The Centers for Medicare and Medicaid Services (CMS) released the review copy of the 2014 Medicare Physician Fee Schedule (PFS) final rule on November 27, 2013. The American College of Radiology (ACR) will be submitting comments to CMS addressing issues of concern by the January 27th deadline. Following are highlights of the final rule.

A. Conversion Factor and Impacts (page 531)

The calendar year (CY) 2013 conversion factor (CF) is $34.023. For 2014, the conversion factor based on the sustainable growth rate (SGR) formula mandated by law is $27.2006, representing a -20.1 percent update. This includes a 0.046 percent increase due to the fact that CMS estimates that the CY 2014 relative value unit (RVU) changes would result in a decrease in Medicare physician expenditures of more than $20 million. CMS is required by law to make this adjustment to maintain budget neutrality. In addition, CMS is increasing the CF by 4.72 percent in order to offset the decrease in Medicare physician payments due to the CY 2014 rescaling of the RVUs so that the proportions of total payments for the work, practice expense (PE), and malpractice RVUs match the proportions in the final revised Medicare Economic Index (MEI) for CY 2014.

CMS also points out that while the Congress has provided temporary relief from negative updates every year since 2003, a long-term solution is critical.

<table>
<thead>
<tr>
<th>Table 44: Calculation of the CY 2014 PFS CF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conversion Factor in effect in CY 2013</strong></td>
</tr>
<tr>
<td><strong>CY 2013 Conversion Factor had statutory increases not applied</strong></td>
</tr>
<tr>
<td><strong>CY 2014 Medicare Economic Index</strong></td>
</tr>
<tr>
<td><strong>CY 2014 Update Adjustment Factor</strong></td>
</tr>
<tr>
<td><strong>CY 2014 RVU Budget Neutrality Adjustment</strong></td>
</tr>
<tr>
<td><strong>CY 2014 Rescaling to Match MEI Weights Budget Neutrality Adjustment</strong></td>
</tr>
<tr>
<td><strong>CY 2014 Conversion Factor</strong></td>
</tr>
<tr>
<td><strong>Percent Change from Conversion Factor in effect in CY 2013 to CY 2014 Conversion Factor</strong></td>
</tr>
</tbody>
</table>
Below is an excerpt from Table 93 on page 1285 of the display copy of the final rule: CY 2014 PFS Final Rule with Comment Period Estimated Impact on Total Allowed Charges by Specialty (not considering the negative conversion factor updated required by statute).

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Impact of Work and Malpractice RVU Changes</th>
<th>Impact of Practice Expense RVU Changes</th>
<th>Impact of Adjusting the RVUs to Match The Revised MEI Weights</th>
<th>Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Radiology</td>
<td>-1%</td>
<td>0%</td>
<td>-1%</td>
<td>-2%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>0%</td>
<td>3%</td>
<td>-2%</td>
<td>1%</td>
</tr>
<tr>
<td>Radiology</td>
<td>0%</td>
<td>-2%</td>
<td>0%</td>
<td>-2%</td>
</tr>
</tbody>
</table>

CMS notes that the payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician could vary from the average and depends on the mix of services the physician furnishes. CMS also states that the average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the PFS.

The most widespread specialty impacts of the RVU changes are generally related to several major factors. The first factor is CMS’s rescaling of the RVUs to match the weights assigned to work, PE and malpractice (MP) in the revised MEI. A CF adjustment is also made to assure budget neutrality for this adjustment in RVUs. The second factor involves service-level changes to RVUs for new, revised, and misvalued services. In addition, a number of other changes contribute to the impacts shown in Table 93. Other factors include a statutory change that requires CMS to use a 90 percent equipment utilization rate rather than the previously used 75 percent for expensive diagnostic imaging equipment, updates to direct practice expense inputs for ultrasound services and adjustments to time for some services. All of these issues are summarized in detail in this document.

B. Multiple Procedure Payment Reduction (Page 115)

CMS did not propose any new multiple procedure payment reduction (MPPR) policies for CY 2014 and reiterated the history of the MPPR policies in the final rule. They note that although they are not implementing any new MPPR policies for CY 2014, they continue to look at
expanding the MPPR based on efficiencies when multiple procedures are furnished together. Any specific proposals would be presented in future rulemaking and subject to further public comment.

C. Utilization Rate (Page 41)

For expensive diagnostic imaging equipment, which is equipment priced at over $1 million (for example, computed tomography (CT) and magnetic resonance imaging (MRI) scanners), CMS used an equipment utilization rate assumption of 75 percent in 2013. The America Taxpayer Relief Act of 2012 (ATRA) requires that for fee schedules established for CY 2014 and subsequent years, in the methodology for determining practice expense relative value units for expensive diagnostic imaging equipment, the Secretary shall use a 90 percent assumption. CMS noted in the final rule that several commenters objected to the change in equipment utilization rate assumptions, but none provided evidence that CMS has the authority to use a different equipment utilization assumption.

Therefore, CMS will apply the 90 percent utilization rate assumption in CY 2014 to all of the services to which the 75 percent equipment utilization rate assumption applies in CY 2013. A list of services to which the 90 percent utilization rate applies may be found in Table 3 on page 42 of the display copy of the PFS.

D. Interest Rate (Page 46)

In the CY 2013 final rule, CMS finalized a proposal to change the interest rates used in the calculation of equipment costs per minute. The interest rates are now based on the Small Business Administration (SBA) maximum interest rates for different categories of loan size (equipment cost) and maturity (useful life). The interest rates, which will also apply for CY 2014, are listed in Table 4 as follows:

<table>
<thead>
<tr>
<th>Price</th>
<th>Useful Life</th>
<th>Interest Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$25K</td>
<td>&lt; 7 Years</td>
<td>7.50%</td>
</tr>
<tr>
<td>$25K-50K</td>
<td>&lt; 7 Years</td>
<td>6.50%</td>
</tr>
<tr>
<td>&gt;$50K</td>
<td>&lt; 7 Years</td>
<td>5.50%</td>
</tr>
<tr>
<td>&lt;$25K</td>
<td>7+ Years</td>
<td>8.00%</td>
</tr>
<tr>
<td>$25K-50K</td>
<td>7+ Years</td>
<td>7.00%</td>
</tr>
<tr>
<td>&gt;$50K</td>
<td>7+ Years</td>
<td>6.00%</td>
</tr>
</tbody>
</table>

E. Using Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Rates in Developing Practice Expense Relative Value Units (RVUs) (Page 68)

CMS proposed a change in the PE methodology beginning in CY 2014 and subsequent years in order to improve the accuracy of PFS nonfacility payment rates for each calendar year. They proposed to use the current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services under the PFS. CMS decided not to finalize this proposal at this time.
In announcing this decision, CMS stated:

“Given the many thoughtful and detailed technical comments that we received, we are not finalizing our proposed policy in this final rule with comment period. We will consider more fully all the comments received, including those suggesting technical improvements to our proposed methodology. After further consideration of the comments, we expect to develop a revised proposal for using OPPS and ASC rates in developing PE RVUs which we will propose through future notice and comment rulemaking.”

They went on to say:

“At this time, we do not believe that our standard process for evaluating potentially misvalued codes, including the use of the AMA RUC is an effective means of addressing these codes. As we stated in the proposed rule, we do not believe that the direct practice expense information we currently use to value these codes is accurate or reflects typical resource costs. We have addressed these issues extensively in previous rulemaking (for example, 75 FR 73252) and again in section II.B.4. of this final rule with comment period. We believe the current review process for direct PE inputs only accommodates incomplete, small sample, and potentially biased or inaccurate resource input costs that may distort the resources used to develop nonfacility PE RVUs used in calculating PFS payment rates for individual services.”

**Background**

When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ASC, the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. CMS believes that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA).

However, CMS noted that they found that for some services, the total Medicare payment when the service is furnished in the physician office setting exceeds the total Medicare payment when the service is furnished in an OPD or an ASC. CMS believes this is not the result of appropriate payment differentials between the services furnished in different settings. Rather, they believe it is due to anomalies in the data used under the PFS and in the application of the resource-based PE methodology to the particular services.

CMS points out that the PFS PE RVUs rely heavily on the voluntary submission of information by individuals furnishing the service and who are paid at least in part based on the data provided.
Currently, CMS has little means to validate whether the information is accurate or reflects typical resource costs. Furthermore, in the case of certain direct costs, like the price of high-cost disposable supplies and expensive capital equipment, CMS noted that even voluntary information has been very difficult to obtain. CMS believes that incomplete, small sample, potentially biased or inaccurate resource input costs may distort the resources used to develop nonfacility PE RVUs used in calculating PFS payment rates for individual services.

In addition to the accuracy issues with some of the physician PE resource inputs, the data used in the PFS PE methodology can often be outdated. CMS believes that in the case of new medical devices for which high growth in volume of a service as it diffuses into clinical practice may lead to a decrease in the cost of expensive items, outdated price inputs can result in significant overestimation of resource costs. Such inaccurate resource input costs may distort the nonfacility PE RVUs used to calculate PFS payment rates for individual services.

CMS went on to note that OPPS payment rates are based on auditable hospital data and are updated annually. Given the differences in the validity of the data used to calculate payments under the PFS and OPPS, CMS believes that the nonfacility PFS payment rates for procedures that exceed those for the same procedure when in a facility result from inadequate or inaccurate direct PE inputs, especially in price or time assumptions, as compared to the more accurate OPPS data.

**Details of the proposal**

In setting PFS rates, CMS would compare the PFS payment rate for a service furnished in an office setting to the total Medicare payment to practitioners and facilities for the same service when furnished in a hospital outpatient setting. For services on the ASC list, CMS would make the same comparison except they would use the ASC rate as the point of comparison instead of the OPPS rate. CMS proposed to limit the nonfacility PE RVUs for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined amount Medicare would pay for the same code in the facility setting. That is, if the nonfacility PE RVUs for a code would result in a higher payment than the corresponding OPPS or ASC payment rate and PFS facility PE RVUs (when applicable) for the same code, CMS would reduce the nonfacility PE RVU rate so that the total nonfacility payment does not exceed the total Medicare payment made for the service in the facility setting.

The proposal applied to all CPT codes, but only affected approximately 200 codes (the rest of the codes are not impacted due to exemptions or the nonfacility PE payment is lower compared to the OPPS rate).

**Highlights of Comments Received by CMS**

One commenter representing primary care physicians supported the proposal and indicated a belief that the proposed policy would help to correct misvaluation between primary care services and the services affected by the policy. Another commenter supported the policy as an interim step until an expedited review of the services could be conducted. Other commenters, while not
supporting the proposal due to the financial impact on certain services, stated that hospitals and ASCs do typically incur higher overhead costs in delivering services than physician offices.

The overwhelmingly majority of commenters objected to the proposed policy. Several commenters believed the services impacted by the policy were potentially misvalued, but still opposed the policy. Many commenters questioned whether facilities’ costs for providing all services are necessarily higher than the costs of physicians or other practitioners. Commenters stated that the resources required to furnish services in nonfacility physician settings cannot be accurately measured using the OPPS methodology and that the proposal would result in rank order anomalies. Commenters indicated that it was inappropriate to base PFS payment on OPPS payment since a single APC contains multiple services that can involve a wide a range of costs that are averaged under the OPPS methodology. Many commenters also stated that since OPPS payment rates rely on the accuracy of APC payments, developed through hospitals accurately allocating their costs and charges to particular departments/APCs. These commenters stated that hospitals may have little incentive to accurately allocate their costs and charges to particular departments/APCs since they typically provide a broad range of services and therefore have the ability to make up for losses on one service with profits on another. The argument is that this ability makes the precise pricing of individual services less important in the OPPS system than it is in the physician setting. Also, the argument is that if physicians are going to be paid based upon the OPPS system it should be for all services so that like the hospitals they benefit from those overpaid in the hospital.

Many commenters also questioned CMS’s authority to use payment rates from other Medicare payment methodologies to cap PFS rates since they asserted the policy violated the statutory requirement that the PFS PE relative values be based on the resources used in furnishing the service. Some commenters also cited the financial impact of the proposed policy on the PFS rates as a further reason that the policy was inappropriate. For all of these reasons, these commenters recommended that CMS not adopt the proposed policy.

Commenters also stated a strong preference to use prospective year OPPS rates instead of current year OPPS rates as the point of comparison to prospective year PFS rates. The CY 2014 OPPS proposed rule proposed significant packaging that raised payment for many APCs, and therefore, raised the associated PFS cap rate.

Commenters urged CMS to establish a means for stakeholders to demonstrate the validity of office costs relative to OPPS payments prior to implementing a cap for any particular code. Commenters also suggested that the American Medical Association (AMA) Relative Value Update Committee (RUC) should examine each code prior to the implementation of the policy for that code and that CMS should exclude codes recently valued, such as certain surgical pathology codes, from the cap as their resource inputs and costs are more accurate than those less recently revalued. Commenters asked that CMS make the cap more transparent by identifying all affected codes and displaying the data used in establishing the capped values.
F. Specific Practice Expense Calculations Recommendations

1. Changes to Direct PE Inputs for Specific Services (Page 55)

As per comments received on the CY 2013 final rule on direct PE inputs, CMS reviewed seven supply inputs to determine the appropriateness of including them as direct costs. The seven items and the associated HCPCS codes are listed in Table 6 below.

<table>
<thead>
<tr>
<th>CMS Supply Code</th>
<th>Item Description</th>
<th>Associated CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SK106</td>
<td>Device shipping cost</td>
<td>93271, 93229, 93268</td>
</tr>
<tr>
<td>SK112</td>
<td>Federal Express cost (average across all zones)</td>
<td>64650, 88363, 64653</td>
</tr>
<tr>
<td>SK113</td>
<td>Communication, wireless per service</td>
<td>93229</td>
</tr>
<tr>
<td>SK107</td>
<td>Fee, usage, cycletron/accelerator, gammaknife, Lincac SRS system</td>
<td>77423, 77422</td>
</tr>
<tr>
<td>SK110</td>
<td>Fee, image analysis</td>
<td>96102, 96101, 99174</td>
</tr>
<tr>
<td>SK111</td>
<td>Fee, licensing, computer, psychology</td>
<td>96102, 96101, 96103, 96120</td>
</tr>
<tr>
<td>SD140</td>
<td>Bag system, 1000ml (for angiography waste fluids)</td>
<td>93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461</td>
</tr>
</tbody>
</table>

For six of the items contained in Table 6, CMS agreed with commenters that the items should not be considered disposable supplies and that they are more appropriately categorized as indirect PE costs. Therefore, CMS proposed to remove the following six items from the direct PE database for CY 2014: device shipping cost (SK106); Federal express cost (SK112); communication, wireless per service (SK113); fee usage, cycletron/accelerator, gammaknife, Lincac SRS system (SK107); fee, image analysis (SK110); and fee, licensing, computer, psychology (SK111).

CMS disagreed with the commenters that the supply item called “bag system, 1000ml (for angiography waste fluids) is analogous to the specimen disposal costs recommended for the surgical pathology codes. They believe that this supply input represents only the costs of the disposable material items associated with the removal of waste fluids that typically result from a particular procedure.

After consideration of comments received, CMS finalized the proposal to remove the specified anomalous supply items from the direct PE input database. The CY 2014 direct PE input database and the PE RVUs displayed in Addendum B of the final rule reflect the finalization of this proposal.
2. **Adjustments to Pre-Service Clinical Labor (CL)Minutes (Page 64)**

CMS finalized the proposal to reduce pre-service clinical labor minutes for the following codes as per recommendations from the AMA RUC. Following is an excerpt from Table 9:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Existing CL Pre-service facility minutes</th>
<th>CL pre-service minutes (AMA RUC recommendations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>37202</td>
<td>Transcatheter therapy infuse</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>61050</td>
<td>Remove brain canal fluid</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>61055</td>
<td>Injection into brain canal</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>61070</td>
<td>Brain canal shunt procedure</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>62268</td>
<td>Drain spinal cord cyst</td>
<td>36</td>
<td>30</td>
</tr>
</tbody>
</table>

3. **Direct PE Inputs for Stereotactic Radiosurgery (SRS) Services (CPT Codes 77372 and 77373) (Page 66)**

Since 2001, Medicare has used HCPCS G-codes, in addition to the CPT codes, for stereotactic radiosurgery (SRS) to distinguish robotic and non-robotic methods of delivery. Based on CMS’s review of the current SRS technology, it is their understanding that most services currently furnished with linac-based SRS technology, including services currently billed using the non-robotic codes, incorporate some type of robotic feature. Therefore, CMS believes that it is no longer necessary to continue to distinguish robotic versus non-robotic linac-based SRS through the HCPCS G-codes.

These two codes, G0339 and G0340, describe robotic SRS treatment delivery and are contractor priced. CPT codes 77372 and 77373, which describe SRS treatment delivery without regard to the method of delivery, are currently paid in the nonfacility setting based on resource-based RVUs developed through the standard PE methodology. Prior to eliminating the contractor-priced G-codes and using the existing CPT code for PFS payment of services previously reported using G-codes, CMS believes that it is appropriate to ensure that the direct PE inputs used to develop PE RVUs for CPT codes 77372 and 77373 accurately reflect the typical resources used in furnishing the services that would be reported in the non-facility setting in the absence of the robotic G-codes.

Therefore, for CY 2014, CMS did not propose to replace the contractor-priced G-codes for PFS payment. CMS sought comment from the public and stakeholders, including the AMA RUC,
regarding whether or not the direct PE inputs for CPT codes 77372 and 77373 would continue to accurately estimate the resources used in furnishing typical SRS delivery were there no coding distinction between robotic and non-robotic methods of delivery.

Several commenters, including the AMA RUC, responded to the request for information regarding whether the direct PE inputs for CPT codes 77372 and 77373 would continue to accurately estimate the resources used in furnishing typical SRS delivery were there no coding distinction between robotic and non-robotic methods of delivery. Most commenters, including the AMA RUC, stated that the most recently recommended direct PE inputs for these services would accurately estimate the resources. One commenter suggested this was not the case and that CMS should maintain the G-codes for purposes of PFS payment. CMS responded that they will consider the information submitted in public comments in future rulemaking for these codes.

4. Ultrasound Room Equipment Recommendations (Page 78)

In the proposed rule, CMS sought comment from stakeholders, including the AMA RUC, on the items included in the ultrasound rooms, especially as compared to the items included in other equipment “rooms.” Specifically, CMS is sought comments on whether equipment package “rooms” should include all of the items that might be included in an actual room, just the items typically used for every service in such a room, or all of the items typically used in typical services furnished in the room. CMS did not propose to revise the equipment items, or to change the prices of items, included in these rooms at this time.

CMS believes that not all of the equipment items listed in the ultrasound room packages are used for all ultrasound services. For example, CMS does not believe that the typical ultrasound study would require the use of five different ultrasound transducers. However, the costs of all of these items are incorporated into the resource inputs for every service for which the ultrasound room is a direct PE input, regardless of whether each of those items is typically used in furnishing the particular service. This increases the resource cost for every service that uses the room.

In the final rule, CMS states that several commenters, including the AMA RUC, suggested that equipment room packages should include all items that are typically in the room and cannot be used for another patient, in order to furnish all typical services performed in that room. In its comment letter, the AMA RUC urged CMS to adopt its previous recommendations and pointed out that CMS has previously stated that equipment time is comprised of any time that clinical labor is using the piece of equipment, plus any additional time the piece of equipment is not available for use with another patient due to its use during the procedure in question. Therefore, any time a piece of equipment is not available for use with another patient, the equipment should be allocated minutes. The AMA RUC also pointed out, as an example, that the equipment item called “otoscope-ophthalmoscope (wall unit)” (EQ189) is a standard equipment input for all E/M codes even though it may not be typically used for each E/M service. Therefore, items included in the room but not necessarily typically used in furnishing particular services should be included as equipment minutes for all codes that typically use the room.
In response to the comments received, CMS stated:

“We appreciate the responses of the AMA RUC and others regarding our questions regarding equipment packages. We remain concerned about the appropriate estimate of resources regarding equipment items, especially those in room packages. We note that in our previous statements regarding allocation of equipment minutes, we have articulated that equipment minutes should be allocated to particular items when those items are unavailable for use with another patient “due to its use during the procedure in question.” Based on the recommended equipment room packages, we are concerned that this definition may not apply consistently in the direct PE input database. While we understand the example of the “otoscopeophthalmoscope (wall unit)” (EQ189) for E/M services, we believe that there may be other medical equipment items in a typical evaluation room in addition to the otoscopeophthalmoscope (wall unit) and an exam table. These comments reinforce our belief that, for the sake of relativity and accuracy, changes to particular equipment room packages should be made in the context of a broader examination of all equipment packages, as well as assumed equipment utilization rates for these packages.”

In addition to the concerns regarding the contents of the ultrasound “room” packages, CMS also indicated concern about the pricing information submitted through the AMA RUC to support its recommendation to add equipment to the ultrasound room packages. They stated in the proposed rule that the recommended price conflicts with certain publicly available information. For example, the Milwaukee Sentinel-Journal reported in a February 9, 2013 article that the price for GE ultrasound equipment ranges from “$7,900 for a hand-held ultrasound to $200,000 for its most advanced model.” The same article points to an item called the “Logiq E9” as the ultrasound machine most used by radiologists and priced from $150,000 to $200,000. http://www.jsonline.com/business/ge-sees-strong-future-with-its-ultrasound-business-uj8mn79-190533061.html

CMS stated that they were unsure how to best reconcile the information disclosed by the manufacturer to the press and the prices submitted by the medical specialty society for use in updating the direct PE input prices. They believe that discrepancies, such as these, exemplify the potential problem with updating prices for particular items based solely on price quotes or information other than copies of paid invoices. However, copies of paid invoices must also be evaluated carefully. The information presented in the article regarding the price for hand-held ultrasound devices raises questions about the adequacy of paid invoices, too, in determining appropriate input costs. The direct PE input described in the database as “ultrasound unit, portable” (EQ250) is currently priced at $29,999 based on a submitted invoice, while the article cites that GE sells a portable unit for as low as $7,900. CMS sought comment on the appropriate price to use as the typical cost for portable ultrasound units.

In response to comments received, CMS reiterated their concerns that, even when proffered, a sole paid invoice is not necessarily the optimal source for identifying typical resource costs. CMS agreed with commenters that information a manufacturer provides the news media is not necessarily accurate. However, when such information stands in stark contrast to single invoices,
CMS believes it is imperative to attempt to reconcile that information to identify the best available information regarding the typical cost. **CMS states that they will continue to consider the perspectives offered by commenters in developing future proposals regarding the pricing of individual items and equipment packages.**

5. **New Equipment Inputs and Price Updates**

CMS made proposed changes to some ultrasound equipment pricing based on RUC recommendations as follows.

a. Ultrasound Unit, portable, breast procedures (page 84)

The AMA RUC recommended that a new direct PE input, "ultrasound unit, portable, breast procedures," be created for breast procedures that are performed in a surgeon's office and where ultrasound imaging is included in the code descriptor. These services are described by CPT codes 19105 (Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma), 19296 (Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy), and 19298 (Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance). CMS proposed a price of $33,930, which reflects the price displayed on the submitted copy of the paid invoice.

**CMS stated in the final rule that the pricing information submitted for this item were a paid invoice and two price quotes. As CMS believes that copies of paid invoices are more likely to reflect actual resource costs associated with equipment and supply items than quotes or other information and they did not receive any additional pricing information, the proposed price of $33,930 was finalized.**

b. Endoscopic Ultrasound Processor (page 85)

The AMA RUC recommended creating a new direct PE input called “endoscopic ultrasound processor,” for use in furnishing the service described by CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])). CMS created this equipment item to use as an input in the proposed direct PE input database. The price associated with the “endoscopic ultrasound processor” will be $59,925, which reflects the price documented on the copy of the paid invoice submitted with the recommendation.
c. Bronchofibervideoscope (page 86)

The AMA RUC recommended creating a new direct PE input called “Bronchofibervideoscope,” for use in furnishing the service described by CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])). CMS is creating this new equipment item to use as an input in the proposed direct PE input database. However, this item has no price associated with it in the proposed direct PE input database because CMS did not receive any information that would allow for accurate pricing. Based on the submission of the invoice information, CMS updated the direct PE input database to reflect a price of $35,200 for the Bronchofibervideoscope (ER093).

d. Endoscope, ultrasound probe, drive (ES015) (page 86)

The AMA RUC forwarded pricing information to CMS regarding the existing input called “endoscope, ultrasound probe, drive” (ES015). This information included a copy of a paid invoice. Based on this information, CMS proposed to increase the price associated with ES015 to $13,256.25, which reflects the price documented on the submitted copy of the paid invoice. CMS did not receive any additional information regarding the price for this equipment item. Therefore, the CY 2014 direct PE input database reflects the price as proposed.

6. Ultrasound Equipment Input Recommendations for Particular Services (Page 87)

The AMA RUC recommended changing the associated equipment inputs that appear in the direct PE input database for some CPT codes. Based on CMS’s review of these recommendations, they have generally agreed with the RUC regarding these recommended changes, and these changes are reflected in Table 10 on page 91 of the final rule.

However, for certain codes CMS does not agree with the recommendations of the AMA RUC.

For a series of cardiovascular services that include ultrasound technology, the AMA RUC recommended removing certain equipment items and replacing those items with a new item called “room, ultrasound, cardiovascular.” As CMS noted in the proposed rule, we believe that the issue of equipment room packages should be addressed in future rulemaking. Based on these comments, CMS did not finalize the use of the existing “room, ultrasound, vascular” (EL016) as a proxy for resource costs for these services pending future consideration of equipment room packages. CMS noted that the AMA RUC based its recommendation on information obtained from the medical specialty societies that represent the specialty of the practitioners who furnish the majority of allowed services for each of these codes using recent Medicare claims data. CMS examined comments received objecting to the finalization of the AMA RUC-recommended equipment recommendations and, in each case, confirmed that the commenters did not represent the practitioners who typically furnish each service according to the Medicare claims data.
Based on review of comments received, CMS remains confident that their proposal is appropriate and finalized the changes in the ultrasound equipment items as proposed, with the exception of updating the equipment items for fetal echocardiography to be consistent with other echocardiography services. These changes are displayed in Table 10 on page 91 of the display copy of the PFS and incorporated in the CY 2014 direct PE input database.

**CPT Code 76942 (Page 89)**

In the case of CPT code 76942 (Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation), CMS agreed with the AMA RUC’s recommendation to replace the current equipment input of the “room, ultrasound, general” (EL015) with “ultrasound unit, portable” (EQ250). CMS noted in the proposed rule that this service is typically reported with other codes that describe the needle placement procedures and that the recommended change in equipment from a room to a portable device reflects a change in the typical kinds of procedures reported with this image guidance service. Given this change, CMS believed that the procedure time assumption currently used in establishing the direct PE inputs for this code (45 minutes) is inaccurate. They stated that they reviewed the services reported with CPT code 76942 to identify the most common procedures furnished with this image guidance. The code most frequently reported with CPT code 76942 is CPT 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa). The assumed procedure time for this service is five minutes. The vast majority of other procedures frequently reported with CPT code 76942 range in procedure time assumptions from 5 to 20 minutes.

Therefore, in addition to proposing the recommended change in equipment inputs associated with the code, **CMS also proposed to change the procedure time assumption used in establishing direct PE inputs for the service from 45 to 10 minutes, based on their analysis of thirty needle placement procedures most frequently reported with CPT code 76942. CMS noted that this would reduce the clinical labor and equipment minutes associated with the code from 58 to 23 minutes.** CMS also indicated that this code has been proposed as a potentially misvalued code.

The ACR and several others commented that the AMA RUC is planning to conduct surveys and review the assumptions regarding the code and that CMS will be in a better position to make more accurate determinations if it waits for that data from the AMA RUC. One commenter stated that CMS should not make a change in the direct PE input database based on information in the Medicare claims data without input from the medical specialty societies whose members furnish and report the ultrasound guidance as described with CPT code 76942 and that a recommendation from the AMA RUC may provide better data than the information contained on Medicare claims.

CMS responded that while they appreciate the partnership of the AMA RUC in the misvalued code initiative, they do not believe that they should refrain from making appropriate changes to code values solely because the AMA RUC is planning to review a service in the future. CMS believes that they should examine claims information and other sources of data and make proposals regarding the appropriate inputs used to develop the amount Medicare pays for PFS.
services. CMS believes that notice and comment rulemaking itself provides a means for the public, including medical specialty societies and the AMA RUC, to respond substantively to proposed changes in resource inputs for particular services. Furthermore, in cases like this one, CMS does not believe that the information reflected in the Medicare claims data is subjective or open to differing interpretations.

Several commenters, including the AMA RUC, pointed out that CPT code 76942 includes supervision and interpretation, which represents both time and work that is separate from the surgical code and that the additional time included in the direct PE inputs may reflect time in addition to the base procedure. CMS responded that while they appreciate the response of the AMA RUC and others in pointing out concerns with our assumptions, the proposed clinical labor service period of 23 minutes includes the 10 minutes of intra-service time in addition to 2 minutes for preparing the room, equipment, and supplies, 3 minutes for preparing and positioning the patient, 3 minutes for cleaning the room, and 5 minutes for processing images, completing data sheet, and presenting images and data to the interpreting physician. CMS did not receive information from any commenters suggesting that the time allocated for these tasks was inadequate. Therefore, CMS finalized the adjustment to the clinical labor minutes associated with this code, as proposed.

G. Misvalued Codes (Page 96)

1. Validation Projects (Page 100)

CMS notes that in addition to the ongoing efforts to address misvalued codes through the typical CMS and AMA RUC processes, they have entered into two contracts with outside entities to develop validation models for RVUs. During a 2-year project, the RAND Corporation will use available data to build a validation model to predict work RVUs and the individual components of work RVUs, time and intensity. The model design will be informed by the statistical methodologies and approach used to develop the initial work RVUs and to identify potentially misvalued procedures under current CMS and AMA RUC processes. RAND will use a representative set of CMS-provided codes to test the model. RAND will consult with a technical expert panel on model design issues and the test results.

The second contract is with the Urban Institute. Given the central role of time in establishing work RVUs and the concerns that have been raised about the current time values, a key focus of the project is collecting data from several practices for services selected by the contractor. The data will be used to develop time estimates. Urban Institute will use a variety of approaches to develop objective time estimates, depending on the type of service, which will be a very resource-intensive part of the project. Objective time estimates will be compared to the current time values used in the fee schedule. The project team will then convene groups of physicians from a range of specialties to review the new time data and their potential implications for work and the ratio of work to time.

The ACR continues to closely monitor these CMS efforts.
2. **Publicly nominated codes (Page 102)**

CMS did not receive any publicly nominated potentially misvalued codes for inclusion in this final rule. CMS notes that they will accept public nominations of potentially misvalued codes with supporting documentation as described in section II.C.3.a. of the final rule with comment period in the CY 2015 proposed rule.

3. **Contractor Medical Director (CMD) Identified Potentially Misvalued Codes (Page 103)**

In response to the decision to solicit input from CMDs on potentially misvalued codes, CMS received comments from groups who believe that the identification of misvalued codes (in addition to review and revision of those codes) should be carried out through the AMA RUC process with input from the medical community. These commenters oppose any effort by CMS to unilaterally change code values. The commenters also noted that CMDs do not represent all medical specialties.

CMS responded while it is accurate that CMDs do not represent all medical specialties, they do work on issues involving all specialties. They point out that their role in this process was simply to assist CMS in identifying codes that could be considered proposing as potentially misvalued codes. After evaluation, CMS proposed them as potentially misvalued codes in the CY 2014 proposed rule and sought public comment. Thus the affected specialties and other stakeholders had the opportunity to provide public comments as to whether or not these codes should be evaluated as potentially misvalued. If, following CMS’s consideration of public comments, they determine that these codes are potentially misvalued, the AMA RUC and others will have further opportunity to submit information and public comment about the appropriate value of the codes before CMS would determine the codes are in fact misvalued and make changes to the values.

Tables 11 and 12 (pages 104 and 109) of the display copy of the final rule are the proposed lists of “Potentially Misvalued Codes” that CMS identified in consultation with Contractor Medical Directors (CMDs). These tables include 8 ultrasound guidance codes.

From Table 11, CMS proposed CPT code 76942 (Ultrasonic guidance for needle placement (for example, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as a potentially misvalued code because of the high frequency with which it is billed with CPT code 20610 (Arthrocentesis aspiration and/or injection; major joint or bursa (for example, shoulder, hip, knee joint, subacromial bursa). One CMD suggests that the payment for CPT code 76942 and CPT code 20610 should be combined to reduce the incentive for providers to always provide and bill separately for ultrasound guidance.

CMS notes that they are making a proposal regarding the direct PE inputs for CPT code 76942 as described above. Claims data show that the procedure time assumption for CPT code 76942 is longer than the typical procedure with which the code is billed (for example, CPT code 20610). CMS believes that the discrepancy in procedure times and the resulting potentially inaccurate payment raises a fundamental concern regarding the incentive to furnish ultrasound guidance. CMS believes this concern spans more than just an individual code for ultrasound guidance. Accordingly, they have proposed additional ultrasound guidance codes as potentially misvalued...
in Table 12 (below). CMS sought public comment on including these codes as potentially misvalued codes.

CMS decided in the final rule to move forward with evaluating CPT code 76942 as a potentially misvalued code. This action is consistent with a comment received recommending that CMS delay action until the AMA RUC acts because CMS routinely considers AMA RUC recommendations through the usual review of potentially misvalued codes. Thus, CMS would seek the AMA RUC recommendation before re-valuing.

Table 12: CPT Codes for Ultrasound Guidance

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>76930</td>
<td>Echo guide cardiocentesis</td>
</tr>
<tr>
<td>76932</td>
<td>Echo guide for heart biopsy</td>
</tr>
<tr>
<td>76936</td>
<td>Echo guide for artery repair</td>
</tr>
<tr>
<td>76940</td>
<td>US guide tissue ablation</td>
</tr>
<tr>
<td>76948</td>
<td>Echo guide ova aspiration</td>
</tr>
<tr>
<td>76950</td>
<td>Echo guidance radiotherapy</td>
</tr>
<tr>
<td>76965</td>
<td>Echo guidance radiotherapy</td>
</tr>
</tbody>
</table>

The ACR commented that 76936 should be removed from the list because it is not an image guidance technique used to supplement a surgical procedure. CMS agreed that code 76936 is not a code used to supplement a surgical procedure and therefore does not raise the concerns discussed in the proposed rule. Accordingly, it will not be included on the list of potentially misvalued codes. CMS also received comments on codes 76930 and 76932, however, they did not provide sufficient information to persuade CMS that these codes should not be considered potentially misvalued. Given that the identification of a code as potentially misvalued merely assures that the current values are evaluated to determine whether changes are warranted, CMS finalized the proposal to consider codes 76930 and 76932 as potentially misvalued.

Table 13: Potentially Misvalued CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>21800</td>
<td>Treatment of rib fracture</td>
</tr>
<tr>
<td>22305</td>
<td>Closed tx spine process fx</td>
</tr>
<tr>
<td>27193</td>
<td>Treat pelvic ring fracture</td>
</tr>
<tr>
<td>33960</td>
<td>External circulation assist</td>
</tr>
<tr>
<td>33961</td>
<td>External circulation assist, each subsequent day</td>
</tr>
<tr>
<td>47560</td>
<td>Laparoscopy w/cholangio</td>
</tr>
<tr>
<td>47562</td>
<td>Laparoscopic cholecystectomy</td>
</tr>
<tr>
<td>47563</td>
<td>Laparo cholecystectomy/graph</td>
</tr>
<tr>
<td>55845</td>
<td>Extensive prostate surgery</td>
</tr>
<tr>
<td>55866</td>
<td>Laparo radical prostatectomy</td>
</tr>
</tbody>
</table>
H. Establishing RVUs for CY 2014 (Page 175)

Finalizing CY 2013 Work RVUs

In the 2013 PFS final rule, CMS published interim work RVU values for new and revised CPT codes. Because of the timing of the CPT Editorial Panel decisions, the RUC recommendations, and the rulemaking cycle, CMS publishes these work RVUs and PE inputs in the PFS final rule as interim values, subject to public comment. CMS developed a refinement panel process to assist in reviewing the public comments received on CPT codes with interim final values in developing final values for the subsequent year. CMS reminds the public in the final rule that the refinement panel is not intended to review every code for which they did not accept the AMA RUC-recommended RVUs. Rather, refinement panels are designed for situations where there is new information available that might provide a reason for a change in work values and for which a multispecialty panel of physicians might provide input that would assist in making work RVU decisions. CMS requests that commenters seeking refinement panel review of work RVUs submit supporting information that has not already been considered by the AMA RUC in creating recommended work RVUs or by CMS in assigning proposed and interim final work RVUs.

In our comments on the 2013 PFS final rule, the ACR requested refinement panel review of the work RVUs for thirteen CPT codes.

- **32557** Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance
- **35475** Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel
- **35476** Transluminal balloon angioplasty, percutaneous; venous
- **37197** Transcatheter retrieval, percutaneous, of intravascular foreign body (e.g., fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed
- **37214** Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64566</td>
<td>Neuroeltrd stim post tibial</td>
</tr>
<tr>
<td>76930</td>
<td>Echo guide cardiocentesis</td>
</tr>
<tr>
<td>76932</td>
<td>Echo guide for heart biopsy</td>
</tr>
<tr>
<td>76940</td>
<td>US guide tissue ablation</td>
</tr>
<tr>
<td>76942</td>
<td>Echo guide for biopsy</td>
</tr>
<tr>
<td>76948</td>
<td>Echo guide ova aspiration</td>
</tr>
<tr>
<td>76950</td>
<td>Echo guidance radiotherapy</td>
</tr>
<tr>
<td>76965</td>
<td>Echo guidance radiotherapy</td>
</tr>
<tr>
<td>76970</td>
<td>Echo guidance radiotherapy</td>
</tr>
<tr>
<td>76975</td>
<td>Echo guidance radiotherapy</td>
</tr>
<tr>
<td>76980</td>
<td>Echo guidance radiotherapy</td>
</tr>
<tr>
<td>76985</td>
<td>Echo guidance radiotherapy</td>
</tr>
<tr>
<td>76990</td>
<td>Echo guidance radiotherapy</td>
</tr>
<tr>
<td>76995</td>
<td>Echo guidance radiotherapy</td>
</tr>
</tbody>
</table>

In our comments on the 2013 PFS final rule, the ACR requested refinement panel review of the work RVUs for thirteen CPT codes.
- 93925 Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
- 36221 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
- 36222 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
- 36223 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
- 36224 Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
- 36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
- 36226 Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
- 36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

CMS finalized eleven of the interim values and sent two of the CPT codes to the refinement panel. For each of the codes that CMS finalized, they explained that they did not feel the criteria for refinement panel review were met and that they were standing by their interim value decisions.

The two codes sent to the refinement panel were 35475 (Angioplasty, arterial) and 35476 (Angioplasty, venous). The ACR attended the refinement panel meeting along with the Renal Physicians Association, Society for Vascular Surgery, Society of Interventional Radiology. The panel determined that the work RVUs for CPT code 35475 should be increased to the AMA RUC-recommended value of 6.60, from the interim value of 5.75 and the work RVUs for CPT code 35476 increased from 4.71 to 5.10.
Table 23 of the final rule included a summary of all of the codes reviewed by the refinement panel in 2013. The excerpt of the table containing the two codes is included below.

**Table 23: Codes Reviewed by the 2013 Multi-Specialty Refinement Panel**

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>35475</td>
<td>Angioplasty, arterial</td>
<td>5.75</td>
<td>6.60</td>
<td>6.60</td>
<td>6.60</td>
</tr>
<tr>
<td>35476</td>
<td>Angioplasty, venous</td>
<td>4.71</td>
<td>5.10</td>
<td>5.10</td>
<td>5.10</td>
</tr>
</tbody>
</table>

**CT Angiography (CPT code 72191) (Page 241)**

As detailed in the CY 2013 final rule with comment period, CPT code 72191 (Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing) was assigned a CY 2013 interim final work RVU of 1.81, consistent with the AMA RUC recommendation. Based upon the AMA RUC recommendations, CMS is establishing interim final values for codes within the CT angiography family. To allow for contemporaneous public comment on this entire family of codes, CMS is maintaining the CY 2013 work value for CPT code 72191 as interim final for CY 2014.

**Radiologic Guidance: Fluoroscopic Guidance (CPT codes 77001, 77002 and 77003) (Page 241)**

As detailed in the CY 2013 final rule with comment period, CPT codes 77001 (Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal), 77002 (Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)) and 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)) were assigned CY 2013 interim final work RVUs of 0.38, 0.54 and 0.60, respectively, based upon AMA RUC recommendations. CMS agrees with the AMA RUC-recommended values but is concerned that the recommended intraservice times for all three codes are generally higher than the procedure codes with which they are typically billed. For example, CPT code 77002 has 15 minutes of intraservice time and CPT code 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)) has an intraservice time of only 5 minutes. CMS is requesting additional public comment and input from the AMA RUC and other stakeholders regarding the appropriate relationship between the intraservice time associated with fluoroscopic guidance and the intraservice time of the procedure codes with which they are typically billed. Therefore, for CY 2014 we are assigning CY 2014 interim final work RVUs of 0.38 to CPT code 77001, 0.54 to CPT code 77002 and 0.60 to CPT code 77003.
CPT codes 75896 and 75898 (Page 242)

CPT code 75896 (Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation) was identified as potentially misvalued through the codes reported together 75 percent or more screen. As CMS noted in the CY 2013 final rule with comment period, the AMA RUC intended to survey and review CPT codes 75896 and 75898 (Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis) for CY 2014 as part of their work on bundling thrombolysis codes. The AMA RUC recommended contractor pricing these two services for CY 2014. However, since CMS had established a national payment rate for the professional component of these services and only the technical component of the services was contractor priced at that time, CMS maintained the national price on the professional component and continued contractor pricing for the technical component for these codes on an interim final basis for CY 2013. CMS did not receive any comments on these codes nor did they receive any recommendations from the AMA RUC. As we anticipate receiving AMA RUC recommendations for these codes, CMS is maintaining the current pricing on an interim final basis for CY 2014.

Finalizing CY 2013 Interim Direct PE Inputs (Page 261)

On an annual basis, the AMA RUC provides CMS with recommendations regarding direct PE inputs, including clinical labor, disposable supplies, and medical equipment, for new, revised, and potentially misvalued codes. CMS reviews the AMA RUC-recommended direct PE inputs on a code-by-code basis. When they determine that the AMA RUC recommendations appropriately estimate the direct PE inputs required for the typical service and reflect their payment policies, CMS uses those direct PE inputs to value a service. If not, they refine the PE inputs to better reflect their estimate of the PE resources required for the service. CMS also confirms whether CPT codes should have facility and/or nonfacility direct PE inputs and refines the inputs accordingly.

The ACR provided extensive comments on the 2013 PFS final rule regarding CMS’s refinement of direct inputs (i.e. clinical staff type, number of supplies used, and equipment time) with “CMS Clinical Review” listed as the sole rationale and no additional details provided. We commented that the societies, PE subcommittee and the RUC spend considerable time and resources on providing CMS with recommendations which are clinically appropriate and thoroughly vetted. We asked that CMS raise any concerns they may have during the PE subcommittee meetings rather than retrospectively through rulemaking. The ACR recommended that CMS be transparent and provide a detailed rationale for the changes seen in the final rule.

In response, CMS reiterates in the final rule the various aspects that are considered as they make their refinement decisions (e.g. standardized number of minutes, typical setting, global period, and procedures that are typically reported together) and responded directly only to very specific comments made for individual CPT codes.
1. **Equipment Time (Page 262)**

With respect to room time refinements, CMS stands by their position that the clinical labor service period includes minutes based on some clinical labor tasks associated with preservice and postservice activities that they do not believe typically preclude equipment items from being used in furnishing services to other patients because these activities typically occur in other rooms. CMS believes that certain highly technical pieces of equipment and equipment rooms are less likely to be used during all of the preservice or postservice tasks performed by clinical labor staff on the day of the procedure (the clinical labor service period) and are typically available for other patients even when one member of clinical staff may be occupied with a preservice or postservice task related to the procedure.

2. **Standard Tasks and Minutes for Clinical Labor Tasks (Page 265)**

Several commenters objected to CMS’s refinement to recommended clinical labor minutes in cases where the recommendation included information suggesting that the service requires specialized clinical labor tasks, especially relating to quality assurance documentation, that are not typically included on the PE worksheets. CMS responded that they believe that these tasks are already accounted for in the overall estimate of clinical labor time. They do not believe it would serve the relativity of the direct PE input database were additional minutes added for each clinical task that could be discretely described for every code. As such, CMS did not make any changes based on this comment.

3. **Equipment Minutes for Film Equipment Inputs (Page 267)**

Several commenters argued that the film equipment should be allocated for the entire service period. CMS believes that the film equipment, when used, is typically only used during the time associated with certain clinical labor tasks, and is otherwise generally available for use in furnishing services to other patients. In reviewing these equipment inputs in the direct PE input database, CMS notes that this equipment is generally not allocated for the full number of minutes of the clinical labor service period. Because CMS does not believe that this equipment would be in use during periods other than during particular clinical labor tasks, and to maintain relativity, they finalized the CY 2013 direct PE inputs based on this general principle.

4. **Film Inputs as a Proxy for Digital Imaging Inputs (Page 267)**

A few commenters objected the CMS refinement of certain film inputs including eliminating VHS video system and tapes, and reducing the number of films for several procedures. Commenters also stated that the film processor was a necessary input for several procedures from which it was removed. CMS believes that for imaging services, digital technology is more typical than film technology. However, stakeholders, including the AMA RUC, recommended that CMS continue to use film technology inputs as a proxy for digital until digital inputs for all imaging services can be considered. In response to these recommendations, CMS maintained inputs for film-based technology as proxy inputs while this review occurs. In the case of new, revised, and potentially misvalued codes, CMS accepted the recommended proxy inputs to the extent that the recommended proxy inputs are those that are usually associated with imaging services.
codes. However, CMS did not accept recommended inputs that are not usually included in other imaging services. CMS reviewed the recommended inclusion of the film processor and, upon additional review, noted that the item is routinely included in other imaging codes. Therefore, CMS included that item in the direct PE input database. CMS anticipates updating all of the associated inputs in future rulemaking.

*Code-Specific Direct PE Inputs (Page 268)*

1. **Cross-Family Comments (Page 269)**

CMS received comments regarding selected items added to various CPT codes during clinical review by CMS that are not typical. Table 26 beginning on page 271 of the display copy of the PFS lists these identified items and whether or not CMS decided to remove them. All items related to imaging services were removed.

2. **Diagnostic Radiology: Abdomen and Pelvis (Page 289)**

The ACR requested additional information on the reduction of service time for CPT codes 72194 (Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections), 74160 (Computed tomography, abdomen; with contrast material(s)), and 74177 (Computed tomography, abdomen and pelvis; with contrast material(s)). CMS responded that they refined the minutes in the service period such that the aggregate number of clinical labor minutes reflected in the direct PE input database and used to develop PE RVUs was consistent within this family of codes. They believe that the aggregate clinical labor time in each clinical service period (preservice period, service period, and postservice period) or aggregate number of minutes for particular equipment items that reflects the total typical resource use is more important than the minutes associated with each clinical labor task, which are a tool used by the AMA RUC to develop their recommendations. CMS hopes that in reviewing future services, commenters consider the aggregate clinical labor time as well, recognizing that it is the aggregate time that ultimately has implications for payment. **CMS welcomes comments that address the appropriateness of the number of clinical labor minutes in each service period and the number of equipment minutes for each service.**

Based on the information provided by the ACR, CMS agrees that CPT codes 72191 (Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing) and 74175 (Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing) should include a CT technologist rather than a radiologic technologist because the CT technologist is typical. However, CMS does not agree that the clinical labor time should be changed per the commenters’ request, as they continue to believe that these tasks are already captured in the preservice clinical labor time. For CPT code 72191, CMS refined the time for equipment item “room, CT” (EL007) to 40 minutes.

CMS agreed that CT room time should be 43 minutes to include the standard clinical labor tasks for highly technical equipment, including cleaning the room.
CMS adjusted the direct PE inputs to include the needle and film processor in CPT codes 72193 (Computed tomography, pelvis; with contrast material(s)), 72194 (Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections), 74160 (Computed tomography, abdomen; with contrast material(s)), and 74170 (Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections). Commenters stated that the biopsy needle (SC025) was not appropriate for these services, and that supply item “needle, 18-27g” (SC029) would be more appropriate. In addition, commenters noted that the “film processor” (ED024) is in use during a portion of the service. CMS agreed with commenters that the “needle, 18-28g” (SC029) is more appropriate for these services, and that the film processor should be included for these codes.

3. Diagnostic Ultrasound: Transvaginal and Transrectal Ultrasound (Page 291)

Based on comments received, CMS agrees that it would be more appropriate to allocate a general ultrasound room for CPT code 76830 (Ultrasound, transvaginal) rather than a portable unit and accompanying items. As such, CMS is including the ultrasound room as a direct PE input for this code.

In establishing interim final direct PE inputs for CY 2013, CMS refined the AMA RUC’s recommendation for CPT code 76872 (Ultrasound, transrectal) by adjusting the equipment time to reflect the typical use exclusive to the patient, and removing clinical labor tasks, “obtain vital signs,” and “prepare ultrasound probe” from the preservice period; removing “obtain vital signs” from the service period; and removing supply items “drape, sterile, for Mayo stand” (SB012), “iv tubing (extension)” (SC019), “lidocaine 2% jelly, topical (Xylocaine)” (SH048), “alcohol isopropyl 70%” (SJ001), “lubricating jelly (K-Y) (5gm uou)” (SJ032), “glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)” (SM018), “glutaraldehyde test strips (Cidex, Metrex)” (SM019), and “sanitizing cloth-wipe (surface, instruments, equipment)” (SM022). Commenters indicated that the equipment time allocated for this procedure should be 68 minutes to reflect the time that the equipment is unavailable for other patients. CMS agreed with commenters that the equipment time for all equipment in this procedure should include time for all of the standard clinical labor tasks in the service period, so they allocated 42 minutes for those equipment items.

Commenters noted that it is necessary to obtain vital signs prior to the service, and that the supplies removed by CMS were necessary for a variety of purposes outlined in the comment. CMS does not agree that it is necessary to obtain vital signs in the preservice period in order to determine if the patient becomes hypotensive during the service period, but agrees that obtaining vital signs in the service period is necessary. After considering the information provided by the commenters, CMS was persuaded that the supplies that were removed are necessary for the procedure. Therefore, they included 3 additional minutes in the service period and reinstated the supplies that we removed from the procedure in establishing interim final direct PE inputs.

4. Radiation Oncology: Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services (Page 293)

In establishing interim final direct PE inputs for CY 2013, CMS refined the AMA RUC’s recommendation for CPT code 77301 (Intensity modulated radiotherapy plan, including dose-
volume histograms for target and critical structure partial tolerance specifications) by removing equipment item “computer system, record and verify” from the service, adjusting the equipment time for “treatment planning system, IMRT (Corvus w-Peregrine 3D Monte Carlo)’ from 376 to 330, among other general refinements. Commenters indicated that the minutes used for the computer system are not captured elsewhere and should be included in the service, and that there is physician time independent of clinical staff time for the treatment planning system. CMS responded that the computer system was not previously an input for this service, and the commenter did not provide sufficient information or evidence for them to conclude that there should be a change. CMS also noted that this service has both a technical and professional component; the professional component has no inputs, and the equipment time associated with the physician time is not appropriately placed in the technical component. Thus, the equipment time is allocated for the technical component only.

5. Nuclear Medicine: Diagnostic (Page 294)

In establishing interim final direct PE inputs for CY 2013, CMS was unable to price the new equipment item “gamma camera system, single-dual head SPECT/CT” for CPT code 78072 (Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization) since they did not receive any paid invoices. Because the cost of the item that they were unable to price is disproportionately large relative to the costs reflected by remainder of the recommended direct PE inputs, CMS contractor priced the technical component of the code for CY 2013, on an interim basis, until the newly recommended equipment item could be appropriately priced. CMS received 4 paid invoices for the SPECT/CT equipment. Out of the four invoices we received, CMS was only able to use one of them to price the equipment because the other three included training and other costs as part of the overall equipment price. Since training and these other costs are not considered part of the price of the equipment in the current PE methodology, CMS is unable to use invoices when these items are not separately priced on the invoice. Based on the invoice that met CMS criteria, this equipment is priced at $600,272. CMS assigned 92 minutes based on standard allocation for highly technical equipment, to include “prepare room, prepare and position patient, administer radiopharmaceutical, acquire images, complete diagnostic forms, and clean room.” This price is considered interim for CY 2014.

Establishing CY 2014 Interim Final RVUs (Page 312)

The ACR presented about 90 new or revised current procedural terminology (CPT) codes to the AMA RUC for valuation. Once approved by the RUC, these values were then shared with CMS. Table 27 beginning on page 312 of the display copy of the final rule contains the CY 2014 interim final work RVUs for all codes for which CMS received AMA RUC recommendations for CY 2014. Table 28 beginning on page 376 of the display copy of the final rule includes codes where CMS accepted without refinement, the direct PE inputs based on the recommendations submitted by the AMA RUC. Table 29 beginning on page 379 of the display copy of the final rule includes the remainder of the AMA RUC’s direct PE recommendations that were accepted with refinements. These values are subject to public comment.
Breast Biopsy

CPT codes 77031 (Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation), 19103 (Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance), 77032 (Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation) and 19290 (Preoperative placement of needle localization wire, breast) were identified through the Codes Reported Together 75 percent or More screen and resulted in the creation of 14 new bundled codes to report breast biopsy and marker placement. CPT codes 77031, 19103, 77032, and 19290 will be deleted, along with 19102 (Biopsy of breast; percutaneous, needle core, using imaging guidance) and 19291 (Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure).

Six new codes, 19081-19086, bundle breast biopsy with the imaging guidance used, either stereotactic, ultrasound, or MRI, each with an add-on code to describe additional lesions. These new codes will result in an estimated 29 percent-54 percent decrease in payment rates for 2014 across the family.

Eight new codes, 19281-19288, bundle marker placement with the imaging guidance used, either stereotactic, ultrasound, mammographic, or MRI, each with an add-on code to describe additional lesions. These new codes will result in an average 17 percent increase in payment rates for 2014 across the family compared to current.

Interventional Radiology

Multi-specialty recommendations were submitted for the following interventional code families:

- embolization (37241-37244)
- intravascular stents (37236-37239)
- abscess drainage (10030, 49405-49407)
- chest tube placement, (32554-32557)
- selective catheter placement (36245)
- fluoroscopic guidance (77001-77003)

New codes were created for the embolization, intravascular stents, and abscess drainage families. These new codes will result in an average 10 percent decrease in payment across the abscess drainage family, an average 47 percent decrease in payment across the embolization family, and an average 20 percent decrease in payment across the intravascular stents family in 2014. The physician work for fluoroscopic guidance and chest tube interventions was maintained, while an estimated increase of 5 percent is anticipated for selective catheter placement.

Body Imaging

Several MRI, CT, and ultrasound codes were captured on CMS High Expenditure screens:

- MRI brain (70551-70553)
The average decrease in payment for the MRI brain, MRI spine, and CT head codes is about 5 percent. The reduction for the global payment will be greater due to the reduction for the technical component. We were able to maintain the physician work for the extracranial studies codes.

**Radiation Oncology**

Five codes from the respiratory motion management (RMMS) code family, 77280-77295, were also presented to the RUC. The majority of the radiation oncology submissions to the RUC focused on the practice expense (PE), or technical component. The RUC reviewed the PE for the following radiation oncology code families:

- Radiation treatment delivery
- Continuing medical physics consultation
- IMRT
- Hyperthermia, and
- High Dose Rate Brachytherapy

The ACR has developed a separate article with the detailed analysis of the impacts of these new codes.

**I. Collecting Data on Services Furnished in Off-Campus Hospital Provider-Based Departments (Page 633)**

Upon acquisition of a physician practice, hospitals frequently treat the practice locations as off-campus provider-based departments of the hospital and bill Medicare for services furnished at those locations under the OPPS. Since October 1, 2002, CMS has not required hospitals to seek from CMS a determination of provider-based status for a facility that is located off campus. CMS also does not have a formal process for gathering information on the frequency, type, and payment for services furnished in off-campus provider-based departments of the hospital.

In the proposed rule, CMS announced that in order to better understand the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments, they were considering collecting information that would allow them to analyze the frequency, type, and payment for services furnished in off-campus provider-based hospital departments. CMS considered several potential methods. Claims-based approaches could include (1) creating a new place of service code for off-campus departments of a provider, comparable to current place of service codes such as “22 Outpatient” and “23 Emergency Room-Hospital” when physician services are furnished in an off-campus provider-based department, or (2) creating a HCPCS modifier that could be reported with every code for services furnished in an off-campus provider-based department of a hospital for hospital outpatient claims. In addition, CMS also considered asking hospitals to break out the costs and
charges for their provider-based departments as outpatient service cost centers on the Medicare hospital cost report. CMS noted that some hospitals already break out these costs voluntarily or because of cost reporting requirements for the Drug Discount program but this practice is not consistent or standardized. CMS invited public comment on the best means for collecting information on the frequency, type, and payment for services furnished in off-campus provider-based departments of hospitals.

CMS notes in the final rule that MedPAC has questioned the appropriateness of increased Medicare payment and beneficiary cost-sharing when physicians’ offices become hospital outpatient departments and has recommended that Medicare pay selected hospital outpatient services at the MPFS rates (MedPAC March 2012 Report to Congress; “Addressing Medicare Payment Differences across Settings,” presentation to the Commission on March 7, 2013). When a service is furnished in a freestanding clinic or physician office, only one payment is made under the MPFS; however when a service is furnished in a hospital-based office, Medicare pays the hospital a “facility fee” and a payment for the physician portion of the service, which is a lower payment than if the service would have been furnished in a physician’s office. Although the physician payment is lower when the services are furnished in a hospital, the total payment (facility fee and physician fee) is generally more than the Medicare payment if the same service was furnished in a freestanding clinic or physician office. The beneficiary pays coinsurance for both the physician payment and the hospital outpatient payment (facility fee). Upon acquisition of a physician practice, hospitals frequently treat the practice locations as off-campus provider-based departments of the hospital and bill Medicare for services furnished at those locations under the OPPS.

Although most commenters agreed on the need to collect information on the frequency, type, and payment for services furnished in off-campus provided-based departments of hospitals, opinions differed on how to best collect this additional data. Some commenters preferred identifying services furnished in provider-based departments on the cost report, while others preferred one of the claims-based approaches. Some commenters supported either approach, noting the trade-offs in terms of the type of data that could be collected accurately and the administrative burden involved. Some suggested CMS convene a group of stakeholders to develop consensus on the best approach. Commenters generally recommended that CMS choose the least administratively burdensome approach that would ensure accurate data, but did not necessarily agree on what approach would optimally achieve that result.

MedPAC believes there may be some limited value in collecting data on services furnished in off-campus provider-based departments to validate the accuracy of site-of-service reporting when the physician office is off-campus but billing as an outpatient department, but did not recommend a particular data collection approach. MedPAC emphasized that any data collection effort should not prevent the development of policies to align payment rates across settings.

CMS indicated that they will take the comments received into consideration as they continue to consider approaches to collecting data on services furnished in off-campus provider-based departments.
J. Malpractice RVUs (Page 465)

For CY 2014, CMS will continue their current approach for determining malpractice RVUs for new/revised codes. A list of new/revised codes and the malpractice crosswalks used to determine their malpractice RVUs are in Table 30 (pages 467-476) in this final rule with comment period. The CY 2014 malpractice RVUs for new/revised codes are being implemented in this CY 2014 PFS final rule with comment period. These RVUs are subject to public comment. They will then be finalized in the CY 2015 PFS final rule with comment period.

CMS received no comments on the CY 2013 interim final malpractice crosswalks and are finalizing them without modification for CY 2014. The malpractices RVUs for these services are reflected in Addendum B of this CY 2014 PFS final rule with comment period.

K. Medicare Economic Index (Page 125)

For CY 2014, CMS proposed to revise the MEI based on the recommendations of the MEI Technical Advisory Panel (TAP). They are not rebasing the MEI and will continue to use the data from 2006 to estimate the cost weights, since these are the most recently available, relevant, and complete data available to develop these weights.

For CY 2014, CMS proposed to implement 10 of the 13 recommendations made by the MEI-TAP. The remaining recommendations require more in-depth research, and CMS will continue evaluating these three recommendations and will propose any further changes to the MEI in future rulemaking. The CY 2014 changes only involve revising the MEI categories, cost shares, and price proxies. CMS did not propose to rebase the MEI for CY 2014 since the MEI-TAP concluded that there is not a newer, reliable, or ongoing source of data to maintain the MEI.

Many commenters appreciated the efforts of CMS to implement the recommendations of the MEI-TAP. They agree with the MEI-TAP’s analysis and recommendations and believe these changes successfully bring the “market basket” of MEI inputs up to date and improve the accuracy of the index going forward. Nearly all commenters supported the following proposals:

- The increase in the physician benefits cost weight in order to ensure consistency with the benefits price proxy.
- The use of professional workers’ earnings as the price proxy for the physician compensation portion of the index. Specifically, the price proxies for physician wages would change from general economy-wide earnings to a wages index for “Professional and related occupations” and the price proxy for physician benefits would be changed from general economy-wide benefits to a benefit index for “Professional and related occupations.”
- The use of commercial rent data for the fixed capital price proxy, replacing the CPI residential rent proxy.
- The creation of a health sector wage category within the index.
- The creation of an “all other professional services” category, encompassing purchased services such as contract billing, legal, and accounting services.
CMS noted that the one area where there was concern from commenters, including the ACR, was with the proposal to reclassify expenses for non-physician practitioners that can independently bill from non-physician compensation to physician compensation. CMS states that based on the public comments, they did not find any reason to reconsider the proposal, nor did they find any compelling technical reason that they should not implement this revision to the MEI. Therefore, CMS is finalizing the proposal to reclassify these expenses from non-physician compensation to physician compensation in the MEI. The effect of moving the expenses related to clinical staff that can bill independently to physician compensation category is to increase the physician compensation cost share by 2.600 percentage points and reduce non-physician compensation costs by the same amount. This change lowers the PE cost weight by 2.600 percent as well, all of which comes from a lower weight for non-physician compensation. The remaining MEI cost weights are unchanged.

CMS indicated that several commenters requested explanation regarding the relationship between the proposed MEI revision and the proposed RVUs. One commenter suggested that it would be better to scale the work RVUs upward instead of scaling the PE RVUs downward to achieve the weighting adjustment. The change in the relationship among work, PE, and malpractice RVUs could be accomplished by applying adjustments directly to the work, PE, and malpractice RVUs or by holding the RVUs constant for one component, scaling the other two components and applying a budget neutrality adjustment to the conversion factor. CMS proposed to make the adjustment by holding work RVUs constant consistent with prior adjustments and in response to many public comments made during previous rulemaking (see, for example, 75 FR 73275) indicating a strong preference and persuasive arguments in favor of keeping the work RVUs stable over time since work RVUs generally only change based on reviews of particular services. In contrast, PE RVUs are developed annually, irrespective of changes in the direct PE inputs for particular services, so that scaling of PE RVUs is less disruptive to the public review of values that determine PFS payment rates. CMS took this approach for the CY 2014 adjustment because they believe the methodology and reasons for making the adjustment in this way are settled and remain valid. For these reasons, CMS is finalizing the proposed rebasing of the relationship among RVU components by holding the work RVUs constant, decreasing the PE RVUs and the MP RVUs, and applying a budget neutrality adjustment to the CF.

Several commenters, including the ACR, strongly urged the agency, in adjusting weights among the PFS components to reflect the MEI cost weight changes, to consider alternative methodologies that would mitigate the redistribution of RVUs from the PE to the work category. These commenters pointed out that the practitioners who furnish services with a higher proportion of PE RVUs are hit hardest by these changes. These comments also suggested that CMS should consider postponing this adjustment of the RVUs until such a methodology can be vetted. Several commenters suggested that, given the magnitude of the reductions, CMS should consider a phase-in of this change. These commenters pointed out that CMS has used a phase-in approach in the past to mitigate the effects of methodological changes to the calculation of payment rates under the MPFS, including a four-year phase-in of the transition from the topdown to the bottom-up methodology of calculating direct PE RVUs.
CMS responded that they appreciate that the increase in the work RVUs relative to PE RVUs will generally result in lower payments for practitioners who furnish more services with a higher proportion of PE RVUs. However, CMS continues to believe that the MEI cost share weights are the best reflection of the PFS component weights. The CY 2014 revisions to the MEI, following the rebasing for 2011 and consideration by the MEI TAP, reflect the best available information. As such, CMS believes that the relationship among the RVU components should conform to the revised cost weights adopted for the MEI.

CMS also states that they understand and recognize the general preference to avoid significant year-to-year reductions in Medicare payment, including practitioners’ interests in phasing in any reduction, and they acknowledge that this revision of the PFS component weights results in an increase in work RVUs relative to PE RVUs, CMS notes that the 2011 rebasing of the MEI resulted in a change of greater magnitude that increased the PE RVUs relative to work RVUs. That change was not phased in. Based on consideration of these comments, CMS is finalizing as proposed the adjustment to the relationship among the work, PE, and malpractice component RVUs to reflect the MEI cost share being finalized in this final rule with comment period, with the necessary adjustment to the conversion factor and to PE and MP RVUs to maintain budget neutrality.

L. Geographic Practice Cost Indices (GPCIs) (Page 477)

Section 1848(e)(1)(C) of the Act requires that “if more than 1 year has elapsed since the date of the last previous GPCI adjustment, the adjustment to be applied in the first year of the next adjustment shall be 1/2 of the adjustment that otherwise would be made.” Therefore, since the previous GPCI update was implemented in CY 2011 and CY 2012, CMS will phase in 1/2 of the latest GPCI adjustment in CY 2014.

The American Taxpayer Relief Act of 2012 (ATRA) extended the 1.0 work GPCI floor only through December 31, 2013. Therefore, the proposed CY 2014 work GPCIs and summarized geographic adjustment factors (GAFs) do not reflect the 1.0 work floor. However, as required by the Act, the 1.5 work GPCI floor for Alaska and the 1.0 PE GPCI floor for frontier states are permanent, and therefore, applicable in CY 2014. Due to the expiration of the work GPCI floor, beginning January 1, 2014, PFS payment amounts will be calculated based upon the actual work GPCI for the locality rather than using the 1.0 work GPCI floor (except in Alaska where the statutory 1.5 work GPCI floor will continue to apply).

The updated GPCI values were calculated by a contractor to CMS. There are three GPCIs (work, PE, and MP), and all GPCIs are calculated through comparison to a national average for each type. Additionally, each of the three GPCIs relies on its own data source(s) and methodology for calculating its value as described below. Additional information on the CY 2014 GPCI update may be found in the contractor’s draft report, “Draft Report on the CY 2014 Update of the Geographic Practice Cost Index for the Medicare Physician Fee Schedule,” which is available on the CMS website. It is located under the supporting documents section of the CY 2014 PFS proposed rule located at http://www.cms.gov/PhysicianFeeSched/. CMS noted in the final rule that the contractor’s final report and associated analysis will be posted on the CMS website after
Additionally, for the past several GPCI updates, CMS was not able to collect MP premium data from insurer rate filings for the Puerto Rico payment locality. For the CY 2014 (seventh) GPCI update, CMS worked directly with the Puerto Rico Insurance Commissioner and Institute of Statistics to obtain data on MP insurance premiums that were used to calculate an updated MP GPCI for Puerto Rico. Using updated MP premium data will result in a 17 percent increase in MP GPCI for the Puerto Rico payment locality under the fully phased-in seventh GPCI update, which will be effective CY 2015.

CMS received a variety of comments on GPCI calculations for Puerto Rico. One comment was that Puerto Rico costs are higher than those on the mainland due to increased shipping costs. CMS stated that in light of the comment that shipping costs are more expensive for the Puerto Rico payment locality (and rural areas, as discussed later in this section by other commenters), they are requesting specific information regarding potential data sources for shipping costs for medical equipment and supplies that are accessible to the public, available on a national basis for both urban and rural areas, and updated regularly.

CMS has historically updated the GPCI cost share weights to make them consistent with the most recent update to the MEI, and they will do so again for CY 2014. As a result, the cost share weight for the work GPCI (as a percentage of the total) is changed from 48.266 percent to 50.866 percent, and the cost share weight for the PE GPCI is revised from 47.439 percent to 44.839 percent with a change in the employee compensation component from 19.153 to 16.553 percentage points. The cost share weights for the office rent component (10.223 percent), purchased services component (8.095 percent), and the medical equipment, supplies, and other miscellaneous expenses component (9.968 percent) of the PE GPCI and the cost share weight for the MP GPCI (4.295 percent) remains unchanged.

The CY 2014 updated GPCIs and summarized GAFs by Medicare PFS locality may be found in Addenda D and E to the CY 2014 final rule available on the CMS website under the supporting documents section of the CY 2014 proposed rule web page at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.

In addition, CMS is considering options for changing the locality configurations and will provide information including a detailed analysis of the impact of the changes for physicians in future rulemaking. CMS would also provide opportunities for public input in this process.

M. Incident To (Page 574)

CMS is finalizing the proposal to amend current regulations to make compliance with state law a requirement for all “incident to” services. In addition to health and safety benefits CMS believes would accrue to the Medicare patient population, this approach will assure that federal dollars are not expended for services that do not meet the standards of the states in which they are being
furnished, and provides the ability for the federal government to recover funds paid where services and supplies are not furnished in accordance with state law.

N. Chronic Care Management Services (Page 589)

CMS indicates that the physician community continues to provide feedback that the care management included in many of the E/M services, such as office visits, does not adequately describe the typical non-face-to-face care management work involved for certain categories of beneficiaries. CMS agrees and believes that the resources required to furnish complex chronic care management services to beneficiaries with multiple chronic conditions are not adequately reflected in the existing E/M codes. CMS is proposing to establish a separate payment for CY 2015 under the PFS for complex chronic care management services furnished to patients with multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

CMS also intends to develop standards for furnishing complex chronic care management services to ensure that the physicians who bill for these services have the capability to provide them. One of the reasons for the proposed 2015 implementation date is to provide sufficient time to develop and obtain public input on these standards. CMS sought comment on potential care coordination standards and the work and practice expense that would be associated with these services. CMS is developing the standards in 2014 and will implement them in 2015. They will be established through notice and comment rulemaking for CY 2015 PFS.

In response to comments that the eligibility standards should be broadened or narrowed, CMS indicated that they may consider changes to the patient eligibility in future rulemaking.

CMS also received comments that use of the word “complex” versus “chronic may cause confusion. Therefore, to reduce potential confusion, CMS will revise the code description for these services to describe “chronic care management” services rather than complex chronic care management services.

In response to commenters’ concerns about a 90-day billing interval, CMS is adopting a 30-day billing interval for chronic care management services. Given the shorter 30-day period, CMS is establishing a billing code that corresponds to 20 minutes of service during the 30-day period. Similar to the proposal, at least 20 minutes of chronic care management services must be provided during the 30-day billing interval. Time of less than 20 minutes over the 30-day period could not be rounded up to 20 minutes to bill for these services.

In response to comments that CMS should not limit chronic care management services to primary care physicians, CMS confirmed that, while they expect the chronic care management code to be billed most frequently by primary care physicians, specialists who meet the requirements may also bill for these services.
O. Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) (Page 671)

CMS finalized their proposal to exercise their discretion and authority to modify coverage of AAA screening consistent with the recommendations of the USPSTF to eliminate the one-year time limit with respect to the referral for this service. This modification will allow coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the initial preventive physical examination (IPPE).

P. Liability for Overpayments to or on Behalf of Individuals including Payments to Providers or Other Persons (Page 698)

In accordance with the ATRA, CMS is finalizing the proposal to change the timeframe for which a provider is presumed for administrative purposes to be “without fault” for an overpayment from three years to five years. This presumption is negated if there is evidence to show that the provider or other person was responsible for causing the overpayment. In response to comments opposing the change, CMS notes that although the Secretary has the authority to reduce the 5-year timeframe to not less than 1 year consistent with the objectives of the program, CMS does not believe that the Secretary has any basis for such reduction at this time, particularly in light of the Congressional intent expressed by the ATRA provisions.