified PLE status is not overly burdensome as a stand-alone process. CMS also recognizes that PLEs that have their AUC posted to the NGC may find that they are at an advantage in the application process to become a qualified PLE because they have already prepared a package with some similar information.

In response to a comment on the implementation timeline, CMS said again that they fully anticipate that they will be able to finalize rules and requirements around the CDS mechanism and approve mechanisms through rulemaking in 2017. This timeline will significantly impact when they would expect practitioners to begin using those CDS mechanisms to consult AUC and report on those consultations. CMS is not in a position to predict the exact timing of implementation, however, they do not anticipate that it will take place until CDS mechanisms are established through rulemaking.

Some commenters suggested that CMS require standardization of AUC for the purposes of CDS mechanism integration. CMS responded that while they are not able to respond fully to these comments in the final rule, they believe comments regarding standardization of AUC and CDS mechanisms for interoperability are very important, and they intend to further consider these comments and address this issue through rulemaking next year.

One commenter recommended that qualified PLEs that develop AUC for a priority clinical area should be required to produce AUC that reasonably encompass the entire scope of that priority area, so as to ensure that ordering professionals cannot use only a very small number of criteria
with the goal of participating in the program as little as possible. CMS agreed that the AUC must address the area comprehensively and they are revising the regulations to include language that addresses this concern.

CMS anticipates that more details regarding consultation with CDS mechanisms and claims-based reporting will be released through rulemaking in CY 2017.

Some commenters expressed concern about conflicting AUC and conflicts between AUC and other policies (such as national coverage determinations). CMS responded that conflicting AUC are now highlighted in the rule as an example of situations in which it might be appropriate for CMS and the MEDCAC to review the evidence base. Dramatically conflicting AUC may be a signal that one of them is not evidence-based. The MEDCAC could review the underlying evidence and the committee could discuss whether that evidence supports the conclusions of the AUC thereby exposing any non-evidence-based AUC.

In response to comments, CMS has added language to enable them to take steps to remove the qualified status of qualified PLEs that have non-evidence-based AUC within their AUC libraries and do not take prompt measures to resolve or remove the criteria.

One commenter suggested that CMS accept applications to become a qualified PLE until March of 2016 rather than requiring them to be submitted by January 1, 2016. CMS finalized the proposed deadline of January 1, 2016 for PLEs to apply to become qualified PLEs because they believe it is important that they avoid further delay of AUC specification and program implementation.

CMS received many comments on how to identify priority clinical areas. They expect to propose the first priority clinical areas in next year’s MPFS rule based on stakeholder consultation, and will solicit further public comment at that time.

CMS will post information for the AUC/CDS program on their website.

Phase-in of Significant RVU Reductions (Page 153)

As a result of lobbying efforts by the ACR, Section 1848(c)(7) of the Act, as added by section 220(e) of the PAMA, specifies that for services that are not new or revised codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year, the applicable adjustments in work, PE, and MP RVUs shall be phased-in over a 2-year period. Although the PAMA required the phase-in to begin for 2017, section 202 of the ABLE Act amended section 1848(c)(7) of the Act to require that the phase-in begin for CY 2016.

Identifying Services that are Not New or Revised Codes

As described in the rule, the statute specifies that services described by new or revised codes are not subject to the phase-in of RVUs. This exclusion recognizes the reality that there is no
practical way to phase-in over 2 years changes to RVUs that occur as a result of a coding change for a particular service because there is no relevant reference code or value on which to base the transition. To determine which services are described by new or revised codes for purposes of the phase-in provision, CMS proposed to apply the phase-in to all services that are described by the same, unrevised code in both the current and update year, and to exclude codes that describe different services in the current and update year. This approach excludes services described by new codes or existing codes for which the descriptors were altered substantially for the update year to change the services that are reported using the code. CMS also excluded as new and revised codes those codes that describe a different set of services in the update year when compared to the current year by virtue of changes in other, related codes, or codes that are part of a family with significant coding revisions. For example, significant coding revisions within a family of codes can change the relationships among codes to the extent that it changes the way that all services in the group are reported, even if some individual codes retain the same number or, in some cases, the same descriptor. Excluding codes from the phase-in when there are significant revisions to the code family would also help to maintain the appropriate rank order among codes in the family, avoiding years for which RVU changes for some codes in a family are in transition while others were fully implemented. This application of the phase-in would also be consistent with previous RVU transitions, especially for PE RVUs, for which CMS only applied transition values to those codes that described the same service in both the current and the update years. CMS also excluded from the phase-in as new and revised codes those codes with changes to the global period, since the code in the current year would not describe the same units of service as the code in the update year.

The ACR recommended in our comment letter that excluded codes be included in the proposed rule, subject to public comment, to ensure appropriate transparency. CMS did not address this recommendation in the final rule.

Estimating the 20 Percent Threshold

Because the phase-in of RVUs falls within the budget neutrality requirements specified in the Act, CMS proposed to estimate total RVUs for a service prior to the budget-neutrality redistributions that result from implementing phase-in values. They recognized that the result of this approach could mean that some codes may not qualify for the phase-in despite a reduction in RVUs that is ultimately slightly greater than 20 percent due to budget neutrality adjustments that are made after identifying the codes that meet the threshold in order to reflect the phase-in values for other codes. CMS believes the only alternative to this approach is not practicable, since it would be circular, resulting in cyclical iteration.

CMS finalized their proposal to identify significant reductions in RVUs based on a comparison of RVUs before application of budget neutrality adjustment.

RVUs in the First Year of the Phase-In

The Act stated that the applicable adjustments in work, PE, and MP RVUs shall be phased-in over a 2-year period when the RVU reduction for a code is estimated to be equal to or greater than 20 percent. CMS believes that there are two reasonable ways to determine the portion of the
reduction to be phase-in for the first year. Most recent RVU transitions have distributed the values evenly across several years. For example, for a 2-year transition CMS would estimate the fully implemented value and set a rate approximately 50 percent between the value for the current year and the value for the update year. CMS believes that this is the most intuitive approach to the phase-in and recognized that it was likely the expectation for many stakeholders.

However, CMS believes that the 50 percent phase-in in the first year has a significant drawback. For instance, since the statute establishes a 20 percent threshold as the trigger for phasing in the change in RVUs, under the 50 percent phase-in approach, a service that is estimated to be reduced by a total of 19 percent for an update year would be reduced by a full 19 percent in that update year, while a service that is estimated to be reduced by 20 percent in an update year would only be reduced 10 percent in that update year. The logical alternative approach is to consider a 19 percent reduction as the maximum 1-year reduction for any service not described by a new or revised code. This approach would be to reduce the service by the maximum allowed amount (that is, 19 percent) in the first year, and then phase in the remainder of the reduction in the second year. Under this approach, the code that is reduced by 19 percent in a year and the code that would otherwise have been reduced by 20 percent would both be reduced by 19 percent in the first year, and the latter code would see an additional 1 percent reduction in the second year of the phase-in. For most services, this would likely mean that the majority of the reduction would take place in the first year of the phase-in. However, for services with the most drastic reductions (greater than 40 percent), the majority of the reduction would take place in the second year of the phase-in.

After considering both of these options, CMS proposed to consider the 19 percent reduction as the maximum 1-year reduction and to phase-in any remaining reduction greater than 19 percent in the second year of the phase-in. They believe that this approach is more equitable for codes with significant reductions but that are less than 20 percent.

The ACR disagreed with this approach and commented that CMS should implement a 50% phase-in approach instead.

CMS remains concerned about several practical problems that could arise from utilizing the 50% approach. The first of these problems would occur whenever some codes within the same family of services would meet threshold reductions while others do not. For example if two codes in a four code family would be reduced by an estimated 20 percent while the other two were estimated to be reduced by 19 percent, then the first two would be reduced by 10 percent while the remaining two would be reduced by 19 percent. Such a scenario could easily create rank order anomalies within families of codes. The risks of such anomalies is associated with the financial incentives toward inaccurate downward coding that could not only jeopardize Medicare claims data as an accurate source of information, but more directly could have serious consequences within the ratesetting methodologies for both purposes of budget neutrality and for allocation of PE and MP RVUs. The second practical issue with the 50 percent approach would be that the impact of using the estimated reduction instead of the final reduction to determine whether or not particular codes qualify for the phase-in would be significant. Under the 19 percent approach, values for codes with reductions estimated to be very close to 19 percent would be similar regardless of whether or not CMS engages in various iterations of budget
neutrality adjustments to determine whether or not the phase-in applies. Under the 50 percent approach, determinations that result from repeated iterations of ratesetting calculations and budget neutrality adjustments could decide significant changes in the rates for individual codes (up to 10 percent of the total payment.) In order to avoid these circumstances and apply the most gradual phase-in possible to codes with the most significant reductions, CMS continues to believe that a 19 percent reduction as the maximum 1-year reduction is the better approach to determining the phase-in amount.

Applicable Adjustments to RVUs

The phase-in provision instructs that the applicable adjustments in work, PE, and MP RVUs be phased-in over 2 years for any service that would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total RVUs for the previous year. However, for several thousand services, CMS develops separate RVUs for facility and nonfacility sites of service. For nearly one thousand other services, including imaging services, they develop separate RVUs for the professional and technical components of the service and sum those RVUs to allow for global billing. Therefore, for individual practitioners furnishing particular services to Medicare beneficiaries, the relevant changes in RVUs for a particular code are based on the total RVUs for a code for a particular setting (facility/nonfacility) or for a particular component (professional/technical.) CMS believes the most straightforward and fair approach to addressing both the site of service differential and the codes with professional and technical components is to consider the RVUs for the different sites of service and components independently for purposes of identifying when and how the phase-in applies. CMS proposed, therefore, to estimate whether a particular code meets the 20 percent threshold for change in total RVUs by taking into account the total RVUs that apply to a particular setting or to a particular component. Therefore, if the change in the total RVUs for the technical component of a service meets the 20 percent threshold, then that change would be phased-in over 2 years, even if the change for the professional component did not meet the threshold. (Because the global is the sum of the professional and technical components, the portion of the global attributable to the technical component would then be phased-in, while the portion attributable to the professional component would not be.) Since variation of PE RVUs is the only constant across all individual codes, codes with site of service differentials, and codes with professional and technical components, CMS proposed to apply all adjustments for the phase-in to the PE RVUs.

The ACR expressed concern with this proposed approach and asked CMS to clarify that the phase-in would apply to both work RVUs and PE RVUs independently, even for codes with separate facility and non-facility PE RVUs.

CMS responded that all adjustments for the phase-in, including for codes with facility and non-facility RVUs and PC/TC splits, will be applied to the PE RVUs only. CMS acknowledges that for some codes it would be hypothetically possible to phase in the reductions proportionately across all three RVU components.

As CMS explained in the proposed rule, they do not feel it would be practical to do so for services with site of service differentials since each of the three RVU components represent a different proportion of overall nonfacility or facility RVUs. Therefore, CMS believes this
alternative approach could only work for codes without site of service differentials and those without PC/TC splits, which represents a minority of PFS services. CMS believes that applying the phase-in for these large categories of codes differently than for the rest of PFS codes would be confusing to the public and make adjustments unpredictable since they would be based on whether or not the service priced in the opposite setting met the phase-in threshold. Furthermore, CMS reminded commenters that because the work RVU is an important allocator of indirect PE in the established methodology, the overall payment impact of any changes in work RVUs is also automatically reflected in corresponding changes to the PE RVUs, whereas changes to direct PE inputs do not have a parallel impact on work RVUs. Therefore, even for individual codes for which it might be possible to establish phase-in values for work RVUs, the necessary adjustments would necessarily be weighted more heavily in PE RVUs.

CMS stated that their approach would dampen the effect of any payment reductions for all codes, including those reductions that would result from reductions to work RVUs when such reductions contributed to an overall reduction of 20 percent or greater, consistent with the statutory provision. As a practical matter, CMS believes that practitioners reporting services furnished to Medicare beneficiaries and paid through the PFS would be paid very similar amounts regardless of which approach they implemented. CMS also noted that commenters did not provide any information that would help them to understand how the suggested phase-in could be applied to services with site of service differentials.

After consideration of the comments received, CMS finalized this aspect of the phase-in methodology as proposed.

**Changes for Computed Tomography (CT) under the Protecting Access to Medicare Act of 2014 (PAMA) (Page 165)**

Section 218(a)(1) of PAMA mandates that for the technical component of applicable computed tomography services paid under the physician fee schedule and HOPPS that a 5-percent reduction in 2016 and a 15-percent reduction in 2017 and subsequent years be made for services furnished using equipment that does not meet the requirements of the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, entitled “Standard Attributes on CT Equipment Related to Dose Optimization and Management.” The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes).

To implement this provision, CMS proposed creation of modifier “CT” (Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard). Beginning in 2016, claims for CT scans described by above-listed CPT codes (and any successor codes) that are furnished on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier “CT” and that modifier will result in the applicable payment reduction for the service.
The ACR requested a 12 month delay in implementation of this policy to allow adequate time for CMS to notify providers of their final implementation expectations and to allow software vendors and providers to implement necessary software coding changes. We also suggested that CMS work with the ACR, RBMA, AHRA, AAPM, and MITA on a means of systematic implementation that ensures appropriate reimbursement for these CT claims.

CMS responded that the statute requires that they apply the payment adjustment as indicated for services furnished on or after January 1, 2016, and as such, they are not delaying implementation of this provision. CMS finalized the creation of the “CT” modifier and will move forward with implementation on January 1, 2016.

Practice Expense (PE) Relative Value Unit (RVU) Methodology (Page 33)

For CY 2016, CMS proposed a technical improvement to the PE RVU methodology. CMS proposed to set the aggregate pool of PE costs equal to the product of the ratio of the current aggregate PE RVUs to current aggregate work RVUs and the proposed aggregate work RVUs. Historically, in allowing the current PE RVUs to determine the size of the base PE pool in the PE methodology, CMS has assumed that the relationship of PE RVUs to work RVUs is constant from year to year. Since this is not ordinarily the case, by not considering the proposed aggregate work RVUs in determining the size of the base PE pool, there has been some minor instability from year to year in the relative shares of work, PE, and MP RVUs. While this proposed modification would result in greater stability in the relationship among the work and PE RVU components in the aggregate, CMS does not anticipate it will affect the distribution of PE RVUs across specialties.

CMS did not receive any comments on this proposal and therefore finalized this refinement as proposed.

Indirect Cost PE RVUs

Historically, CMS has used the specialties that furnish the service in the most recent full year of Medicare claims data (crosswalked to the current year set of codes) to determine which specialties furnish individual procedures. For example, for CY 2015 ratesetting, CMS used the mix of specialties that furnished the services in the CY 2013 claims data to determine the specialty mix assigned to each code. While CMS believes that there are clear advantages to using the most recent available data in making these determinations, they have also found that using a single year of data contributes to greater year-to-year instability in PE RVUs for individual codes and often creates extreme, annual fluctuations for low-volume services, as well as delayed fluctuations for some services described by new codes once claims data for those codes becomes available. CMS believes that using an average of the three most recent years of available data may increase stability of PE RVUs and mitigate code-level fluctuations for both the full range of MPFS codes, and for new and low-volume codes in particular. Therefore, CMS proposed to refine this step of the PE methodology to use an average of the 3 most recent years of available Medicare claims data to determine the specialty mix assigned to each code.
CMS finalized the policy as proposed for CY 2016, but will seek comment on the proposed CY 2017 MPFS rates and whether or not the incorporation of a new year of utilization data mitigates the need for service-level overrides. At that time, CMS would reconsider whether or not to use a claims-based approach (dominant specialty) or stakeholder-recommended approach (expected specialty) in the development of PE RVUs for low-volume codes.

**Equipment Maintenance Costs (Page 44)**

CMS raised the issue of equipment maintenance costs in the 2015 rulemaking cycle. They received several comments about variable maintenance costs, and in reviewing the information offered in those comments, they believe it is clear that the relationship between maintenance costs and the price of equipment is not necessarily uniform across equipment. However, based on their review of comments, CMS was unable to identify a systematic way of varying the maintenance cost assumption relative to the price or useful life of equipment. Therefore, in order to accommodate a variable, as opposed to a standard, maintenance rate within the equipment cost per minute calculation, CMS believes they would have to gather and maintain valid data on the maintenance costs for each equipment item in the direct PE input database, much like they do for price and useful life. Given longstanding difficulties in acquiring accurate pricing information for equipment items, CMS is seeking comment on whether adding another item-specific financial variable for equipment costs will be likely to increase the accuracy of PE RVUs across the MPFS.

The ACR commented that we support the survey data gathered by the RBMA during the 2015 rulemaking cycle. On average, maintenance agreements run anywhere between 7 to 12 percent of equipment's purchase price. Maintenance contracts for mammographic equipment tend to be higher.

CMS agrees with commenters that the current rate likely understates the maintenance costs for equipment. However, in the absence of publicly available datasets regarding equipment maintenance costs or another systematic data collection methodology for determining maintenance factor, they do not believe that there is sufficient information at present to adopt a variable maintenance factor for equipment cost per minute pricing. While CMS believes that these costs ideally should be incorporated into the PE methodology, they also have serious concerns about the problems that result from incorporating anecdotal data based solely on voluntarily submitted pricing information. Therefore, CMS believes that absent an auditable, robust data source, using anecdotal data for maintenance costs is likely to compound the current problems of pricing equipment costs accurately, not increase accuracy. CMS will continue to investigate potential avenues for determining equipment maintenance costs across a broad range of equipment items.

**Clinical Labor Tasks Associated with Digital Imaging (Page 55)**

In MPFS rulemaking for CY 2015, CMS noted that the RUC recommendation regarding inputs for digital imaging services indicated that, as each code is reviewed under the misvalued code initiative, the clinical labor tasks associated with digital technology (instead of film) would need to be addressed. When CMS reviewed that recommendation, they did not have the capability of
assigning standard clinical labor times for the hundreds of individual codes since the direct PE input database did not previously allow for comprehensive adjustments for clinical labor times based on particular clinical labor tasks. Therefore, consistent with the recommendation, CMS proposed to remove film-based supply and equipment items but maintain clinical labor minutes that were assigned based on film technology.

CMS believes it would be appropriate to establish standard times for clinical labor tasks associated with all digital imaging for purposes of reviewing individual services at present, and for possible broad-based standardization once the changes to the database facilitate their ability to adjust time for existing services. Therefore, they sought comment on the appropriate standard minutes for the clinical labor tasks associated with services that use digital technology.

The ACR agreed that the proposed times for four of the five activities were representative across imaging, but we commented to CMS that the “Technologist quality control’s (QC) images” time could vary significantly for different modalities. CMS agreed that this task may require a variable length of time depending on the number of images to be reviewed. CMS believes that it may be appropriate to establish several different standard times for this clinical labor task for a low/medium/high quantity of images to be reviewed, in the same fashion that the clinical labor assigned to clean a surgical instrument package has two different standard times depending on the use of a basic pack or a medium pack. CMS is interested in soliciting public comment and feedback on this subject, with the anticipation of including a proposal in next year’s proposed rule.

CMS finalized the standard times for clinical labor tasks associated with digital imaging at 2 minutes for “Availability of prior images confirmed”, 2 minutes for “Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocoled by radiologist”, 2 minutes for “Review examination with interpreting MD”, and 1 minute for “Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue.” They did not finalize a standard time for clinical labor task “Technologist QC’s images in PACS, checking for all images, reformats, and dose page” at this time, pending consideration of any additional public comment and future rulemaking, as described above.

Clinical Labor Input Inconsistencies (Page 64)

Subsequent to the publication of the CY 2015 MPFS final rule with comment period, CMS was alerted by stakeholders to several clerical inconsistencies in the clinical labor nonfacility intraservice time for several vertebroplasty codes with interim final values for CY 2015, based on CMS’s understanding of RUC recommended values. CMS proposed to correct these inconsistencies in the CY 2016 proposed direct PE input database to reflect the RUC recommended values, without refinement, as stated in the CY 2015 MPFS final rule with comment period.

CMS received comments regarding additional errors for these codes.
For CPT code 22510, commenters pointed out that the clinical labor assigned to the RadTech (L041B) for “Assist Physician” was incorrectly listed twice in the direct PE input database. The clinical labor staff type was also incorrectly entered as L041C, which is priced at the same rate but refers to a second Radiologic Technologist for Vertebroplasty. CMS will remove the duplicative clinical labor and assign type L041B to the “Assist Physician” activity. CMS did not agree with commenters that the time for clinical labor task “Check dressings & wound” was missing, as it is present in the database. **CMS agreed with the commenters that the clinical labor time for the office visit was missing from CPT code 22510, and added it to the direct PE database.**

For CPT code 22511, CMS indicated that commenters were correct that the time for clinical labor task “Assist physician” was entered at the correct value of 45 minutes, and the 5 minutes of clinical labor for “Check dressings & wound” does not appear in the non-facility setting. This clinical labor time appears to have been incorrectly entered for the facility setting instead; CMS removed this time and added it to its proper non-facility setting. **CMS agreed with the commenters that the clinical labor time for the office visit was again missing from CPT code 22511, and added it to the direct PE input database.**

For CPT code 22514, the time for clinical labor task “Assist physician” was refined to 50 minutes as detailed in the CY 2016 PFS proposed rule. **CMS agreed with the commenters that the 5 minutes of clinical labor time for “Check dressings & wound” was missing from the direct PE input database. They agreed that the clinical labor for this activity should not be treated differently from the rest of the codes in the family, and therefore these 5 minutes are included in the direct PE input database. The postoperative office visit is included in the direct PE input database for CPT code 22514.**

**Potentially Misvalued Services (Page 91)**

_Identification of Potentially Misvalued Codes for CY 2016: Review of High Expenditure Services across Specialties with Medicare Allowed Charges of $10,000,000 or More (Page 95)_

CMS proposed 118 codes listed as potentially misvalued codes, identified using the high expenditure screen under the statutory category, “codes that account for the majority of spending under the MPFS.” To develop this list, CMS identified the top 20 codes by specialty in terms of allowed charges. As was done last year, CMS excluded codes that have been reviewed since CY 2010, those with fewer than $10 million in allowed charges, and those that describe anesthesia or E/M services. CMS excluded E/M services from the list of proposed potentially misvalued codes for the same reasons that they were excluded in a similar review in CY 2012. CMS also excluded all codes with 10- and 90-day global periods since CMS believes these codes should be reviewed as part of the global surgery revaluation.

CMS responded to comments that the high expenditure screen is not an appropriate criterion to use to identify the codes for the potentially misvalued codes initiative by stating that they identify potentially misvalued codes in order to prioritize review of subsets of PFS services. They prioritize review of individual services based on indications that a particular code is likely to be misvalued and on the impact that the potential misvaluation of the code would have on the
valuation of PFS services broadly. The high expenditure screen is largely intended to address the
latter situation where improved valuation would have the most significant impact on the
valuation of PFS services more broadly. CMS believes this approach is also consistent with
another category of codes identified for screening by statute: codes with high PE relative value
units. In proposing to prioritize this list of high expenditure codes, CMS stated that the reason
they identified these codes is because they have significant impact on PFS payment on a
specialty level and have not been recently reviewed.

CMS also stated that because of the concerns expressed by commenters about the burden
associated with code reviews, they continue to believe that it is appropriate to prioritize review of
codes to a manageable subset that also have a high impact on the PFS and work with the
specialty society to spread review of the remaining codes identified as potentially misvalued over
a reasonable timeframe.

The ACR requested that CPT codes 76536 (Ultrasound of head and neck), 78452 (Nuclear
medicine study of vessels of heart using drugs or exercise multiple studies), 77263
(Radiation therapy planning) and 77264 (Radiation treatment aid(s)) be removed from the
potentially misvalued codes list as they have been reviewed by the RUC since 2010. CMS
agreed with the ACR for CPT codes 76536 and 78452 and removed those codes from the
list, however, they did not acknowledge the recommendation to remove 77263 and 77264.

Below is the finalized list of potentially misvalued codes that pertain to radiology.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>10022</td>
<td>Fna w/image</td>
</tr>
<tr>
<td>20550</td>
<td>Inj tendon sheath/ligament</td>
</tr>
<tr>
<td>27370</td>
<td>Injection for knee x-ray</td>
</tr>
<tr>
<td>31500</td>
<td>Insert emergency airway</td>
</tr>
<tr>
<td>36215</td>
<td>Place catheter in artery</td>
</tr>
<tr>
<td>36556</td>
<td>Insert non-tunnel cv cath</td>
</tr>
<tr>
<td>36569</td>
<td>Insert picc cath</td>
</tr>
<tr>
<td>36620</td>
<td>Insertion catheter artery</td>
</tr>
<tr>
<td>38221</td>
<td>Bone marrow biopsy</td>
</tr>
<tr>
<td>51700</td>
<td>Irrigation of bladder</td>
</tr>
<tr>
<td>51702</td>
<td>Insert temp bladder cath</td>
</tr>
<tr>
<td>52000</td>
<td>Cystoscopy</td>
</tr>
<tr>
<td>55700</td>
<td>Biopsy of prostate</td>
</tr>
<tr>
<td>70491</td>
<td>Ct soft tissue neck w/dye</td>
</tr>
<tr>
<td>70543</td>
<td>MRI ORB/FAC/NCK W/O&amp;W/DYE</td>
</tr>
<tr>
<td>70544</td>
<td>MR angiography head w/o dye</td>
</tr>
<tr>
<td>70549</td>
<td>MR angiograph neck w/o&amp;w/dye</td>
</tr>
<tr>
<td>71010</td>
<td>Chest x-ray 1 view frontal</td>
</tr>
<tr>
<td>71020</td>
<td>Chest x-ray 2vw frontal&amp;latl</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>71260</td>
<td>Ct thorax w/dye</td>
</tr>
<tr>
<td>71270</td>
<td>Ct thorax w/o &amp; w/dye</td>
</tr>
<tr>
<td>72195</td>
<td>MRI pelvis w/o dye</td>
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<tr>
<td>72197</td>
<td>MRI pelvis w/o &amp; w/dye</td>
</tr>
<tr>
<td>73110</td>
<td>X-ray exam of wrist</td>
</tr>
<tr>
<td>73130</td>
<td>X-ray exam of hand</td>
</tr>
<tr>
<td>73718</td>
<td>MRI lower extremity w/o dye</td>
</tr>
<tr>
<td>73720</td>
<td>MRI lwr extremity w/o&amp;w/dye</td>
</tr>
<tr>
<td>74000</td>
<td>X-ray exam of abdomen</td>
</tr>
<tr>
<td>74022</td>
<td>X-ray exam series abdomen</td>
</tr>
<tr>
<td>74181</td>
<td>MRI abdomen w/o dye</td>
</tr>
<tr>
<td>74183</td>
<td>MRI abdomen w/o &amp; w/dye</td>
</tr>
<tr>
<td>75635</td>
<td>Ct angio abdominal arteries</td>
</tr>
<tr>
<td>75710</td>
<td>Artery x-rays arm/leg</td>
</tr>
<tr>
<td>75978</td>
<td>Repair venous blockage</td>
</tr>
<tr>
<td>76512</td>
<td>Ophth us b w/non-quant a</td>
</tr>
<tr>
<td>76519</td>
<td>Echo exam of eye</td>
</tr>
<tr>
<td>77059</td>
<td>MRI both breasts</td>
</tr>
<tr>
<td>77263</td>
<td>Radiation therapy planning</td>
</tr>
<tr>
<td>77334</td>
<td>Radiation treatment aid(s)</td>
</tr>
<tr>
<td>77470</td>
<td>Special radiation treatment</td>
</tr>
<tr>
<td>78306</td>
<td>Bone imaging whole body</td>
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<tr>
<td>93306</td>
<td>Tte w/doppler complete</td>
</tr>
<tr>
<td>93350</td>
<td>Stress tte only</td>
</tr>
<tr>
<td>93351</td>
<td>Stress tte complete</td>
</tr>
<tr>
<td>93965</td>
<td>Extremity study</td>
</tr>
</tbody>
</table>

*Valuing Services That Include Moderate Sedation as an Inherent Part of Furnishing the Procedure (Page 106)*

In the CY 2015 MPFS proposed rule, CMS noted that it appeared that practice patterns for endoscopic procedures were changing, with anesthesia increasingly being separately reported for these procedures. Due to the changing nature of medical practice, CMS considered establishing a uniform approach to valuation for all Appendix G services. CMS continues to seek an approach that is based on using the best available objective information about the provision of moderate sedation broadly, rather than merely addressing this issue on a code-by-code basis using RUC survey data when individual procedures are revalued. CMS sought public comment on approaches to address the appropriate valuation of these services given that moderate sedation is no longer inherent for many of these services. To the extent that Appendix G procedure values are adjusted to no longer include moderate sedation, CMS requested suggestions as to how moderate sedation should be reported and valued, and how to remove from existing valuations the RVUs and inputs related to moderate sedation.
To establish an approach to valuation for all Appendix G services based on the best data about the provision of moderate sedation, CMS notes that they need to determine the extent of the misvaluation for each code. They know that there are standard packages for the direct PE inputs associated with moderate sedation, and they began to develop approaches to estimate how much of the work is attributable to moderate sedation. However, CMS believes that they should seek input from the medical community prior to proposing changes in values for these services, given the different methodologies used to develop work RVUs for the hundreds of services in Appendix G. Therefore, CMS is seeking recommendations from the RUC and other interested stakeholders for appropriate valuation of the work associated with moderate sedation before formally proposing an approach that allows Medicare to adjust payments based on the resource costs associated with the moderate sedation or anesthesia services that are being furnished.

CMS received many comments on this issue, but very few specific recommendations on the approach they should take. In the final rule, CMS thanked the public for their comments and indicated that they will consider input from the medical community on this issue through the evaluation of CPT coding changes and associated RUC recommendations, as well as feedback received through public comments as these services are valued through future notice and comment rulemaking.

Improving the Valuation and Coding of the Global Package (Page 109)

In the CY 2015 PFS final rule, CMS finalized a policy to transition all 10-day and 90-day global codes to 0-day global periods in order to improve the accuracy of valuation and payment for the various components of global surgical packages, including pre- and postoperative visits and the surgical procedure itself.

Section 1848(c)(8)(B)(i) of the Act requires CMS to develop through rulemaking a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection shall begin no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate. This information must be reported on claims at the end of the global period or in another manner specified by the Secretary. Section 1848(c)(8)(B)(ii) of the Act requires that, every 4 years, CMS must reassess the value of this collected information, and allows CMS to discontinue the collection if the Secretary determines that there is adequate information from other sources in order to accurately value global surgical services. Section 1848(c)(8)(B)(iii) of the Act specifies that the Inspector General will audit a sample of the collected information to verify its accuracy.

Section 1848(c)(8)(C) of the Act requires that, beginning in CY 2019, CMS must use the information collected as appropriate, along with other available data, to improve the accuracy of valuation of surgical services under the MPFS. Section 523(b) of the MACRA adds a new paragraph at section 1848(c)(9) of the Act which authorizes the Secretary, through rulemaking, to delay up to 5 percent of the MPFS payment for services for which a physician is required to report information under section 1848(c)(8)(B)(i) of the Act until the required information is reported.
Since section 1848(c)(8)(B)(i) of the Act, as added by section 523(a) of the MACRA, requires CMS to use rulemaking to develop and implement the process to gather information needed to value surgical services no later than January 1, 2017, CMS sought input from stakeholders on various aspects of this task. They solicited comments from the public regarding the kinds of auditable, objective data (including the number and type of visits and other services furnished by the practitioner reporting the procedure code during the current post-operative periods) needed to increase the accuracy of the values for surgical services. CMS is also sought comment on the most efficient means of acquiring these data as accurately and efficiently as possible. For example, they sought information on the extent to which individual practitioners or practices may currently maintain their own data on services, including those furnished during the post-operative period, and how they might collect and objectively evaluate those data for use in increasing the accuracy of the values beginning in CY 2019. CMS will use the information from the public comments to help develop a proposed approach for the collection of this information in future rulemaking.

CMS received many comments on this topic, including the following:

- Use a measured approach to valuing the individual components of the global surgical package rather than implementing a blanket data collection policy.
- Examine and consider the level of the postoperative E/M visits, including differences between specialties.
- Consider the interaction between valuing the global surgery package and the multiple procedure payment reduction (MPPR) policy.

CMS will consider these comments and will provide further opportunity for public comment through future rulemaking. CMS also received strong support for the proposal to hold an open door forum or town hall meetings with the public.

Refinement Panel (Page 115)

Beginning in CY 2016, CMS proposed to permanently eliminate the refinement panel and instead publish the proposed rates for all interim final codes in the MPFS proposed rule for the subsequent year.

As explained in the CY 2015 final rule with comment period, only a small number of codes being valued for CY 2016 will be published as interim final in the 2016 MPFS final rule with comment period and be subject to comment. CMS will evaluate the comments they receive on these code values, and both respond to these comments and propose values for these codes for CY 2017 in the CY 2017 MPFS proposed rule. Therefore, CMS points out that stakeholders will have two opportunities to comment and to provide any new clinical information that was not available at the time of the RUC valuation that might affect work RVU values that are adopted on an interim final basis. CMS believes that this proposed process, which includes two opportunities for public notice and comment, offers stakeholders a better mechanism and ample opportunity for providing any additional data for our consideration, and discussing any concerns with the interim final values, than the current refinement process. It also provides greater
transparency because comments on the rules are made available to the public at www.regulations.gov.

The ACR commented that the CMS Refinement Panel process has been considered by stakeholders to be an appeals process. It was organized and composed by CMS and consisted of members from the primary care organizations, contractor medical directors, a specialty related to the commenter and commenting specialty. We suggested that the complete elimination of the Refinement Panel indicates that CMS will no longer rely upon outside stakeholders to provide accountability through an appeals process for stakeholders who do not agree with the Agency’s decisions. The ACR recommended that CMS consider these issues and maintain an objective, transparent and consistently-applied formal appeals process that would be open to any commenting organization. The AMA submitted similar comments.

CMS disagrees that the Refinement Panel ever served as an “appeals” or reconsideration process that some stakeholders, including the ACR, envisioned in their comments. CMS also stated that they have come to believe that the refinement panel is not achieving its intended purpose. They feel that rather than providing them with additional information, balanced across specialty interests, to assist them in establishing work RVUs, the refinement panel process generally serves to rehash the issues raised and information already discussed at the RUC meetings and considered by CMS. They believe that focusing their resources on notice and comment rulemaking would facilitate greater transparency.

CMS stated that they appreciate commenters’ concerns that the new process has not been fully implemented and there may be unanticipated needs for additional input like the kind made available through the refinement panels. Therefore, CMS did not finalize the proposal to eliminate the refinement panel process at this time. Instead, they will retain the ability to convene refinement panels for codes with interim final values under circumstances where additional input provided by the panel is likely to add value as a supplement to notice and comment rulemaking. CMS also reminds stakeholders that CY 2016 is the final year for which they anticipate establishing interim final values for existing services.

Valuation of Specific Codes (Page 169)

In the CY 2015 MPFS final rule with comment period, CMS finalized a new process for establishing values for new, revised and potentially misvalued codes. Under the new process, CMS includes proposed values for these services in the proposed rule, rather than establishing them as interim final in the final rule with comment period. CY 2016 represents a transition year for this new process. For CY 2016, CMS proposed new values in the proposed rule for the codes for which they received complete RUC recommendations by February 10, 2015. For recommendations regarding any new or revised codes received after the February 10, 2015 deadline, including updated recommendations for codes included in this proposed rule, CMS established interim final values in the final rule with comment period, consistent with previous practice. CMS notes that they considered all comments received in response to proposed values for codes in the proposed rule, including alternative recommendations to those used in developing the proposed rule.
Proposed Values for New, Revised, and Potentially Misvalued CPT Codes

CMS details proposed work RVUs for new, revised and potentially misvalued CPT codes in Tables 11 (beginning on page 131). For PE input recommendations, CMS lists those codes whose RUC recommendations were accepted without refinement in Table 12 (beginning on page 139) and those codes that have proposed refinements in Table 13 (beginning on page 141). Of the codes presented to the RUC by the ACR, CMS accepted approximately 60 percent of the RUC approved values. ACR staff and physician volunteers are conducting a thorough review and analysis of the codes related to radiology.

Radiation Treatment and Related Image Guidance Services (Page 215)

For CY 2015, the CPT Editorial Panel revised the set of codes that describe radiation treatment delivery services based in part on the CMS identification of these services as potentially misvalued in CY 2012. CMS identified these codes as potentially misvalued under a screen called “Services with Stand-Alone PE Procedure Time.” CMS proposed this screen following their discovery of significant discrepancies between the RUC-recommended 60 minute procedure time assumptions for intensity modulated radiation therapy (IMRT) and information available to the public suggesting that the procedure typically took between 5 and 30 minutes per treatment.

The CPT Editorial Panel’s revisions included the addition and deletion of several codes and the development of new guidelines and coding instructions. Four treatment delivery codes (77402, 77403, 77404, and 77406) were condensed into 77402 (Radiation Treatment Delivery, Simple), three treatment delivery codes (77407, 77408, 77409) were condensed into 77407 (Radiation treatment delivery, intermediate), and four treatment codes (77412, 77413, 77414, 77416) were condensed into 77412 (Radiation treatment delivery, complex). Intensity Modulated Radiation Therapy (IMRT) treatment delivery, previously reported under a single code, was split into two codes, 77385 (IMRT treatment delivery, simple) and 77386 (IMRT treatment delivery, complex). The CPT Editorial Panel also created a new image guidance code, 77387 (Guidance for localization of target volume for delivery of treatment, includes intrafraction tracking when performed) to replace 77014 (computed tomography guidance for placement of radiation therapy fields), 77421 (stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy,) and 76950 (ultrasonic guidance for placement of radiation therapy fields) when any of these services were furnished in conjunction with radiation treatment delivery.

In response to stakeholder concerns, CMS delayed implementation of the new code set until 2016 and instead created G-codes that mimicked the predecessor CPT codes. In the CY 2016 proposed rule, CMS proposed to establish values for the new codes based on RUC recommendations, subject to standard CMS refinements. CMS also noted that because the invoices used to price the capital equipment included “onboard imaging,” the cost of that equipment is already reflected in the price per minute associated with the capital equipment. Therefore, CMS did not included it as a separate item in the proposed direct PE inputs for these codes, even though it appeared as a separate item on the PE worksheet included with the RUC recommendations for these codes.
1) Image Guidance Services

Under the previous CPT coding structure, image guidance was separately billable when furnished in conjunction with the radiation treatment delivery services. The image guidance was reported using different CPT codes, depending on which image guidance modality was used. In the revised coding structure, one new image guidance code is to be reported regardless of the modality used, and in developing its recommended values, the RUC assumed that CT guidance would be typical.

However, the 2013 Medicare claims data for separately reported image guidance indicated that stereotactic guidance for radiation treatment services was furnished more frequently than CT guidance. The RUC recommended a work RVU of 0.58 and associated work times of 3 pre-service minutes, 10 intraservice minutes, and 3 post-service minutes for image guidance CPT code 77387. CMS reviewed this recommendation considering the discrepancy between the modality the RUC assumed to be typical in the vignette and the modality typically reported in the Medicare claims data. Given that the recommended work RVU for the new single code is similar to the work RVUs of the predecessor codes, roughly prorated based on their distribution in Medicare claims data, CMS agreed with the RUC recommended work RVU for the service. However, the RUC also recommended an increase in overall work time associated with image guidance consistent with the survey data used to value the new services. If accurate, this increase in time and maintenance of total work would suggest a decrease in the overall intensity for image guidance relative to the current codes. Given this implication, CMS solicited comment as to the appropriate work time associated with CPT code 77387.

The ACR commented that we believe the RUC recommendations regarding CPT code 77387 are accurate and requested that CMS implement these recommendations. CMS responded that they did not receive rationale for why the recommended work time for the new code would be significantly different than the current work time for the most frequently reported predecessor code. Absent an explanation, CMS remains concerned that the aspects of the recommended values for the new single modality code were developed based on erroneous assumptions regarding what imaging modality is most frequently used to provide guidance for radiation treatment services.

Although 77421 (stereotactic guidance) and 76950 (ultrasonic guidance) have been deleted, CMS noted that CPT maintained CPT code 77014 (Computed tomography guidance for placement of radiation therapy fields) and the RUC recommendation stated that CPT did so based on concerns that without this option, some practitioners might have no valid CPT alternative than to use higher valued diagnostic CT codes when they used this CT guidance. The RUC recommendation also included a statement that utilization of this code is expected to drop to negligible levels by 2015, assuming that practitioners would use the new codes that are not differentiated based on imaging modality. Once all the new codes are implemented for Medicare, CMS anticipates that CPT and/or the RUC will address the continued use of 77014 and, if it continues to be part of the code set, provide recommendations as to the appropriate values given changes in utilization. The ACR accepted the decision to continue to monitor and review use of this code.
Regarding the reporting of the new image guidance codes, CPT guidance instructs that the technical portion of image guidance is now bundled into the IMRT and Stereotactic Radiation Treatment delivery codes, but it is not bundled into the simple, intermediate, and complex radiation treatment delivery codes. CPT guidance stated that the technical component of the image guidance code can be reported with codes 77402, 77407, and 77412 (simple, intermediate, and complex radiation treatment) when furnished, which means that the technical component of the image guidance code should not be reported with the IMRT or Stereotactic Radiation Treatment delivery codes. The RUC recommendation, however, incorporated the same capital cost of image guidance equipment (a linear accelerator, or linac), for all these radiation treatment delivery codes, including the codes that describe IMRT and Stereotactic Radiation Treatment delivery services. The RUC explained that the recommendations were done this way because the older lower-dose external beam radiation machines are no longer manufactured and the image guidance technology is integrated into the single kind of linear accelerator used for all the radiation treatment services. In reviewing the new code structure and the RUC recommendations, CMS assumed that the CPT editorial panel did not foresee that the RUC would recommend that they develop PE RVUs for all the radiation treatment delivery codes based on the assumption that the same capital equipment is typically used in furnishing the entire range of external beam radiation treatments. Because the RUC recommendations incorporate the more extensive capital equipment in the lower dose treatment codes as well, a portion of the resource costs of the technical portion of imaging guidance are already allocated into the PE RVUs for all of the treatment delivery codes, not just the IMRT and Stereotactic Radiation Treatment delivery codes as CPT guidance would suggest.

In order to avoid incorporating the cost of this equipment into both the treatment delivery codes (77402, 77407, and 77412) and the technical component of the new imaging guidance code (77387-TC), CMS considered valuing 77387 as a professional service only and not creating the professional/technical component splits envisioned by CPT. In the context of the budget neutral MPFS, incorporating a duplicative direct input with a cost of more than six dollars per minute has significant impacts on the PE RVUs for all other services. However, CMS also noted that the RUC did not address this apparent contradiction in its recommendation and not all of the recommended direct PE inputs for the technical component of 77387 are capital equipment costs. Therefore, CMS proposed to allow for professional and technical component billing for these services, as reflected in CPT guidance, and proposed to use the RUC recommended direct PE inputs for these services (refined as described in Table 15). However, they sought comment on the apparent contradiction between technical component billing for image guidance in the context of the inclusion of a single linac with integrated imaging guidance technology being included for all external beam treatment codes.

In the final rule, CMS stated that despite comments received, they were unable to reconcile the inconsistencies and potential rank order anomalies associated with including the image guidance costs in the IMRT treatment delivery codes but not including the image guidance costs in the conventional radiation treatment delivery codes even though both use the same capital equipment. Based on the RUC recommendations and the information from the commenters, CMS understands that the same linear accelerator is typically used for all of these services and that the image guidance is integrated into the only linear accelerator that is currently being
manufactured and that, therefore, the image guidance costs should always be included in the RVUs for the IMRT treatment delivery codes. After review of the comments, CMS continues to believe that these issues create rank order anomalies, both relative to the accuracy of the assumed costs and the financial incentives associated with Medicare paying more overall for conventional radiation treatment than for IMRT services.

2) Equipment Utilization Rate for Linear Accelerators

Based on the RUC recommendations for the new codes that describe radiation treatment services, CMS does not believe the default assumptions regarding equipment usage are accurate for the capitated equipment used in radiation treatment services. The RUC recommendations assume that the same type of linear accelerator is now typically used to furnish all levels and types of external beam radiation treatment services because the machines previously used to furnish these services are no longer manufactured. In valuing the previous code set and making procedure time assumptions, different equipment items were assumed to be used to furnish the different levels and types of radiation treatment. With the current RUC recommended inputs, CMS can then assume that the same equipment item is used to furnish more services. If it is assumed the RUC recommendation to include the same kind of capital equipment for all of these codes is accurate, CMS believes that it is illogical to continue to assume that the equipment is only used for 25 out of a possible 50 hours per week. In order to estimate the difference between the previous number of minutes the linear accelerator was assumed to be in use under the previous valuation and the number of minutes now being recommended, CMS applied the change in assumptions to the services reported in the most recent year of Medicare claims data. Under the assumptions reflected in the previous direct PE inputs, the kind of linear accelerator used for IMRT made up a total of 44.8 million out of 65 million minutes of external beam treatments furnished to Medicare beneficiaries. Under the new code set, however, a single kind of linear accelerator would be used for all of the 65 million minutes furnished to Medicare beneficiaries. This represents a 45 percent increase in the aggregate amount of time that this kind of linac is in use. Of course, the utilization rate that corresponds with that increase in minutes is not necessarily precise since the current utilization rate only reflects the default assumption and is not itself rooted in empirical data. Additionally, in some cases, individual practices that already use linear accelerators for IMRT may have replaced the now-obsolete capital equipment with new, additional linear accelerators instead of increasing the use of capital equipment already owned. However, CMS does not believe that the latter scenario is likely to be common in cases where the linear accelerators had previously been used only 25 hours per week.

Therefore, CMS proposed to adjust the equipment utilization rate assumption for the linear accelerator to account for the significant increase in usage. Instead of applying the default 50 percent assumption, they proposed to use a 70 percent assumption based on the recognition that the item is now being typically used in a significantly broader range of services, and that would increase its overall usage in comparison to the previous assumption. CMS noted that they developed the 70 percent rate based on a rough reconciliation between the number of minutes the equipment is being used according to the new recommendations versus the current number of minutes based on an analysis of claims data.
CMS believes that comparing the changes in direct PE input recommendations and using the Medicare claims data indicates that the utilization assumption to 70 percent is more accurate than the default utilization assumption of 50 percent. However, they have reviewed other information that suggests this utilization rate may be higher than 70 percent and that the number of available hours per week is greater than 50.

For example, as part of the 2014 RUC recommendations for the Radiation Treatment Delivery codes, the RUC submitted a 2011 staffing survey conducted by the American Society for Radiology Technicians (ASRT). Using the 2014 version of the same study, CMS noted that there are an average of 2.3 linacs per radiation treatment facility and 52.7 patients per day treated per radiation treatment facility. These data suggest that an average of 22.9 patients is treated on each linac per day. Using an average of the RUC-recommended procedure times for CPT codes 77385, 77386, 77402, 77407, and 77412 weighted by the annual volume of procedures derived from Medicare claims data yielded a total of 670.39 minutes or 11.2 hours that a single linac is in use per day. This is in contrast to both the number of hours of use reflected in the default assumptions (5 of the 10 available business hours per day) and in the proposed revision to the proposed revision to the equipment utilization rate assumption (7 hours out of 10 available business hours per day).

Given the fact that it is likely that the transition to the linear accelerator began prior to the 2013 revaluation of the radiation treatment delivery codes by CPT and that the useful life of the newest generation of linear accelerator is 7 years, CMS believes a 2-year transition to the 70 percent utilization rate assumption would account for any remaining time to transition to the new equipment. Therefore, in developing PE RVUs for these services, CMS proposed to use a 60 percent utilization rate assumption for CY 2016 and a 70 percent utilization rate assumption for CY 2017. Additionally, CMS sought empirical data on the capital equipment costs, including equipment utilization rates, for the linac and other capital-intensive machines, and comment on how to most accurately address issues surrounding those costs within the PE methodology.

The ACR recommended that CMS delay the implementation of this equipment utilization assumption change until 2017, which would allow time to monitor utilization changes that may stem from the implementation of the new treatment delivery codes. We asked that if CMS decided not to delay implementation, they extend the phase-in period to four years to mitigate the significant payment cuts caused by this policy. In addition, the ACR urged CMS to modify the proposal for radiation oncology practices that serve medically underserved populations by maintaining the equipment utilization rate assumption of 50 percent. Finally, we noted that it appeared that CMS applied the increased utilization rate change to all equipment items, beyond just the linear accelerator. We stated that this is inconsistent with the text of the proposed rule and inappropriately magnifies the impact of the adjustment.

CMS responded that they considered a longer phase-in period, however, they did not identify any persuasive rationale for delaying implementation or phasing in implementation over more than 2 years. CMS also acknowledged the application of the increased utilization rate assumption to all equipment items generally located in the same
The ACR also commented on a rank order anomaly issue in the PE RVUs among CPT codes 77402, 77407, and 77412 which assigns a higher RVU to the intermediate radiation treatment delivery code than the complex radiation treatment delivery code. We suggested that the anomaly may be a result of the allocation of indirect PE because the specialty reporting the utilization for the intermediate code is more frequently dermatology than radiation oncology and dermatology is allocated more indirect PE within the PE methodology. CMS responded that they agree with commenters that this rank order anomaly is due to a difference in the mix of specialties in the utilization for these services.

CMS believes that the best approach to correct the issue would be to maintain the total number of PE RVUs for these services overall, but to redistribute them among the three codes in order to eliminate the rank order anomaly. In order to do this, they would calculate the PE RVUs for these services under the established methodology and multiply these RVUs by the volume associated with each code. They would then reallocate the total number of PE RVUs among the three codes based on the weights of their direct costs included in the direct PE input database, since the total direct costs for these codes reflect appropriate valuation. CMS is seeking comment on this approach or other possible ways to mitigate the impact of the rank order anomaly among these codes.

In consideration of comments received, CMS does not believe that they should finalize the new code set for CY 2016. Therefore, did not finalize the proposal to implement the new code set. They will continue to use the current G-codes and values for CY 2016 while they seek more information, including public comments and recommendations regarding new codes to be developed either through the CPT process or through future MPFS rulemaking.

CMS finalized the proposals to include the single linear accelerator for radiation treatment delivery services as recommended by the RUC and to update the default utilization rate assumption for linear accelerators used in radiation treatment services from 50 to 70 percent, phased in over 2 years.

CMS also notes that they will engage in market research to develop independent estimates of utilization and pricing for linear accelerators and image guidance used in furnishing radiation treatment services. They will also consider how data collected from hospitals under the OPPS may be helpful in establishing rates for these and other technical component services.

3) Superficial Radiation Treatment Delivery

In the CY 2015 MPFS final rule with comment period, CMS noted that changes to the CPT prefatory language modify the services that are appropriately billed with CPT code 77401 (radiation treatment delivery, superficial and/or ortho voltage, per day). The changes effectively meant that many other procedures supporting superficial radiation therapy were bundled with 77401. The RUC, however, did not review the inputs for superficial radiation therapy
procedures, and therefore, did not assess whether changes in its valuation were appropriate in light of this bundling. In the CY 2015 MPFS final rule with comment period, CMS requested information on whether the new radiation therapy code set combined with modifications in prefatory text allowed for appropriate reporting of the services associated with superficial radiation and whether the payment continued to reflect the relative resources required to furnish superficial radiation therapy services.

In response to the request, CMS received a recommendation from a stakeholder to make adjustments to both the physician work and PE components for code 77401. The stakeholder suggested that since crucial aspects of the service, such as treatment planning and device design and construction, were not currently reflected in 77401, and practitioners were precluded from reporting these activities separately, that physician work should be included for CPT code 77401. Additionally, the stakeholders suggested that the current inputs used to value the code are not accurate because the inputs include zero physician work and minutes for a radiation therapist to provide the service directly to the patient. The stakeholders suggested, alternatively, that physicians, not radiation therapists, typically provide superficial radiation services directly. Therefore, CMS solicited recommendations from other stakeholders, including the RUC, regarding whether or not it would be appropriate to add physician work for this service and remove minutes for the radiation therapists, even though physician work is not included in other radiation treatment services.

CMS also sought information on the possible inclusion of nurse time for this service as part of the comments and/or recommendations regarding physician work for the service.

**Given disagreement among commenters on the work involved in furnishing CPT code 77401, CMS is considering the possibility of creating a code to describe total work associated with the course of treatment for these services and is seeking additional information on alternative descriptions and valuations for such a code for consideration in future rulemaking.**

CMS reviewed the submitted invoices for the request to update the capital equipment for the service and proposed to update the equipment item ER045 “orthovoltage radiotherapy system” by renaming it “SRT-100 superficial radiation therapy system” and updating the price from $140,000 to $216,000, on the basis of the submitted invoices. **CMS finalized this update as proposed.**

Genitourinary Catheter Procedures (CPT Codes 50430, 50431, 50432, 50433, 50434, 50435, 50693, 50694, and 50695) (Page 269)

For CY 2016, the CPT Editorial Panel deleted six codes (50392, 50393, 50394, 50398, 74475, and 74480) that were commonly reported together, and are creating 12 new codes both to describe these genitourinary catheter procedures more accurately and to bundle inherent imaging services. Three of these codes (506XF, 507XK, and 507XL) were referred back to CPT to be resurveyed as add-on codes. The other nine codes were reviewed at the January 2015 RUC meeting and assigned recommended work RVUs and direct PE inputs.
1) Work RVUs

CMS proposed to use the RUC-recommended work RVU of 3.15 for CPT code 50430. They agreed that this is an appropriate value, and that the code should be used as a basis for establishing relativity with the rest of the family. As a result, CMS began by making comparisons between the service times of CPT code 50430 and the other codes in the family in order to determine the appropriate proposed work value of each procedure.

For CPT code 50431, CMS disagreed with the RUC recommended work RVU of 1.42, and they instead proposed a work RVU of 1.10, based on three separate data points. First, the RUC summary of recommendations stated that CPT code 50431 describes work previously described by a combination of CPT codes 50394 and 74425. These two codes have work RVUs of 0.76 and 0.36, respectively, which sum together to 1.12. Second, CMS noted that the work of CPT code 49460 (Mechanical removal of obstructive material from gastrostomy) is similar, with the same intraservice time of 15 minutes and same total time of 55 minutes but a work RVU of 0.96. Finally, CMS observed that the minimum survey result had a work RVU of 1.10, and they believe this value appropriately reflects the total work for the service. Accordingly, CMS proposed 1.10 as the work RVU for CPT code 50431.

CMS employed a similar methodology to develop a proposed work RVU of 4.25 for CPT code 50432. The three previously established codes are being combined in CPT code 50432; these had respective work values of 3.37 (CPT code 50392), 0.54 (CPT code 74475), and 0.36 (CPT code 74425); together these sum to 4.27 work RVUs. CMS also looked at valuing CPT code 50432 based on relativity with other codes in the family. The ratio of the intraservice time of 35 minutes for CPT code 50430 and the intraservice time of 48 minutes for CPT code 50432; applied to the work RVU of base code 50430 (3.15) results in a potential work RVU of 4.32. The total time compared to CPT code 50430 also went from 91 minutes to 107 minutes and this ratio applied to the base work RVU results in a work RVU of 3.70. CMS utilized these data to inform their choice of an appropriate crosswalk. They believe CPT code 31660 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance) is an appropriate reference crosswalk for CPT code 50432. CPT code 31660 has an intraservice time of 50 minutes, total time of 105 minutes, and a work RVU of 4.25. Therefore, CMS proposed to establish the work RVU for CPT code 50432 at the crosswalked value of 4.25 work RVUs.

According to the RUC recommendations, CPT codes 50432 and 50433 are very similar procedures, with CPT code 50433 making use of a nephroureteral catheter instead of a nephrostomy catheter. The RUC valued the added difficulty of CPT code 50433 at 1.05 work RVUs compared to code CPT code 50432. CMS maintained the relative difference in work between these two codes by proposing a value of 5.30 for CPT code 50433. (This is the work RVU of 4.25 for CPT code 50432 plus 1.05 RVUs.) Additionally, CMS used CPT code 57155 (Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy) as their reference crosswalk. CPT code 57155 has a work RVU of 5.40 and an identical intraservice time of 60 minutes, but it also has fourteen additional minutes of total time, 133 minutes compared to 119 minutes for CPT code 50433, which supports the difference of 0.10 RVUs. For these reasons, CMS proposed the value of CPT code 50433 at 5.30 work RVUs.
As with the other genitourinary codes, CMS developed the proposed work value of CPT code 50434 in order to preserve relativity within the family. CPT code 50434 has 15 fewer minutes of intraservice time compared to CPT code 50433 (45 minutes compared to 60 minutes). This is a ratio of 0.75, applied to the base work RVU of CPT code 50433 (5.30) resulted in a potential work RVU of 3.98. CPT code 50432 was another close match within the family, with 3 more minutes of intraservice time compared to 50434, 48 minutes of intraservice time instead of 45 minutes. This ratio (0.94) applied to the base work RVU of CPT code 50432 (4.25) also resulted in a potential work RVU of 3.98. Based on this information, CMS identified CPT code 31634 (Bronchoscopy, rigid or flexible, with balloon occlusion) as an appropriate crosswalk, and proposed a work RVU of 4.00 for CPT code 50434. The two codes share an identical intraservice time of 45 minutes, though the latter possesses a lower total time of 90 minutes.

For CPT code 50435, CMS considered how the code and work RVU would fit within the family in comparison to the proposed values for CPT codes 50430 and 50432. CPT code 50430 serves as the base code for this group; it has 35 minutes of intraservice time in comparison to 20 minutes for CPT code 50435. This intraservice time ratio of 0.57 resulted in a potential work RVU of 1.80 for CPT code 50435 when applied to the work RVU of CPT code 50430 (3.15). Similarly, CPT code 50432 is the most clinically similar procedure to CPT code 50435. CPT code 50432 has 48 minutes of intraservice time compared to 20 minutes of intraservice time for CPT code 50435. This ratio of 0.42 applied to the base work RVU of CPT code 50432 (4.25) results in a potential work RVU of 1.77. CMS also made use of two crosswalks to help determine a proposed value for CPT code 50435. CPT code 64416 (Injection, anesthetic agent; brachial plexus) also includes 20 minutes of intraservice time and has a work RVU of 1.81. CPT code 36569 (Insertion of peripherally inserted central venous catheter) has the same intraservice and total time as CPT code 50435, with a work RVU of 1.82. Accordingly, CMS crosswalked the work RVU for CPT code 50435 to CPT code 36569 and proposed a work RVU of 1.82 for CY 2016.

The remaining three codes all utilize ureteral stents and form their own small subfamily within the larger group of genitourinary catheter procedures. For CPT code 50693, CMS proposed a work RVU of 4.21, which is the 25th percentile result from the survey information. CMS believes that the 25th percentile provides a more accurate value for CPT code 50693 based on the work involved in the procedure and within the context of other codes in the family. They also referenced CPT code 31648 (Bronchoscopy, rigid or flexible, with removal of bronchial valve), which shares 45 minutes of intraservice time and has a work RVU of 4.20, as an appropriate crosswalk for CPT code 50693.

For CPT code 50694, CMS compared its intraservice time to the code within the family that had the most similar duration, CPT code 50433. This code has 60 minutes of intraservice time compared to 62 minutes for CPT code 50694. This is a ratio of 1.03 applied to the base work RVU of CPT code 50433 (5.30) resulted in a potential work RVU of 5.48. CMS also looked to crosswalks with similar numbers, in particular CPT code 50382 (Removal and replacement of internally dwelling ureteral stent). This code has 60 minutes of intraservice time, 125 minutes of total time, and a work RVU of 5.50. For these reasons, CMS crosswalked CPT code 50694 to CPT code 50382 and proposed a work RVU of 5.50.
Finally, CMS developed the proposed value for CPT code 50695 using three related methods. CPT codes 50694 and 50695 describe very similar procedures, with 50695 adding the use of a nephrostomy tube. The RUC addressed the additional difficulty of this procedure by recommending 1.55 more work RVUs for CPT code 50695 than for CPT code 50694. Adding the 1.55 work RVUs to the proposed work RVU for CPT code 50694 (5.50) would produce a work RVU of 7.05 for CPT code 50695. CMS also looked at the ratio of intraservice times for CPT code 50695 (75 minutes) and the base code in the subfamily, CPT code 50693 (45 minutes). The intraservice time ratio between these two codes is 1.67 when applied to the base work RVU of CPT code 50693 (4.21) resulted in a potential work RVU of 7.02. CMS also identified an appropriate crosswalk reference in CPT code 36481 (Percutaneous portal vein catheterization by any method) which shares the same intraservice time as CPT code 50695 and has a work RVU of 6.98. Accordingly, to maintain relativity among this subfamily of codes, CMS proposed a work RVU of 7.05 for CPT code 50695 based on an incremental increase of 1.55 RVUs from CPT code 50694.

2) Practice Expense Inputs

In reviewing the direct PE inputs for this family of codes, CMS refined a series of the RUC recommended inputs in order to maintain relativity with current standards. All of the following refinements refer to the non-facility setting for this family of codes. Under the clinical labor inputs, CMS proposed to remove the RN/LPN/MTA (L037D) (intraservice time for assisting physician in performing procedure) for CPT codes 50431 and 50435. This amounts to 15 minutes for CPT code 50431 and 20 minutes for CPT code 50435. Moderate sedation is not inherent in these procedures and, therefore, CMS does not believe that this clinical labor task would typically be completed in the course of this procedure. They also reduced the RadTech (L041B) intraservice time for acquiring images from 47 minutes to 46 minutes for CPT code 50694. This procedure contains 62 minutes of intraservice time, with clinical labor assigned for acquiring images (75 percent) and a circulator (25 percent). The exact time for these clinical labor tasks multiplies out to 46.5 minutes and 15.5 minutes, respectively. The RUC recommendation for CPT code 50694 rounded both of these values upwards, assigning 47 minutes for acquiring images and 16 minutes for the circulator, which together sum to 63 minutes. CMS reduced the clinical labor time for acquiring images to 46 minutes to preserve the 62 minutes of total intraservice time for CPT code 50694.

During the post-service portion of the clinical labor service period, CMS proposed to change the labor type for the “patient monitoring following service/check tubes, monitors, drains (not related to moderate sedation)” input. There are 45 minutes of clinical labor time assigned under this category to CPT codes 50430, 50432, 50433, 50434, 50693, 50694, and 50695. Although CMS agreed that the 45 minutes are appropriate for these procedures as part of moderate sedation, they changed the clinical labor type from the recommended RN (L051A) to RN/LPN/MTA (L037D) to reflect the staff that will typically be doing the monitoring for these procedures. Even though the CPT Editorial Committee’s description of post-service work for CPT code 50435 includes a recovery period for sedation, CMS recognized that according to the recommendation, CPT codes 50431 and 50435 do not use moderate sedation, so they did not propose to include moderate sedation inputs for these codes.
The RUC recommendation for CPT code 50433 included a nephroureteral catheter as a new supply input with an included invoice. However, in the RUC summary of recommendations for this code, there is no mention of a nephroureteral catheter in the intraservice work description. CPT code 50433 did mention the use of a nephroureteral stent in this description, but there is no request for a nephroureteral stent supply item on the PE worksheet for this code. CMS sought clarification from stakeholders regarding the use of the nephroureteral catheter for CPT code 50433. They did not propose to add the nephroureteral catheter as a supply item for CPT code 50433 pending this information. CMS also requested a clarification to the intraservice work description in the summary of recommendations for this code to explain the use, if any, of the nephroureteral catheter in this procedure.

The RUC recommended the inclusion of “room, angiography” (EL011) for this family of codes. CMS did not agree with the RUC that an angiography room would be used in the typical case for these procedures, as there are other rooms available which can provide fluoroscopic guidance. Most of the codes that make use of an angiography room are cardiovascular codes, and much of the equipment listed for this room would not be used for non-cardiovascular procedures. CMS therefore proposed to replace equipment item “room, angiography” (EL011) with equipment item “room, radiographic-fluoroscopic” (EL014) for the same number of minutes. CMS requested public comment regarding the typical room type used to furnish the services described by these CPT codes, as well as the more general question of the typical room type used for GU and GI procedures. In the past, the RUC has developed broad recommendations regarding the typical uses of rooms for particular procedures, including the radiographic-fluoroscopy room. CMS believes that such a recommendation from the RUC concerning all of these codes could be useful in ensuring relativity across the MPFS.

Comments and CMS Response

The ACR commented that we disagreed with the methodology CMS used to arrive at the proposed values. We stated that by relying solely on intraservice time, this method of valuation does not account for the differences in work, intensity, risk, and skill required to perform each individual procedure. CMS responded by noting that these refined work RVUs were supported in all cases by the use of crosswalks to existing CPT codes which they believe reflect similar intensity, which further supported the refined work RVUs.

The ACR also disagreed with CMS’ use of crosswalks to other CPT codes. The proposed crosswalks were consistently dissimilar from the codes being valued. The crosswalks share either time or work values that match the proposals from CMS; however, the physician work between the codes is not appropriately comparable. CMS responded that they maintain that their crosswalks are appropriate.

CMS finalized the proposed work RVUs for this family of codes.

The ACR also strongly disagreed with CMS’ proposal to eliminate the RN/LPN/MTA blend (L037D) of clinical labor for assisting the physician during procedures 50431 and 50435. The CMS rationale was based on the lack of moderate sedation taking place in these two procedures. The ACR commented that these procedures do require monitoring for patient stability that the
attending physician cannot provide. **CMS responded that they are not aware of any other procedures in which there is a third assistant in the procedure room when moderate sedation is not being provided. They believe that the standard use of clinical labor staff would be typical when performing these procedures.**

The ACR also disagreed with the CMS proposal to substitute an RN with a nurse blend for post-procedure monitoring tasks. The ACR worked closely with the RUC/PE Subcommittee when guidelines were established for post-procedure monitoring. The specialty societies made compelling arguments for the use of an RN in post-procedure monitoring in non-vascular and vascular interventional procedures. CMS responded that after consideration of comments, they agree that the use of the RN clinical labor is typical for patient monitoring following service for these particular specialty groups. Therefore, **CMS restored the recommended L051A labor type for this clinical labor task for CPT codes 50430, 50432, 50433, 50434, 50693, 50694, and 50695. CMS will also consider making a formal proposal regarding the most suitable type of clinical labor staff for this monitoring in future rulemaking.**

CMS sought clarification regarding the use of the nephroureteral catheter (SD306) for CPT code 50433. CMS removed this supply from CPT code 50433 since it was not mentioned in the information about the survey included in the RUC recommendation. The ACR explained in our comment letter that the phrase “An 8 Fr nephroureteral stent is inserted with the distal pigtail in the bladder” is included in the description of work for CPT code 50433, and in the context of genitourinary and biliary procedures, the historic term “stent” has been used interchangeably with the term “catheter”. We requested that the nephroureteral catheter should be maintained as a supply item for this code and for CPT code 50434. **CMS responded that they agree that the nephroureteral catheter should be maintained as a supply item for CPT codes 50433 and 50434, based on the presentation of this additional information.**

The ACR also disagreed with the CMS decision to replace the angiography room (EL011) with a fluoroscopic room (EL014) for the genitourinary catheter family of codes. We stressed that the fluoroscopic room is incapable of 3-axis rotational imaging, that it would require dangerous movement of the patient, and that it presents sterility concerns. We also disagreed that use of the angiography room was typically limited to cardiovascular procedures. The ACR suggested that looking at service utilization, rather than number of CPT codes, indicates that non-vascular interventional procedures together comprise more than 50 percent of utilization of a typical angiography room. We provided a list of the equipment found in an angiography room, and stated that everything other than the “Injector, Provis” would be typically utilized for the genitourinary catheter procedures. We urged CMS to reverse the proposed refinement and restore the use of the angiography room for these codes.

**CMS responded that they continue to believe that the use of an angiography room would not be typical for these genitourinary catheter procedures. The new genitourinary catheter codes in this family are being constructed through the bundling of imaging guidance with previously existing genitourinary catheter procedures. With the exception of CPT code 50398, the direct PE inputs for the predecessor codes do not include the use of an angiography room. CMS indicated that they do not have reason to believe the coding changes related to these procedures would necessitate the use of different technology in furnishing the services. While it is true that the**
angiography room was included as a direct PE input for some of the predecessor imaging services, such as CPT codes 77475, 77480, and 77485, the equipment times for these services were significantly shorter than the time included for the base procedures, where use of the room was not considered to be typical. Given the six fold increase in recommended time and the significantly higher expenses of the newly recommended equipment versus the equipment costs associated with the predecessor codes, CMS seeks not only a rationale for the use of the angiography room, but also evidence that this room is typically used when these services are reported in the nonfacility setting.

In response to comments received, CMS restored one pair of sterile gloves, one sterile surgical gown, one IV starter kit, and one threeway stop cock to these codes, consistent with the RUC recommendation.

After consideration of comments received, CMS finalized the direct PE inputs as proposed, with the addition of the nephroureteral catheter for CPT code 50433, the change in clinical labor type from L037D to L051A for patient monitoring following service (not related to moderate sedation), and the additional four supplies detailed in the previous paragraph for CPT codes 50430, 50432, 50433, 50434, 50693, 50694, and 50695.

Spinal Instability (CPT code 72081, 72082, 72083, and 72084) (Page 292)

For CY 2015, the CPT Editorial Panel deleted codes 72010 (radiologic examination, spine, entire, survey study, anteroposterior and lateral), 72069 (radiologic examination, spine, thoracolumbar, standing (scoliosis)), and 72090 (radiological examination, spine; scoliosis study, including supine and erect studies), revised one code, 72080 (Radiologic examination, spine; thoracolumbar junction, minimum of 2 views) and created four new codes which cover radiologic examination of the entire thoracic and lumbar spine, including the skull, cervical and sacral spine if performed. The new codes were organized by number of views, ranging from one view in 72081, two to three views in 72082, four to five views in 72083, and minimum of 6 views in 72084.

In the proposed rule, CMS disagreed with the RUC’s work RVU recommendations for these four codes. For 72081, CMS noted that the one minute increase in time resulted in a larger work RVU than would be expected when taking the ratio between time and RVU in the source code and comparing that to the time and work RVU ratio in the new code. Using the relationship between time and RVU from deleted code 72069, CMS proposed a work RVU of 0.26 for 72081, which differs from the RUC-recommended value of 0.30. Using an incremental methodology based on the relationship between work and time in the first code they proposed to adjust the RUC recommended work RVUs for CPT codes 72082, 72083 and 72084 to, respectively, 0.31, 0.35, and 0.41.

The ACR disagreed with CMS’ rationale for lowering the value of 72081. We and other commenters stated that since CPT code 72069 is being deleted due to changes in technology and patient population, it is a poor comparison. Other commenters pointed out that CPT code 72081 typically includes an X-ray of skull, cervical spine, and pelvis and therefore is by definition more
work than CPT code 72069. CPT code 72069 is also noted as “CMS/other” code in the RUC’s time file and the times in that file are not divided into time periods as CPT code 72081 is.

CMS responded that they continue to believe that CPT code 72069 is an accurate crosswalk. While CPT code 72069 may not be divided into time periods, the ratio between the total time and the RVU adequately reflects the relationship between time and intensity in CPT code 72081. Although CMS used CPT code 72069 as a comparison to CPT code 72081, they note that CPT code 72081 has a higher work RVU, which accounts for the extra work associated with imaging the skull, cervical spine, and pelvis.

After considering comments received, CMS finalized the work RVUs for 72081, 72082, 72083, and 72084 as proposed.

Lung Cancer Screening Counseling and Shared Decision Making Visit and Lung Cancer Screening with Low Dose Computed Tomography (CPT Codes G0296 and G0297) (Page 304)

CMS issued a national coverage determination (NCD) for the coverage of a lung cancer screening counseling and shared decision making visit and, for appropriate beneficiaries, annual screening with low dose computed tomography (LDCT) as an additional preventive benefit in February 2015. The ACR submitted recommendations for work and direct PE inputs and CMS acknowledged these recommendations. The ACR recommended that CMS crosswalk G0297 to 71250 (computed tomography, thorax; without contrast material) with additional physician work added to account for the added intensity of the service and reiterated the recommendations in our proposed rule comment letter. After reviewing this recommendation, CMS continues to believe that the physician work (time and intensity) is identical in both G0297 and 71250, and therefore, they finalized the proposed work RVU of 1.02 for G0297.

CMS proposed to value the lung cancer screening counseling and shared decision making visit (G0296) using a crosswalk from the work value for G0443 (Brief face-to-face counseling for alcohol misuse, 15 minutes) which has a work RVU of 0.45. They added 2 minutes of pre-service time, and 1 minute post-service time which CMS valued at 0.0224 RVU per minute yielding a total of 0.062 additional RVUs which they then added to 0.45, bringing the total proposed work RVUs for G0296 to 0.52.

The ACR asked CMS to clarify whether the shared decision making visit could be billed on the same day as a E/M visit. CMS responded that as long as the NCD requirement for the counseling and shared decision making visit are met, the counseling visit may be billed on the same day as a medically necessary E/M visit or an annual wellness visit with the -25 modifier. CMS also clarified that the shared decision making visit would not be subject to coinsurance or deductibles.

With regard to billing instructions for retroactive payment for 2015 claims, CMS indicated that they are in the process of developing claims processing, coding, and billing instructions and this information is forthcoming.
CMS addresses each code for which they received comments on the CY 2015 interim final work RVU or work time during the comment period for the CY 2015 final rule or for which they are modifying the CY 2015 interim final work RVU, work time, or procedure status indicator for CY 2016. Table 13, beginning on page 349 of the display copy of the CY 2016 final rule summarizes actions on codes with CY 2015 interim final values.

Myelography (CPT codes 62284, 62302, 62303, 62304, 62305, 72240, 72255, 72265, and 72270) (Page 380)

The ACR commented that while the RUC recommended a single staff type (L037D – RN/LPN/MTA) for the bundled myelography codes, allocating the physician intra-service time to that staff, CMS divided the time between L037D and L041B (RT). We do not believe it is typical to have two staff involved in the procedure and suggested allocating all minutes to L037D.

CMS agreed with the ACR’s comments and changed the clinical labor type from L041B to L037D for the clinical labor activities “Availability of prior images confirmed”, “Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocolled by radiologist” and “Assist physician in performing procedure” for CPT codes 62302, 62303, 62304, and 62305. This ensures a single staff type for each of the nine codes in this family.

Maxillofacial Computed Tomography (CPT codes 70486, 70487, and 70488) (Page 381)

The ACR commented that we were disappointed that CMS did not accept the RUC recommendations for CPT codes 70487 and 70488. The RUC recommended the 25th percentile survey values across the family, providing appropriate comparison codes. CMS reduced the values of 70487 and 70488 to equal the comparable head CT codes, 70460 (Computed tomography, head or brain; with contrast material(s)) and 70470 (Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections), respectively. While the head CT codes are comparable in service period times, the maxillofacial CT is more complex and intense, as was described in the specialty society recommendations.

CMS responded that they continue to believe that the interim final values are accurate and that the refinement panel request did not include information reflecting new clinical evidence, and therefore, did not meet the established criteria for review by the multidisciplinary refinement panel.

In response to a comment received, CMS added 3 minutes for “provide pre-service education and obtain consent in the direct PE input database for CPT codes 70487 and 70488.

Breast Ultrasound (CPT codes 76641 and 76642) (Page 382)
The ACR requested that CMS refine the input for ultrasound room from 27 minutes to 29 minutes for CPT code 76641 and from 20 to 22 minutes for CPT code 76642 because ultrasound uses distinctive imaging equipment. All clinical labor tasks require usage of the machine, making the room unavailable during that time. CMS responded that the number of minutes assigned to the ultrasound room for both codes conforms to established times for highly technical equipment. CMS believes that adherence to these standard methodologies maintains relativity within the development of PE RVUs. Therefore, CMS finalized the interim final direct PE inputs for these services.

Breast Tomosynthesis (CPT codes 77061, 77062, and 77063) (Page 384)

In the CY 2015 PFS final rule with comment period, CMS assigned a PFS indicator of “I” to CPT codes 77061 and 77062 on an interim basis while awaiting recommendations from the RUC for all mammography services. Since CPT code 77063 is an add-on code and did not have an equivalent CY 2014 code, CMS believed it was appropriate to value it on an interim final basis in advance of receiving the RUC recommendations for other mammography services. CMS assigned it a CY 2015 interim final work RVU of 0.60 as recommended by the RUC. They also removed the equipment time for the PACS Workstation proxy from all three codes, and removed the time for task “Federally Mandated MQSA Activities Allocated To Each Mammogram” from CPT code 77063.

The ACR provided extensive comments to CMS on this topic and stated that the CMS-revised coding structure will create confusion among providers as they will be required to bill differently for Medicare and private payer patients. The ACR also expressed concern with the value of the G code created by CMS.

After consideration of comments received, CMS finalized the PFS indicator “I” for CPT codes 77061 and 77062, the interim final work RVU of 0.60 for CPT code 77063, and the interim final direct PE inputs for all three codes.

Dosimetry (CPT Codes 77300, 77306, and 77307) (Page 384)

The ACR requested that CMS consider equipment item ED011 (record and verify) as a direct PE input because it is typically used during the procedures. CMS reviewed the “record and verify” equipment item and agreed with commenters that “record and verify” should be included as a direct PE to maintain consistency with other services in the direct PE database, and updated the direct PE input database accordingly.

Brachytherapy Isodose Plan (CPT Codes 77316, 77317, and 77318) (Page 385)

For CY 2015, the CPT Editorial Panel replaced six CPT codes (77305, 77310, 77315, 77326, 77327, and 77328) with five new CPT codes to bundle basic dosimetry calculation(s) with teletherapy and brachytherapy isodose planning. CMS established interim final work RVUs based on the RUC-recommended work RVUs for CY 2015 for all of the codes in this family except CPT code 77316. Instead of using the RUC-recommended work RVU for CPT code 77316, a simple isodose planning code, CMS developed an interim final work RVU based on a
The ACR disagreed with CMS' refinements to CPT code 77316 and stated that although CPT code 77316 is the simple isodose planning code in the family, the CMS recommended crosswalk to CPT code 77306 does not accurately capture the intensity of the procedure. Commenters suggested that CPT code 77316 is typically used for HDR brachytherapy with a single channel and more than four dwell positions. This requires more work than CPT code 77306, which is for external beam radiation planning.

CMS believes that if the work resources for the complex isodose planning codes are comparable between the two families, then the work resources between the simple isodose planning codes are also comparable. Therefore, CMS believes that the most accurate work RVU for CPT code 77316 is 1.40, based on a crosswalk to CPT code 77306.

Duplex Scans (CPT codes 93880, 93882, 93886, 93888, 93926, 93975, 93976, 93977, 93978 and 93979) (Page 392)

The ACR was disappointed that CMS did not accept the RUC recommendations for CPT codes 93975 and 93976. CMS made the following generalization which affected 93975 and 93976: across the entire Doppler/duplex family, all codes with 15 minutes of intra-service time would be assigned the 25th percentile survey value. However, 93975 includes 20 minutes of intra-service time so this generalization would not apply, even if it were appropriate. The ACR believes that CMS' rationale for not accepting the RUC recommendations for this code is inadequate. The ACR disagrees with such time-based generalizations since this ignores the importance of magnitude estimation within the larger RBRVS. Transabdominal/transpelvic Doppler examinations are generally more intense than Doppler studies of other parts of the body such as the extremities so warrant consideration of the median survey value. Even though code 93976 is a limited study, it involves both arterial inflow and venous outflow evaluation of an organ justifying the increased intensity. The ACR also believes that clinical considerations were not adequately considered in applying these reductions so we requested refinement panel review of codes 93975 and 93976.

CMS lowered the RUC recommendation for 93886 from 1.00 RVU to 0.91 RVU based on a comparison to the value accepted for CPT code 93880 (Duplex scan of extracranial arteries; complete bilateral study) of 0.80 RVU with an intra-service time of 15 minutes. CPT code 93886 has an intraservice time of 17 minutes so CMS applied the work RVU to time ratio of CPT code 93880 to the intra-service time of CPT code. The ACR disagreed with this methodology since intra-cranial examinations are greater in intensity than extra-cranial examinations and this difference should be recognized.

CMS made the following generalization which affected 93888: across the entire Doppler/duplex family, all codes with 10 minutes of intra-service time would be assigned a work RVU of 0.50 RVU. The ACR disagrees with such time-based generalizations since this ignores the importance
of magnitude estimation within the larger Resource Based Relative Value Scale (RBRVS). Transcranial Doppler examinations are generally more intense than Doppler studies of other parts of the body, including the extra-cranial circulation. Further, the specialty society recommendation is well supported by the survey key reference service (KRS) 95819 (Electroencephalogram (EEG); including recording awake and asleep) valued at 1.08 RVUs with 15 minutes of intra-service time and 76821 (Doppler velocimetry, fetal; middle cerebral artery) valued at 0.70 RVU with 10 minutes of intra-service time. Given the important clinical considerations described above, the ACR requested referral of both of these codes to the Refinement Panel.

The ACR presented CPT codes 93886, 93888, 93975, and 93976 to the Refinement Panel in August 2015 for further review. However, in the final rule, CMS indicated that two of these codes (93886 and 93888) did not meet the criteria for review. For the other two codes, 93975 and 93976, CMS stated that commenters requested review to the Refinement Panel. CMS finalized the CY 2015 interim final values as established.

CY 2016 Interim Final Codes

For recommendations regarding any new or revised codes received after the February 10, 2015 deadline, including updated recommendations for codes included in the CY 2016 proposed rule, CMS established interim final values in this final rule with comment period, consistent with previous practice.

Below are summaries of the CPT code values that were refined by CMS.

Percutaneous Image Guided Sclerotherapy (CPT Code 49185) (Page 458)

The CPT Editorial Panel created CPT code 49185 (Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s)) to describe percutaneous image-guided sclerotherapy of fluid collections. These services were previously reported using CPT code 20500 (Injection of sinus tract; therapeutic (separate procedure)). To develop recommended work RVUs for CPT code 49185, the RUC used a direct crosswalk from reference code 31622 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed), which has an intraservice time of 30 minutes and work RVU of 2.78.

Although CPT code 31622 is clinically similar to CPT code 49185, CMS does not believe CPT code 31622 has a similar intensity to CPT code 49185. To establish the CY 2016 interim final work RVU for CPT code 49185, CMS instead used a direct crosswalk from CPT code 62305 (injection, radiologic supervision and interpretation), which shares an intraservice time of 30 minutes and is clinically similar, as it also includes an injection, radiologic supervision, and interpretation. CMS established an interim final work RVU of 2.35 for CPT code 49185.

CMS is concerned that supply item SH062 may not be used in the typical case for this procedure. They note that other CPT codes that include supply item SH062 include between 1 and 10 ml. CMS requests that stakeholders review this supply item and provide
invoices to improve the accuracy of pricing. They are also requesting information regarding the price of supply item SH062 given the significant increase in volume used in this procedure relative to other procedures.

_Intracranial Endovascular Intervention (CPT Codes 61645, 61650 and 61651) (Page 461)_

The CPT Editorial Panel created three new codes to describe percutaneous intracranial endovascular intervention procedures and to bundle inherent imaging services. These services were previously reported using CPT codes 61640-61642 (Balloon dilatation of intracranial vasospasm). In establishing interim final values for these services, CMS refined the RUC recommended work RVUs for all of the codes in this family.

**CMS established an interim final work RVU of 15.00 for CPT code 61645.** CMS refined the work time for CPT code 61645 by removing the 55 minutes of work time associated with CPT code 99233 (subsequent hospital care) and instead included the 30 minutes of intraservice time from CPT code 99233 in the immediate postservice time of the procedure. This reduces the total work time from 266 minutes to 241 minutes and increases the immediate post service time from 53 minutes to 83 minutes.

**CMS established an interim final work RVU of 10.00 for CPT code 61650.** CMS also established interim final work time by removing the 55 minutes total time associated with CPT code 99233 (subsequent hospital care) as recommended by the RUC and instead allocating the intraservice time of 30 minutes to the immediate postservice time of the procedure. This reduces the total time from 231 minutes to 206 minutes and the immediate post service time from 45 minutes to 75 minutes.

**CMS established an interim final work RVU of 4.25 for CPT code 61651.**

CMS also refined the RUC-recommended malpractice crosswalks for this family of codes to align with the specialty mix that furnish the services in this family. CMS established the following interim final malpractice crosswalks in place of the RUC-recommended malpractice crosswalks: CPT code 37218 to CPT code 61645; and CPT code 37202 to CPT codes 61650 and 61651.

_Paravertebral Block Injection (CPT Codes 64461, 64462, and 64463) (Page 464)_

In CY 2015, the CPT Editorial Panel created three new codes to describe paravertebral block injections at single or multiple levels, as well as for continuous infusion for the administration of local anesthetic for post-operative pain control and thoracic and abdominal wall analgesia. CMS established as interim final the RUC-recommended work RVUs for CPT codes 64461 and 64462. For CPT code 64463 (Paravertebral block (PVB) (paraspinal block), thoracic continuous infusion by catheter (includes imaging guidance, when performed) the RUC recommended a work RVU of 1.90, which corresponds to the 25th percentile survey result. After considering similar injection codes with identical intra-service time and longer total times, CMS believes the RUC recommendation for CPT code 64463 overestimates the work involved in furnishing the service. They believe a direct crosswalk from three other injection codes which all
have a work RVU of 1.81 (CPT codes 64461, 64446, and 64449) more accurately reflects the work involved in furnishing this service. Therefore, for CY 2016, CMS established an interim final work RVU of 1.81 for CPT code 64463.

Fetal MRI (CPT Codes 74712 and 74713) (Page 468)

For CY 2016, the CPT Editorial Panel established two new codes to describe fetal MRI services, which were previously billed using CPT codes 72195 (Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)), 72196 (with contrast material(s)) and 72197 (without contrast material(s), followed by contrast material(s) and further sequences). For CY 2016, CMS established as interim final the RUC-recommended work RVU of 3.00 for 74712.

The RUC recommended a work RVU of 1.85 for add-on code 74713, with an intra-service time of 35 minutes. Based on the ratio of work to time for these codes, CMS believes that the add-on code should approximate the relationship between work and time in the base code; therefore, CMS established as interim final a work RVU of 1.78 for CPT code 74713, which corresponds to the 25th percentile survey result.

Interstitial Radiation Source Codes (CPT Codes 77778 and 77790) (Page 468)

The RUC identified CPT code 77778 (interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed) and CPT code 77790 (supervision, handling, loading of radiation source) through a misvalued code screen of codes reported together more than 75 percent of the time. After reviewing the entire code family (CPT codes 77776, 77777, 77778, and 77790), the CPT Editorial Panel deleted the interstitial radiation source codes (CPT codes 77776 and 77777) and revised CPT code 77778 to incorporate the supervision and handling of brachytherapy sources previously reported with CPT code 77790.

The RUC recommended that CPT code 77790 be valued without work, and recommended a work RVU of 8.78 for CPT code 77778. CMS established an interim final value for CPT code 77790 without a work RVU, consistent with the RUC’s recommendation. The specialty society’s survey indicated that the total service time for CPT code 77778 was 220 minutes and the median work RVU was 8.78; however, the RUC recommended a total work time of 145 minutes. In reviewing that recommendation, CMS cannot reconcile how the RUC determined that the same survey results that overestimated the time by over 50 percent at the same time accurately estimated the work, given that time is a component of overall work.

CMS believes that the 25th percentile survey result is more likely to represent the typical overall work in a survey in which time is overestimated. Therefore, they established an interim final work RVU of 8.00 for CPT code 77778 based on the 25th percentile survey. However, CMS is also seeking comment regarding the accuracy of the survey results given the significant disparity between the survey results and the considered judgment of the RUC regarding the amount of overall time required to furnish this service.
Colon Transit Imaging (CPT Codes 78264, 78265, and 78266) (Page 469)

For CY 2016, the CPT Editorial Panel revised CPT code 78264 (gastric emptying study) to describe gastric emptying procedure, and also created two new add-on codes, CPT code 78265 (gastric emptying imaging study (eg, liquid, solid, or both); with small bowel transit up to 24 hours) and CPT code 78266 (gastric emptying study (eg, liquid, solid, or both with small bowel and colon transit for multiple days)). The RUC recommendation indicates that the base CPT code 78264 was previously used to report three distinct procedural variations. The new codes were created to describe the services in the procedures.

CMS established as interim final the RUC-recommended work RVUs for CPT codes 78265 and 78266. However, CMS believes the RUC-recommended work RVU of 0.80 overstates the work involved in CPT code 78264. They note that CPT code 78264 has a higher recommended work RVU and a shorter intraservice time relative to the other codes in the family. Additionally, the CY 2016 RUC survey result showed a two minute decrease, from 12 to 10 minutes, in the intraservice time for CPT code 78264. CMS considered reference CPT code 78226 (Hepatobiliary system imaging, including gallbladder when present), as it shares the same intraservice time of 10 minutes and has similar intensity, and used a direct crosswalk from the work RVU of 0.74. **CMS established an interim final work RVU of 0.74 for CPT code 78264.**

CMS requests that stakeholders review the prices and provide invoices or other information on the costs for the supply and equipment items listed in Table 21 (page 474) in order to improve the accuracy of pricing for these and other items in the direct PE database. Additionally, as discussed in section II.A of the proposed rule, CMS reminds stakeholders that due to the relativity inherent in the development of RVUs, reductions in existing prices for any items in the direct PE database increase the pool of direct PE RVUs available to all other PFS services.

**Malpractice RVUs (Page 77)**

For CY 2016, CMS proposed to continue their current approach for determining MP RVUs for new/revised codes. For the new and revised codes for which they include proposed work values and PE inputs in the proposed rule, CMS will also publish the proposed MP crosswalks used to determine their MP RVUs in the proposed rule. The MP crosswalks for those new and revised codes were subject to public comment and finalized in this CY 2016 MPFS final rule. The MP crosswalks for new and revised codes with interim final values established in the CY 2016 final rule will be implemented for CY 2016 and subject to public comment. They will then be finalized in the CY 2017 MPFS final rule with comment period.

**Annual Update for Malpractice RVUs**

For CY 2016, CMS proposed to begin conducting annual MP RVU updates to reflect changes in the mix of practitioners providing services, and to adjust MP RVUs for risk. Under this approach, the specialty-specific risk factors would continue to be updated every five years using updated premium data, but would remain unchanged between the 5-year reviews. However, in an
effort to ensure that MP RVUs are as current as possible, the proposal would involve recalibrating all MP RVUs on an annual basis to reflect the specialty mix based on updated Medicare claims data. Since under this proposal, CMS would be recalculating the MP RVUs annually, they also proposed to maintain the relative pool of MP RVUs from year to year; this will preserve the relative weight of MP RVUs to work and PE RVUs. CMS proposed to calculate the current pool of MP RVUs by using a process parallel to that used in calculating the pool of PE RVUs. To determine the specialty mix assigned to each code, CMS also proposed to use the same process used in the PE methodology, described in section II.2.b.(6) of this proposed rule. They note that for CY 2016, as described above, CMS proposed to modify the specialty mix assignment methodology to use an average of the 3 most recent years of available data instead of a single year of data as is the current policy. CMS anticipates that this change will increase the stability of PE and MP RVUs and mitigate code-level fluctuations for all services paid under the MPFS, and for new and low-volume codes in particular. CMS also proposed to no longer apply the dominant specialty for low volume services, because the primary rationale for the policy has been mitigated by this proposed change in methodology. However, CMS did not propose to adjust the code-specific overrides established in prior rulemaking for codes where the claims data are inconsistent with a specialty that could be reasonably expected to furnish the service. CMS believes that these changes will serve to balance the advantages of using annually updated information with the need for year-to-year stability in values.

**CMS finalized the policies as proposed.**

CMS also proposed an additional refinement in the process for assigning MP RVUs to individual codes. Historically, they have used a floor of 0.01 MP RVUs for all nationally-priced MPFS codes. This means that even when the code-level calculation for the MP RVU falls below 0.005, CMS has rounded to 0.01. In general, CMS believes this approach accounts for the minimum MP costs associated with each service furnished to a Medicare beneficiary. However, in examining the calculation of MP RVUs, CMS does not believe that this floor should apply to add-on codes. Since add-on codes must be reported with another code, there is already an MP floor of 0.01 that applies to the base code, and therefore, to each individual service. By applying the floor to add-on codes, the current methodology practically creates a 0.02 floor for any service reported with one add-on code, and 0.03 for those with 2 add-on codes, etc. Therefore, CMS proposed to maintain the 0.01 MP RVU floor for all nationally-priced MPFS services that are described by base codes, but not for add-on codes. They will continue to calculate, display, and make payments that include MP RVUs for add-on codes that are calculated to 0.01 or greater, including those that round to 0.01. CMS only proposed to allow the MP RVUs for add-on codes to round to 0.00 where the calculated MP RVU is less than 0.005. CMS will continue to study the appropriate frequency for collecting and updating premium data and will address any further proposed changes in future rulemaking.

Several commenters, including the RUC, opposed the proposal to remove the MP RVU floor of 0.01 for add-on services. CMS responded that they do not believe the comments responded to the rationale for the proposed refinement. CMS continues to believe that this refinement is the most appropriate approach, since they would continue to account for the incremental risk associated with add-on codes without overestimating the risk in
circumstances where the MP RVU falls below 0.005. Therefore, CMS finalized the policy as proposed.

**MP RVU Methodology Refinements**

CMS proposed to update the calculation to use a price-adjusted premium (that is, the premium divided by the GPCI) in each area, and then taking a weighted average of those adjusted premiums. The CY 2016 MPFS proposed rule MP RVUs were calculated in this manner.

Additionally, in the calculation of the national average premium for each specialty, the current methodology used the total RVUs in each area as the weight in the numerator (that is, for premiums), and total MP RVUs as the weights in the denominator (that is, for the MP GPCIs). After further consideration, CMS believes that the use of these RVU weights is problematic. Use of weights that are central to the process at hand presents potential circularity since both weights incorporate MP RVUs as part of the computation to calculate MP RVUs. The use of different weights for the numerator and denominator introduces potential inconsistency. Instead, CMS believes that it would be better to use a different measure that is independent of MP RVUs and better represents the reason for weighting. Specifically, CMS proposed to use area population as a share of total U.S. population as the weight. The premium data are for all MP premium costs, not just those associated with Medicare patients, so CMS believes that the distribution of the population does a better job of capturing the role of each area’s premium in the “national” premium for each specialty than the previous Medicare-specific measure. Use of population weights also avoids the potential problems of circularity and inconsistency.

CMS finalized these refinements as proposed.

**Target for Relative Value Adjustments for Misvalued Services**

*Background*

Section 220(d) of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93, enacted on April 1, 2014) added a new subparagraph to the Act to establish an annual target for reductions in MPFS expenditures resulting from adjustments to relative values of misvalued codes. Under section the Act, if the estimated net reduction in expenditures for a year is equal to or greater than the target for the year, reduced expenditures attributable to such adjustments shall be redistributed in a budget-neutral manner within the MPFS in accordance with the existing budget neutrality requirement of the Act. The provision also specifies that the amount by which such reduced expenditures exceeds the target for the year shall be treated as a net reduction in expenditures for the succeeding year, for purposes of determining whether the target has been met for that subsequent year. The Act defines a target recapture amount as the amount by which the target for the year exceeds the estimated net reduction in expenditures under the MPFS resulting from adjustments to RVUs for misvalued codes. The Act also specifies that, if the estimated net reduction in MPFS expenditures for the year is less than the target for the year, an amount equal to the target recapture amount shall not be taken into account when applying the budget neutrality requirements specified in the Act. Section 220(d) of the PAMA applied to
calendar years (CYs) 2017 through 2020 and set the target at 0.5 percent of the estimated amount of expenditures under the MPFS for each of those 4 years.

Section 202 of the Achieving a Better Life Experience Act of 2014 (ABLE) (Division B of Pub. L. 113-295, enacted December 19, 2014)) amended the Act to accelerate the application of the MPFS expenditure reduction target to CYs 2016, 2017, and 2018, and to set a 1 percent target for CY 2016 and 0.5 percent for CYs 2017 and 2018. As a result of these provisions, if the estimated net reduction for a given year is less than the target for that year, payments under the fee schedule will be reduced.

***Distinguishing “Misvalued Code” Adjustments from Other RVU Adjustments***

CMS pointed out that the identification of particular codes as potentially misvalued has led to the review and revaluation of related codes, and frequently, to revisions to the underlying coding for large sets of related services. Similarly, the review of individual codes has initiated reviews and proposals to make broader adjustments to values for codes across the MPFS, such as when the review of a series of imaging codes prompted a RUC recommendation and CMS proposal to update the direct PE inputs for imaging services to assume digital instead of film costs. This change, originating through the misvalued code initiative, resulted in a significant reduction in RVUs for a large set of MPFS services, even though the majority of affected codes were not initially identified through potentially misvalued code screens. Finally, due to both the relativity inherent in the MPFS ratesetting process and the budget neutrality requirements specified in the Act, adjustments to the RVUs for individual services necessarily result in the shifting of RVUs to broad sets of other services across the MPFS.

After considering several options, CMS believes that the best approach is to define the reduction in expenditures as a result of adjustments to RVUs for misvalued codes to include the estimated pool of all services with revised input values. This would limit the pool of RVU adjustments used to calculate the net reduction in expenditures to those for the services for which individual, comprehensive review or broader proposed adjustments have resulted in changes to service-level inputs of work RVUs, direct PE inputs, or MP RVUs, as well as services directly affected by changes to coding for related services. For example, coding changes in certain codes can sometimes necessitate revaluations for related codes that have not been reviewed as misvalued codes, because the coding changes have also affected the scope of the related services. This definition would incorporate all reduced expenditures from revaluations for services that are deliberately addressed as potentially misvalued codes, as well as those for services with broadbased adjustments like film-to-digital and services that are redefined through coding changes as a result of the review of misvalued codes.

CMS also proposed to exclude code-level input changes for CY 2015 interim final values from the calculation of the CY 2016 misvalued code target since the misvalued change occurred over multiple years, including years not applicable to the misvalued code target provision.

CMS notes that the impact of interim final values in the calculation of targets for future years will be diminished as they transition to proposing values for almost all new, revised, and potentially misvalued codes in the proposed rule. They anticipate a smaller number of interim
final values for CY 2016 relative to CY 2015. For calculation of the CY 2018 target, they anticipate almost no impact based on misvalued code adjustments that occur over multiple years.

The ACR requested that CMS should include existing codes which are either being deleted or have changes in utilization as a result of the misvalued code project and/or the CPT Editorial Panel process. CMS clarified in the final rule that they are including changes in values for any codes for which changes in coding or policies may result in differences in how a given service is reported from one year to the next. Under the current ratesetting methodology, CMS already considers how coding revisions change the way services are reported from one year to the next. The crosswalk used to incorporate such changes in methodology is based on RUC and specialty society recommendations that explicitly address the kinds of procedure-to-procedure comparisons suggested by the commenter. Since it reflects the best information available, CMS used the same crosswalk to account for coding changes in the calculation of the target.

The ACR pointed out in our comment letter that it is important to recall the work that the RUC and specialty societies, including to a very significant extent the ACR, have already undertaken since the creation of the misvalued code project in 2006. By implementing this target almost ten years into the misvalued code project, this legislation is essentially penalizing physicians for having undertaken the difficult work of identifying and re-valuing potentially misvalued codes.

After consideration of the public comments received, CMS finalized the proposals as described above.

Calculating “Net Reduction”

Once the RVU changes attributable to misvalued codes are identified, estimated net reductions would be calculated summing the decreases and offsetting any applicable increases in valuation within the changes defined as misvalued, as described above. Because the provision only explicitly addresses reductions, and CMS recognizes many stakeholders will want to maximize the overall magnitude of the measured reductions in order to prevent an overall reduction to the MPFS conversion factor, CMS considered the possibility of ignoring the applicable increases in valuation in the calculation of net reduction. However, CMS believes that the requirement to calculate “net” reductions implies that they are to take into consideration both decreases and increases. Additionally, they believe this approach may be the only practical one due to the presence of new and deleted codes on an annual basis.

For example, a service that is described by a single code in a given year, like intensity modulated radiation therapy (IMRT) treatment delivery, could be addressed as a misvalued service in a subsequent year through a coding revision that splits the service into two codes, “simple” and “complex.” If CMS counted only the reductions in RVUs, they would count only the change in value between the single code and the new code that describes the “simple” treatment delivery code. In this scenario, the change in value from the single code to the new “complex” treatment delivery code would be ignored, so that even if there were an increase in the payment for IMRT treatment delivery service(s) overall, the mere change in coding would contribute inappropriately to a “net reduction in expenditures.” Therefore, CMS proposed to net the increases and decreases
in values for services, including those for which there are coding revisions, in calculating the estimated net reduction in expenditures as a result of adjustments to RVUs for misvalued codes.

The ACR commented that CMS should establish a transparent process to ensure stakeholders can independently verify the updated net reduction calculations each year. We requested that CMS publish the exact target reduction number and individual service-level impacts for each year.

In response to the request for greater transparency, CMS posted a public use file that provides a comprehensive description of how the target is calculated as well as the estimated impact by code family on the CMS website under the supporting data files for the CY 2016 final rule.

After considering public comments, CMS finalized the policy as proposed with a modification to exclude from the calculation of the “net reduction” in expenditures changes in coding and valuation for services, such as care management for CY 2016, that are newly reportable, but for which no corresponding reduction is made to existing codes and instead reductions are taken exclusively through a budget neutrality adjustment.

Measuring the Adjustments

CMS recognizes that the most straightforward method to estimating the net reduction in expenditures due to adjustments to RVUs for misvalued codes is to compare the total RVUs of the relevant set of codes (by volume) in the current year to the update year, and divide that by the total RVUs for all codes (by volume) for the current year. This approach is intuitive and relatively easy to replicate. However, CMS believes this method is imprecise for several reasons. First, and most significantly, the code-level PE RVUs in the update year include either increases due to the redistribution of RVUs from other services or reductions due to increases in PE for other services. Second, because relativity for work RVUs is maintained through annual adjustments to the CF, the precise value of a work RVU in any given year is adjusted based on the total number of work RVUs in that year. Finally, relativity for the MP RVUs is maintained by both redistribution of MP RVUs and adjustments to the CF, when necessary (under the proposed methodology this is true annually; based on the established methodology the redistribution of the MP RVUs only takes place once every 5 years and the CF is adjusted otherwise). Therefore, to make a more precise assessment of the net reduction in expenditures that are the result of adjustments to the RVUs for misvalued codes, CMS would need to compare, for the included codes, the update year’s total work RVUs (by volume), direct PE RVUs (by volume), indirect PE RVUs (by volume), and MP RVUs (by volume) to the same RVUs in the current year, prior to the application of any scaling factors or adjustments. This would make for a direct comparison between years.

However, this approach would mean that the calculation of the net reduction in expenditures would occur within various steps of the MPFS ratesetting methodology. While CMS believes that this approach would be transparent and external stakeholders could replicate this method, it may be difficult and time-consuming for stakeholders to do so. CMS also noted that when they modeled the interaction of the phase-in legislation and the calculation of the target using this
approach during the development of this proposal, there were methodological challenges in making these calculations. When they simulated the two approaches using information from prior MPFS years, they found that both approaches generally resulted in similar estimated net reductions. After considering these options, CMS proposed to use the approach of comparing the total RVUs (by volume) for the relevant set of codes in the current year to the update year, and divide that result by the total RVUs (by volume) for the current year.

The ACR commented that CMS should calculate the full impact of the change in the linear accelerator equipment utilization rate change for radiation treatment services, and any future instances of multi-year phase-in proposals, from the year CMS initially establishes the decision. CMS responded that they do not believe they can include changes that would occur in future years based solely on the rulemaking cycle during which the policies are established.

CMS finalized the approach as proposed.

Estimating the Target for CY 2016 (Page 1247)

CMS estimates the CY 2016 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.23 percent. Since this does not meet the 1 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 (the “Target Recapture Amount”). As a result, CMS estimates that the CY 2016 Target Recapture Amount will produce a reduction to the CF of -0.77 percent.

Incident to Proposals: Billing Physician as the Supervising Physician and Ancillary Personnel Requirements (Page 497)

CMS proposed to amend §410.26(b)(5) to state that the physician or other practitioner who bills for incident to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident to services. Also, to further clarify the meaning of the proposed amendment to this regulation, CMS proposed to remove the last sentence from §410.26(b)(5) specifying that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident to service is based.

In the final rule, CMS clarified that the proposed policy was not intended to require that the supervising physician or other practitioner must be the same individual as the physician or other practitioner who orders or refers the beneficiary for the services, or who initiates treatment. The Medicare billing number of the ordering physician or other practitioner should not be used if that person did not directly supervise the auxiliary personnel. When the billing number of the physician or other practitioner is reported on the claim form, the physician or practitioner is stating that he or she directly performed the service, or supervised the auxiliary personnel performing the service consistent with the required level of supervision.
Many commenters opposed the removal of the last sentence from §410.26(b)(5) specifying that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident to service is based. The removal of this sentence may be construed to be a change in policy that would require that the physician (or other practitioner) supervising the auxiliary personnel must be the same physician (or other practitioner) who is treating the patient more generally. Given the concerns expressed, CMS did not finalize the proposal to delete the final sentence of the regulatory language. Instead, CMS will revise this sentence to reflect their policy that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) treating the patient more broadly. In addition to this revised sentence, CMS will add clarifying regulation text specifying that only the physician or other practitioner under whose supervision the incident to services are being provided is permitted to bill the Medicare program for the incident to services.

CMS proposed to amend the regulation to explicitly prohibit auxiliary personnel from providing incident to services who have either been excluded from Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or who have had their enrollment revoked for any reason. These excluded or revoked individuals are already prohibited from providing services to Medicare beneficiaries, so this revision is an additional safeguard to ensure that these excluded or revoked individuals are not providing incident to services and supplies under the direct supervision of a physician or other authorized supervising practitioner. These revisions to the incident to regulations will provide the Medicare program with additional recourse for denying or recovering Part B payment for incident to services and supplies that are not furnished in compliance with program requirements. CMS finalized this proposal.

**Portable X-Ray: Billing of the Transportation Fee (Page 509)**

CMS proposed to clarify that when more than one patient is X-rayed at the same location, the single transportation payment under the MPFS is to be prorated among all patients (Medicare Parts A and B, and non-Medicare) receiving portable X-ray services during that trip, regardless of their insurance status. For example, for portable x-ray services furnished at a SNF, CMS believes that the transportation fee should be allocated among all patients receiving portable X-ray services at the same location in a single trip irrespective of whether the patient is in a Part A stay, a Part B patient, or not a Medicare beneficiary at all. If the patient is in a Part A SNF stay, payment for the allocated portion of the transportation fee (and the X-ray) would be the SNF’s responsibility. For a privately insured patient, it would be the responsibility of that patient’s insurer. For a Medicare Part B patient, payment would be made under Part B for the share of the transportation fee attributable to that patient. CMS finalized this policy as proposed.