The Centers for Medicare and Medicaid Services (CMS) released the review copy of the 2015 Medicare Physician Fee Schedule (PFS) Final Rule on October 31, 2014. The American College of Radiology (ACR) will be submitting comments to CMS within the 60-day comment period. The following is a detailed summary of the Final Rule.

**Conversion Factor and Impacts (p. 517)**

The calendar year (CY) 2014 conversion factor (CF) is $35.8228. The CY 2015 CF will remain at $35.8013 from January 1 through March 31 as mandated by section 101 of the Protecting Access to Medicare Act (PAMA) legislation. Effective April 1, 2015, the conversion factor based on the sustainable growth rate (SGR) formula will be $28.22 representing a 21.2 percent decrease unless Congress acts to override this mandate. (See table 45 below.)

**TABLE 45: Calculation of the CY 2015 PFS**

<table>
<thead>
<tr>
<th></th>
<th>January 1, 2015 through March 31, 2015</th>
<th>April 1, 2015 through December 31, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversion Factor in effect in CY 2014</td>
<td>$35.8228</td>
<td></td>
</tr>
<tr>
<td>Update</td>
<td>0.0 percent (1.00)</td>
<td></td>
</tr>
<tr>
<td>CY 2015 RVU Budget Neutrality Adjustment</td>
<td>-0.06 percent (0.9994)</td>
<td></td>
</tr>
<tr>
<td><strong>CY 2015 Conversion Factor</strong></td>
<td><strong>$35.8013</strong></td>
<td></td>
</tr>
<tr>
<td>(1/1/2015 through 3/31/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conversion Factor in effect in CY 2014</td>
<td>$35.8228</td>
<td></td>
</tr>
<tr>
<td>CY 2014 Conversion Factor had statutory increases not applied</td>
<td>$27.2006</td>
<td></td>
</tr>
<tr>
<td>CY 2015 Medicare Economic Index</td>
<td>0.8 percent (1.008)</td>
<td></td>
</tr>
<tr>
<td>CY 2015 Update Adjustment Factor</td>
<td>-3.0 percent (1.03)</td>
<td></td>
</tr>
<tr>
<td>CY 2015 RVU Budget Neutrality Adjustment</td>
<td>-0.06 percent (0.9994)</td>
<td></td>
</tr>
<tr>
<td><strong>CY 2015 Conversion Factor</strong></td>
<td><strong>$28.2239</strong></td>
<td></td>
</tr>
<tr>
<td>(4/1/2015 through 12/31/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Change in Conversion Factor on 4/1/2015 (relative to the CY 2014 CF)</td>
<td>-21.2%</td>
<td></td>
</tr>
<tr>
<td>Percent Change in Update (without budget neutrality adjustment) on 4/1/2015 (relative to the CY 2014 CF)</td>
<td>-20.9%</td>
<td></td>
</tr>
</tbody>
</table>

An excerpt from Table 93 (p. 1113 of the display copy of the Final Rule) shows the impact on radiology and radiation oncology for the period January 1-March 31, 2015.
These impacts are a national aggregate of the specialty and do not reflect the case-mix of individual radiology and radiation oncology practices nor changes to individual Current Procedural Terminology (CPT®) code as a result of policy changes in this rule. These impacts are also independent from any changes that might take place in the conversion factor after March 31, 2015.

**TABLE 93: CY 2015 PFS Final Rule with Comment Period Estimated Impact Table:**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>(B) Allowed Charges (mil)</th>
<th>(C) Impact of Work RVU Changes</th>
<th>(D) Impact of PE RVU Changes</th>
<th>(E) Impact of MP RVU Changes</th>
<th>(F) Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTERVENTIONAL RADIOLOGY</td>
<td>$273</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>NUCLEAR MEDICINE</td>
<td>$49</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>RADIATION ONCOLOGY</td>
<td>$1,794</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>RADIATION THERAPY CENTERS</td>
<td>$57</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>RADIOLGY</td>
<td>$4,523</td>
<td>0%</td>
<td>-1%</td>
<td>0%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

**Valuing New, Revised, and Potentially Misvalued Codes (p.202)**

As the ACR and other specialty societies recommended, CMS will use CY 2016 as a transition year to further refine the process of disclosing the values of new and revised codes in the proposed rule instead of the final rule. Codes submitted for the CY 2016 cycle will not be negatively affected by the timing of this change. This delay in implementation will provide additional time for the CPT Editorial Panel and the Relative Value Scale Update Committee (RUC) to adjust their agendas and the timing of their recommendations to CMS to more appropriately align with the new process. The ACR feels strongly that radiology practices should have this type of information as soon as possible in the calendar year so that they can be aware of any changes that may affect their payments for the following year.

CMS understands that the implementation of a new process affects stakeholders in differing ways and has, therefore, delayed the adoption of two new code sets (radiation therapy and lower gastrointestinal endoscopies) until CY 2016 as requested by the specialty societies. This will afford those affected by these significant changes an opportunity to comment on CMS’ proposals for valuing these code sets before they are implemented. (See section II.G.3 of this final rule.)

In preparation for the changes in the CPT and RUC cycle to coincide with the proposed rule and final rule cycle, the AMA has been working to develop timeframes that would allow a much higher percentage of codes to be addressed in
the proposed rule, and has shared with CMS some plans to achieve that goal. CMS is confident that with the finalization of this process, the CPT Editorial Panel and the RUC will be able to adjust their timelines and processes so that most, if not all, of the annual coding changes and valuation recommendations can be addressed in the proposed rule prior to the effective date of the coding changes. This transition year will provide more time for CMS and AMA to negotiate the details of the needed changes.

**Proposed Potentially Misvalued Codes through High Expenditure Specialty Screen (p. 105)**

CMS noted that high program expenditures and high utilization have varying causes and do not necessarily reflect misvalued codes. However, CMS continues to believe that the high expenditure screen is nevertheless an appropriate means of focusing their reviews, ensuring appropriate relativity among Physician Fee Schedule (PFS) services, and identifying services that are either over or undervalued. The codes included in the screen have significant impact on PFS payment at the specialty level; therefore, a review of the relativity of the codes is essential to ensure that the work and practice expense (PE) relative value units (RVUs) are appropriately relative within the specialty and across specialties. To develop a robust and representative list of codes for review, CMS examines the highest PFS expenditure services by specialty and identifies those codes that have not been recently reviewed (76 FR 73060).

Because CMS is not finalizing a particular list of codes for this screen in the final rule, they are not addressing individual codes at this time. However, CMS does not agree with commenters that codes that have been referred to CPT by the RUC should be excluded from the potentially misvalued list; rather, they believe that only when these codes are either deleted or revised, and/or they receive new RUC recommendations for re-valuing these codes, would it be appropriate to remove these services from the list.

Several radiology codes were identified through this high expenditure specialty screen. The ACR will not be surveying or presenting recommendations on these codes. See Table 11 below:
Digital breast tomosynthesis (DBT) has been assigned new billing codes and reimbursement rates in the CY 2015 Medicare Physician Fee Schedule (MPFS) Final Rule.

In response to a request from the ACR, American Roentgen Ray Society and Radiological Society of North America, the CPT Editorial Panel created three new codes (77061, 77062, 77063) to describe the physician work and practice expense associated with screening and diagnostic DBT. However, CMS recommends in the 2015 MPFS that only 77063, (*screening digital breast tomosynthesis, bilateral*) be used at this time in conjunction with the digital screening mammography code G0202. The recommendation is based on a Food & Drug Administration
requirement that a 2-D mammogram accompany a DBT when used for screening purposes.

In lieu of using the new diagnostic DBT CPT codes (77061, 77062), CMS created a new add-on G code (G0279) to be used with the existing digital diagnostic mammography codes (G0204, G0206) to reflect the work of tomosynthesis when provided with diagnostic digital mammography. Therefore, the stand-alone diagnostic DBT codes have been replaced by add-on codes, leaving no means to report diagnostic DBT when it is reported separately from a full-field digital mammogram (FFDM).

Further, the payment rate for the new diagnostic DBT code G0279 (0.6 RVU) is lower than the recommendation made by the AMA/ Specialty Society RVS Update Committee (RUC) for the diagnostic DBT CPT codes (0.7 RVU for unilateral and 0.9 RVUs for bilateral). The ACR disagrees with the payment rate for screening and diagnostic DBT being equal as diagnostic is more work intensive. Medicare will continue to pay separately for the existing FFDM G codes and film CPT mammography codes and has put its proposal to retire the G codes for digital mammography on hold pending a review of the entire mammography code family in 2015. CMS also will modify the descriptor for the FFDM G codes (G0202-G0204) so that they are specific to 2-D digital mammography.

The 2014 RVUs from each of the following codes will be used to price mammography for 2015: G0202, G0204, G0206, 77055, 77056, and 77057. CMS noted in the Medicare Physician Fee Schedule Final Rule that they will continue to pay for mammography services at the 2014 rates until they revalue all mammography services. As noted in the following table, the diagnostic DBT codes, 77061 and 77062, have not been assigned an RVU value, and the new add-on diagnostic DBT code, G0279, has been assigned the same value as the screening DBT code 77063.

The ACR and RUC also made recommendations to CMS regarding the direct inputs used to determine practice expense (PE) RVUs (technical component (TC) payment). CMS lowered the price of the DBT unit from the RUC recommended invoice price of $498,412 to $381,380 based on separately acquired invoices.

View table

The ACR recommended in its comment letter on the 2015 proposed rule that CMS maintain the 2014 payment rate beyond CY 2015. CMS had asked the RUC to review the mammography CPT and G codes, but the ACR discouraged survey or formal recommendations until the RUC’s recommendations for DBT were finalized by CMS; and the film-to-digital conversion, reflected in the use of Picture Archiving and Communication System (PACS), was fully implemented beyond the proposal in the CY 2015 proposed rule.
The ACR argued before the RUC that surveying mammography along with DBT would preclude an accurate valuation of DBT. DBT and mammography involve different technologies, different work, different practice expenses, and often different patients. Because DBT is a new technology, the data regarding utilization, site of service, and specialty remain to be seen. To include DBT as simply part of the mammography code family is premature and may eventually prove to be inaccurate. The ACR plan is to re-review the DBT family in three years per the conventional Relativity Assessment Workgroup (RAW) schedule for the re-review of new technologies.

CMS noted in the final rule that it is including the codes for digital mammography on the potentially misvalued code list. However, CMS will wait to value the new diagnostic mammography tomosynthesis codes until CMS staff receives recommendations from the RUC for all mammography services. As noted above, codes 77061 and 77062 for diagnostic DBT will not be used in 2015. Diagnostic mammography using tomosynthesis will be reported with the diagnostic digital mammography codes G0204 and G0206, and add-on code G0279 (Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206)).

Using the 2015 conversion factor of $35.80, the following global national payment rates will apply for mammography:

<table>
<thead>
<tr>
<th></th>
<th>Film</th>
<th>Digital</th>
<th>Digital With Tomo</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unilateral</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Mammogram</td>
<td>77055</td>
<td>G0206</td>
<td>G0206 + G0279</td>
</tr>
<tr>
<td></td>
<td>$90.22</td>
<td>$129.60</td>
<td>$129.60 + $56.57</td>
</tr>
<tr>
<td><strong>Bilateral</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Mammogram</td>
<td>77056</td>
<td>G0204</td>
<td>G0204 + G0279</td>
</tr>
<tr>
<td></td>
<td>$116.00</td>
<td>$164.69</td>
<td>$164.69 + $56.57</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td>77057</td>
<td>G0202</td>
<td>G0202 + 77063</td>
</tr>
<tr>
<td></td>
<td>$82.70</td>
<td>$134.97</td>
<td>$134.97 + $56.57</td>
</tr>
</tbody>
</table>

Note: Patients will not be responsible for any co-pays associated with the new screening DBT codes. The screening tomosynthesis add-on code, 77063, would be subject to the same co-insurance/deductible policies as other screening mammography services. Code G0279 relates to a diagnostic procedure, therefore, it would not follow the same policies as those established for the screening studies.

**Breast Biopsy (Page 256)**

In its comments on the 2014 Final Rule, the ACR commented on the reduced payments for breast biopsy and percutaneous placement of devices as a result of the development of new bundled codes. The physician work values recommended by the RUC for these codes were too low and CMS further lowered the value for the...
MR-guided marker placement codes. In addition, ACR commented that the practice expense payments do not adequately cover the cost of the mammotome device.

CMS notified ACR that they would honor our request to review the physician work of the breast biopsy codes (19081-19086) and percutaneous placement of device(s) codes (19281-19288) in their Refinement Panel process. Dr. Ezequiel Silva ably represented the ACR, and provided an overview of the family of 14 codes. The Panel discussion centered on the MR-guided placement codes, 19287-19288 and did not specifically address the other codes in the family. The specialties represented, including ACR, SIR, ACS and ASBS, reiterated concerns that reductions across the family could potentially impact access for patients, and encouraged the Panel to reconsider the value for the breast biopsy codes. The Refinement Panel recommended an increase in the value for the two stereotactic biopsy codes and the two MR clip placement codes. However, in the 2015 final rule, CMS ignored the decision of the Refinement Panel electing to finalize the existing 2014 values for all 14 codes.

Also, the new breast biopsy codes do not make the distinction in payment between a needle core approach versus vacuum-assisted of which have significantly different practice expense inputs and therefore costs. CMS received many comments requesting that they remedy this since the technical component payment rates are too low when the biopsy service is provided using the vacuum-assisted device. CMS noted that the commenters are mistaken regarding how the inputs for these codes were determined, as they are based upon the typical service being vacuum assisted. CMS reviewed the practice expense inputs and will be making adjustments to eliminate items they consider duplicative, as well as establishing a new equipment item, “breast biopsy device (coil) (EQ371) at a price of $12,238.

Therefore, CMS is finalizing the 2014 physician work values and code structure for the breast biopsy codes, and will make adjustments to the practice expense inputs.

Urban Institute Interim Report (p. 100)

Section 1848(c) (2) (L) of the Social Security Act requires the Secretary to establish a formal process to validate RVUs under the MPFS. To that end, CMS contracted with the Urban Institute (UI) to collect time data from several practices for services selected by the contractor in consultation with CMS. The services to be studied by the UI include a large proportion of radiology studies. The data from this effort will be used to develop time estimates to 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. In its efforts to collect primary data on the time involved in MPFS services, the Urban Institute has encountered numerous challenges. An interim report, Development of a Model for the Valuation of Work Relative Value Units, discusses the challenges encountered in collecting objective
time data and offers some thoughts on how these can be overcome. This interim report is on the [CMS website](https://www.cms.gov).

CMS also has a second contract with the RAND Corporation, which is using available data to build a validation model to predict work RVUs and the individual components of work RVUs, time, and intensity. CMS anticipates a report from this project by the end of the year and will make the report available on the CMS website.

The ACR expressed significant concerns regarding study design, pre-study bias, inadequate sampling of services studied, and flaws in the data collection protocols in its comments on the proposed rule. In this final rule CMS did not respond to the ACR’s concerns but indicated that any changes to payment policies under the PFS will be disclosed in a future proposed rule and subjected to public comment before they would be finalized and implemented.

**Migration from Film-to-Digital Practice Expense (PE) Inputs (p. 51)**

The RUC created the Film-to-Digital Imaging Workgroup to formulate recommendations regarding the transition from film-to-digital imaging. The ACR was an active participant in this RUC workgroup, which submitted recommendations to CMS following the April 2013 RUC meeting. The RUC recommended that CMS replace the film supplies and equipment from 604 existing imaging codes with PACS specific supplies and equipment. A list of 30 film-related supply and equipment items was provided to CMS, along with a comprehensive list of replacement PACS related supplies and equipment. The PACS related supplies and equipment (listed in Table 6 of the final rule) include such items as the quality assurance (QA) station, PACS servers, PACS software, and PACS physician workstations. CMS states that “since they did not receive any invoices for the PACS system, they are unable to determine the appropriate pricing to use for the inputs. CMS proposed to accept the RUC recommendation to remove the film supply and equipment items, and to allocate minutes for a desktop computer (ED021) as a proxy for the PACS workstation as a direct expense.

The ACR agrees that removal of the RUC-recommended list of supplies and equipment items associated with film technology is appropriate for the 604 imaging codes provided by the RUC, but only if it is conducted in a reasonable manner where an actual migration of valid inputs takes place that reflects appropriate PACS related inputs. To unilaterally remove the film-based inputs and simply allocate minutes to a desktop computer (ED021) greatly underestimates the expenses incurred by physicians.

The impacts of these input changes are sizeable for a number of codes, such as the 38 codes that CMS highlights in Table 8 below which includes myelography, CTA and ultrasound studies. Many other codes, such as 76377 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging,
ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation), suffers from this transition as well.

### TABLE 8: 2015 Codes Affected by Removal of Film Inputs

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>HCPCS</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>22510</td>
<td>Percervicothoracic injection</td>
<td>93314</td>
<td>Echo transesophageal</td>
</tr>
<tr>
<td>22511</td>
<td>Perclumbosacral injection</td>
<td>93320</td>
<td>Doppler echo exam heart</td>
</tr>
<tr>
<td>22513</td>
<td>Percvertebral augmentation</td>
<td>93321</td>
<td>Doppler echo exam heart</td>
</tr>
<tr>
<td>22514</td>
<td>Perc vertebral augmentation</td>
<td>93325</td>
<td>Doppler color flow add-on</td>
</tr>
<tr>
<td>62302</td>
<td>Myelography lumbar injection</td>
<td>93880</td>
<td>Extracranial bilat study</td>
</tr>
<tr>
<td>62303</td>
<td>Myelography lumbar injection</td>
<td>93882</td>
<td>Extracranial uni/ltd study</td>
</tr>
<tr>
<td>62304</td>
<td>Myelography lumbar injection</td>
<td>93886</td>
<td>Intracranial complete study</td>
</tr>
<tr>
<td>62305</td>
<td>Myelography lumbar injection</td>
<td>93888</td>
<td>Intracranial limited study</td>
</tr>
<tr>
<td>71275</td>
<td>Ctangiography chest</td>
<td>93895</td>
<td>Carotid intima atheroma eval</td>
</tr>
<tr>
<td>71276</td>
<td>Ct angiography pelv w/o&amp;w/dye</td>
<td>93925</td>
<td>Lower extremity study</td>
</tr>
<tr>
<td>72240</td>
<td>Myelography neck spine</td>
<td>93926</td>
<td>Lower extremity study</td>
</tr>
<tr>
<td>72255</td>
<td>Myelography thoracic spine</td>
<td>93930</td>
<td>Upper extremity study</td>
</tr>
<tr>
<td>72265</td>
<td>Myelography l-s spine</td>
<td>93931</td>
<td>Upper extremity study</td>
</tr>
<tr>
<td>72270</td>
<td>Myelography 2/&gt; spine regions</td>
<td>93970</td>
<td>Extremity study</td>
</tr>
<tr>
<td>74174</td>
<td>Ctaangi abd&amp;pelv w/o&amp;w/dye</td>
<td>93971</td>
<td>Extremity study</td>
</tr>
<tr>
<td>74175</td>
<td>Ctanio abdomen w/o &amp; w/dye</td>
<td>93975</td>
<td>Vascular study</td>
</tr>
<tr>
<td>74230</td>
<td>Cine/vid x-ray throat/esoph</td>
<td>93976</td>
<td>Vascular study</td>
</tr>
<tr>
<td>76942</td>
<td>Echo guide for biopsy</td>
<td>93978</td>
<td>Vascular study</td>
</tr>
<tr>
<td>93312</td>
<td>Echo transesophageal</td>
<td>93979</td>
<td>Vascular study</td>
</tr>
</tbody>
</table>

In our proposed rule comment letter, the ACR requested that CMS delay, for one year, removal of the supply and equipment items associated with film technology and the use of a desktop computer as a proxy for the PACS workstation. In the meantime, the ACR committed to work with CMS to ensure that the proper digital inputs are identified and integrated into the CMS database along with appropriate invoices.

Since that time, the ACR PACS workgroup was formed. The PACS workgroup is comprised of physicians, business managers, and IT and other industry professionals. Per the suggestion of CMS, we have also involved consultants to ensure that our recommendations coincide with the current PE methodology. The PACS workgroup is working to gather information to present to CMS. ACR’s goal is to collaborate on recommendations in time for public comment during the CY 2016 notice of proposed rule making (NPRM).

CMS ignored the ACR’s request for a delay and has finalized its decision to move forward with removing the direct inputs for the use of film-based studies and use the computer work station as a proxy until they receive further information. CMS is seeking specific information on what direct inputs are related to the PACS system including clinical time, supplies and equipment, and is requesting related invoices that reflect current market pricing.
Abdominal Aortic Aneurysm (AAA) Ultrasound Screening (p. 120)

Medicare began paying for abdominal aortic aneurysm (AAA) ultrasound screening in 2007 when HCPCS code G0389 (Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening) was created in response to the Deficit Reduction Act of 2005. The RVUs were set at the same level as CPT code 76775 (Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), B-scan and/or real time with image documentation; limited). Code 76775 is used to report the service when furnished as a diagnostic test, and CMS believed the service reflected by G0389 used equivalent resources and work intensity [71 FR 69664 through 69665]. In the CY 2014 final rule, CMS replaced the ultrasound room included as a direct PE input for CPT code 76775 with a portable ultrasound unit based upon a RUC recommendation. Since the RVUs for G0389 were crosswalked from CPT code 76775, the PE RVUs for G0389 were reduced significantly as a result of this change.

CMS proposed G0389 as a potentially misvalued code and is seeking recommendations regarding the appropriate inputs that should be used to develop RVUs for this code. In the interim, CMS is proposing to maintain the work RVU for this code and to revert to the same PE RVUs that were used for CY 2013, adjusted for budget neutrality.

The ACR agreed that the reduction in the PE RVUs in CY 2014 for G0389 was inappropriate and unintended, and recommended that G0389 maintain the general ultrasound room and have its PE RVUs set and maintained as such.

CMS did not accept ACR’s request to maintain the general ultrasound room but instead will still consider G0389 misvalued and is requesting that new inputs be submitted for this code in 2015 to be considered for value in the next proposed rule cycle.

Radiation Treatment Vault (p. 63)

CMS proposed to remove the radiation treatment vault as a direct practice expense (PE) input from the radiation treatment procedures [stereotactic body radiation therapy delivery (77373) and radiation treatment delivery (77402-77418)] in CY 2015. Specifically, they questioned whether it was consistent with the principles underlying the PE methodology to include the radiation treatment vault as a direct cost given that it appears to be more similar to building infrastructure costs (indirect) than to medical equipment costs (direct).

The ACR believed it was premature for CMS to make a determination on removing the vault as a direct PE when the agency was scheduled to introduce significant payment rate changes to the radiation treatment delivery code set in the CY 2015 final MPFS. The combination of these two monumental changes to radiation
oncology treatment codes was of great concern to the ACR. On the individual code level, the impact ranges from -2% to almost -16%.

The ACR strongly urged CMS to consider the totality of variables impacting radiation oncology payments in 2015 and to take the most reasonable and balanced approach by delaying any final decision on the vault until after implementing the 2015 radiation oncology coding changes.

After continued review of the issues pertaining to the vault in the context of the comments, CMS believes that these issues require further study. Therefore, at this time, CMS will continue to include the vault as a direct PE input for stereotactic body radiation therapy delivery (77373) and radiation treatment delivery (77402-77418).


In the MPFS, SRS and Stereotactic Body Radiation Therapy (SBRT) services furnished using robotic methods are billed using contractor-priced G-codes: G0339 (Image-guided robotic linear accelerator based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment), and G0340 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment). Based on comments received in the CY 2014 cycle, including those from the ACR, CMS concluded that the PE relative value units for the CPT codes accurately captured the resources utilized for robotic SRS and SBRT services. For CY 2015, CMS proposed to recognize only the CPT codes for payment of SRS and SBRT services, and to delete the G-codes used to report robotic delivery of SRS and SBRT.

The deletion of the G-codes and use of CPT codes could have a potential significant impact on reimbursement for this effective treatment for a high-risk population of cancer patients, and the ACR urged CMS to closely monitor access to SRS and SBRT services to ensure that this proposed policy change did not limit patient access.

After consideration of the comments regarding the appropriate inputs to use in pricing the SRS services, CMS concluded that at this time, they lack sufficient information to make a determination about the appropriateness of deleting the G-codes and paying for all SRS and SBRT services using the CPT codes. Therefore, CMS will not delete the G-codes for 2015, but will instead work with stakeholders to identify an alternate approach and reconsider this issue in future rulemaking.
Transcatheter Placement Intravascular Stent (CPT Codes 37236 and 37237) (p. 304)

For CY 2014, CMS established the RUC-recommended work RVUs for newly created CPT codes 37236, 37237, and 37238 as the interim final values. CMS disagreed with the RUC recommended work RVU for CPT code 37239, which is the add-on code to CPT code 37238, for the placement of an intravascular stent in each additional vein. CMS stated in the CY 2014 final rule that they believe that the work for placement of an additional vein stent versus the initial vein stent should bear the same relationship as the work of placing an additional artery stent versus the initial artery stent.

In addition, a multispecialty group, which included the ACR, requested that CMS correct a practice expense problem with CPT codes 37236 (Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery) and 37237 (Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)). The multispecialty group submitted PE recommendations on four new stent CPT codes in April 2013. A "new item" for a stent system was submitted for CPT codes 37236 and 37237. Proper documentation indicating a price of $1500 was included. When CMS implemented the codes, it replaced the new item with an existing input - SD152 a balloon catheter for $243. The issue was not discussed in the CY 2015 proposed rule. The CMS 2015 direct practice input files still include SD152 for CPT codes 37236 and 37237. The ACR urged CMS to correct this error in the 2015 fee schedule.

After re-review, CMS continues to believe that the ratio of the work of the placement of the initial stent to the placement of additional stents is the same whether the stents are placed in an artery or a vein, and accordingly the appropriate ratio is found in the RUC-recommended work RVUs of CPT codes 37236 and 37237, the comparable codes for the arteries. For that reason, they are finalizing their CY 2014 interim final values. Additionally, they did not refer these codes for refinement panel review because the criteria for refinement panel review were not met.

CMS acknowledged the ACR’s clarification on the practice expense supply items, and have added the “balloon implantable stent” at a price of $1,500, removing the proxy item SD152 for CPT codes 37236 and 37237. CMS indicated that when line items on the invoices provided are not clearly labeled, it is often difficult for CMS to determine how to relate the items on the PE spreadsheet with the items on the invoices.
Relative Value Scale Update Committee (RUC) Recommendation for Standard Moderate Sedation Package (p. 49)

CMS proposed to modify the standard moderate sedation input package to include a stretcher for the same length of time as the other equipment items in the moderate sedation package.

The ACR agreed that the stretcher should be allocated with the same time as the other moderate sedation specific inputs since it is used by the patient for the duration of their recovery and is not available to other patients during that time.

CMS finalized their decision to add a stretcher to the standard moderate sedation package for the same length of time as the other equipment items in the package. CMS will not apply this change retroactively, but will apply the revised package to relevant procedure codes for which moderate sedation is inherent as they are reviewed in the future.

Using Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Rates in Developing Practice Expense Relative Value Units (RVUs) (p. 76)

As stated in our comment letter on the CY 2014 proposed rule, the ACR believes that the proposal to use the current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services under the MPFS is inappropriate. We appreciate CMS’ recognition of the concerns raised in last year’s rulemaking process and thank the agency for not proposing a similar policy for CY 2015.

CMS in the CY 2015 PFS proposed rule sought comment on the possible uses of the Medicare hospital outpatient cost data in potential revisions of the PFS PE methodology. The majority of comments received by CMS urged a withdrawal of the proposal, yet CMS continues to believe that there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology.

CMS will move forward with the use of a new modifier to collect data to assess the extent to which the shift toward hospital-based physician practices is occurring. Reporting of the 2-digit “PO” modifier “Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments” will be voluntary for one year (CY 2015), with reporting required beginning on January 1, 2016. Through this data collection CMS is seeking to gain a better understanding of which practice expense costs typically are incurred by physician-owned imaging centers, which are incurred by the hospital, and whether there is a significant difference in resource costs given the differences in ownership arrangements. This is in reaction to Medicare Payment Advisory Commission’s (MedPAC) comments that CMS should set hospital outpatient payment rates at the same rate as physician offices when the office rates are the lowest. CMS feels that this effort is also within
Medicare’s expanded authority to evaluate mis-valued codes as provided under the Protecting Access to Medicare Act.

The ACR does not support the concept of using hospital outpatient cost data in potential revisions of the PFS PE methodology, as we know from our experience with the CT and MR cost centers that the OPPS cost reports are often inadequate and inappropriate for application to the MPFS. The ACR provided comment stating that the proposal to use the current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services under the MPFS would be inappropriate, as hospitals can spread costs across multiple cost centers or use unconventional accounting methods such as square foot allocation.

After consideration of the comments received, CMS has chosen to finalize its proposal with modifications. Moving forward, with respect to the point of service (POS) code for professional claims, CMS will be requesting two new POS codes to replace POS code 22 (Hospital Outpatient) through the POS Workgroup with the full expectation that it will take some time for these new codes to be established. The effective date of the POS codes will be as soon as CMS can create and release them. Additionally, CMS is finalizing their proposal to create a HCPCs modifier for hospital services furnished in an off-campus provider-based department setting. The reporting period for this new modifier will be voluntary for one year and will not be mandatory until January 1, 2016, in order to allow providers time to make systems changes, test those changes, and train staff on use of the new modifier before reporting is required. Additional instruction and provider education will be available in forthcoming sub-regulatory guidance.

Valuing Services that Include Moderate Sedation as an Inherent Part of Furnishing the Procedure (p.159)

Recently, CMS performed an analysis of Medicare claims data, which “clearly indicated that moderate sedation was no longer typical for all of the procedures listed in CPT’s Appendix G, and, in fact, the data suggest that the percentage of cases in which it is used is declining.”

The ACR disagreed with this assertion and believes that the radiology codes in Appendix G are typically reported with moderate sedation. Appendix G of the CPT manual contains over 300 diagnostic and therapeutic procedure codes for which moderate sedation is thought to be an inherent part of the procedure. Because these codes are included in Appendix G, moderate sedation (i.e. 99144) is not separately reimbursed. Therefore, providers, by convention, do not report the moderate sedation codes separately. It is not clear how CMS could conclude that “moderate sedation is no longer typical” for radiology codes through any meaningful claims-based analysis. CMS references studies indicating that moderate sedation may not be typical for colonoscopies, but we are not aware of similar findings.
regarding the radiology codes in Appendix G. ACR requested that if other data is available, this should be shared for public comment.

CMS is not making any changes at this time to how they value Appendix G codes for which moderate sedation is an inherent part of the procedure. CMS intends to address this topic in future notice and comment rulemaking, taking into account the comments they received. In section II.G., CMS addresses interim final values and establishes CY 2015 inputs for the lower gastrointestinal procedures, many of which are also listed in Appendix G.

New Standard Supply Package for Contrast Imaging (p. 72)

The RUC recommended the creation of a direct PE input standard supply package “Imaging w/contrast, standard package” for contrast enhanced imaging, valued at $6.82. The package aims to include medical supplies typically used in procedures involving contrast administration, and the price of the package reflects the combined prices of the individual supply items.

While CMS acknowledges a commenter’s suggestion that additional items may be used when echocardiography labs conduct contrast-enhanced ultrasound studies, they do not have information to suggest that these items are used for other imaging studies, such as CT and MRI contrast-enhanced studies. They would welcome more information on whether these items should be included in the newly created standard contrast imaging kit, as well as whether the power injector is used whenever the other inputs in the standard contrast imaging supply package are used, or whether they are used only in certain instances. They note that the reason for the discrepancy in the price for the IV starter kit is that they proposed to update the price at the same time that they proposed to create a new contrast imaging kit. Finally, they disagree with the commenter’s suggestion that CMS provided limited information about the pricing for the items included in the kit, as these items are existing inputs in the direct PE database, and the codes associated with these items were listed in the table in the proposed rule.

The ACR worked extensively with the RUC to identify the supply inputs for, and supports the use of, the new “imaging w/contrast” package for new codes, as appropriate.

After reviewing stakeholder comments, CMS has finalized the creation of the “Imaging w/contrast” package, and also revised the price from $6.82 to $7.06 to reflect the updated price for the “kit, IV starter” (SA019), a component of the package. The price for SA019 was updated from $1.37 to $1.60.

Equipment Cost Per Minute (p. 41)

The equipment cost per minute is calculated as:
(1/(minutes per year * usage)) * price * ((interest rate/(1-(1/((1 + interest rate)^ life of equipment)))) + maintenance)

CMS notes the current 90 percent equipment utilization rate assumption for expensive diagnostic imaging equipment is mandated by The American Taxpayer Relief Act of 2012 (ATRA).

Another piece of the formula used to calculate equipment cost per minute is maintenance costs. CMS received comments that the maintenance factor assumption should be variable. However, CMS does not believe that high-level summary data from informal surveys constitutes as reliable data; rather, CMS noted that multiple invoices containing equipment prices that are accompanied by maintenance contracts would provide support for a maintenance cost other than CMS’ currently assumed 5 percent. CMS will consider this in future rulemaking and will continue to seek reliable data about variable maintenance costs.

The ACR recommended in its proposed rule comments that CMS review the Radiology Business Management Association (RBMA) survey data and increase the maintenance assumption in the equipment cost formula to 10% for all imaging modalities and 15% for mammography.

CMS responded that it does not believe that high-level summary data from informal surveys constitutes as reliable data. Rather than assertions that a particular maintenance rate is typical, multiple invoices containing equipment prices that are accompanied by maintenance contracts would provide support for a maintenance cost other than the currently assumed 5 percent.

The final rule also noted that CMS received comments from stakeholders suggesting that their PE methodology should incorporate usage fees and other per-use equipment costs as direct costs. Other comments suggested CMS adjust their cost formula to include equipment costs that do not vary based on the equipment time, and reclassifying the anomalous supply inputs removed from the direct PE database. CMS will consider these comments in future rulemaking.

Interest Rate Used in Calculation of Equipment Costs per Minute (p. 42)
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 are listed in Table 3 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 to $50K</td>
<td>&lt;7 Years</td>
<td>6.50%</td>
</tr>
</tbody>
</table>
### Payment of Secondary Interpretation of Images (p. 507)

In the proposed rule, CMS solicited comments to determine whether there are an expanded set of circumstances under which more routine Medicare payment for a second professional component (PC) for radiology services would be appropriate, and whether such a policy would likely reduce the incidence of duplicative advanced imaging studies.

Specifically, CMS solicited comments on the following:

- The circumstances under which physicians are currently conducting secondary interpretations and whether they are seeking payment for these interpretations
- Whether more routine payment for secondary interpretations should be restricted to certain high-cost advanced diagnostic imaging services
- Considerations for valuing secondary interpretation services
- The settings in which secondary interpretations chiefly occur
- Considerations for operationalizing more routine payment of secondary interpretations in a manner that would minimize burden on providers and others

The ACR commented in the proposed rule that it believes the entire spectrum of radiology services often involves secondary interpretations and comparison to existing studies, as such all studies have the potential to be clinically relevant. In general, Medicare does not pay radiologists for second interpretations, so radiologists typically do not seek payment for these services. However, paying for secondary interpretations would reduce unnecessary repeat studies and lessen radiation exposure. ACR also noted that secondary interpretations occur in hospital, outpatient and freestanding imaging center settings and should be treated the same as a primary interpretation and the CPT code for the primary interpretation for the examination should apply since equal or even more work, such as comparison to multiple prior examinations, is often required.

CMS noted that it received helpful information about how to implement this policy. Commenters also offered diverse opinions on the time period for which an existing image would be pertinent in support of a secondary interpretation. Most commenters were in agreement that cost savings would be derived from the implementation of a secondary interpretation policy, but there was no consensus as to the amount of such savings. In addition, many commenters pointed out that they were already furnishing secondary interpretations and would appreciate adoption of a policy that would
allow them to receive payment for these services. **CMS responded that they did not propose to make any changes to the treatment of these services in 2015, any changes to their current policy on allowing physicians to more routinely bill for secondary interpretations of images will be addressed in future rulemaking.**

**Payment Policy for Substitute Physician Billing Arrangements (p. 585)**

Through this solicitation, CMS hoped to understand better current industry practices for the use of substitute physicians and the impact that policy changes limiting the use of substitute physicians might have on beneficiary access to physician services.

CMS solicited comments in the proposed rule due to concerns regarding operational and program integrity issues that result from the use of substitute physicians to fill staffing needs or to replace a physician who has permanently left a medical group or employer. CMS is concerned that for a period, both the departed physician and the departed physician’s former medical group might bill Medicare under the departed physician’s National Provider Identifier (NPI) for furnished services. This could occur where a substitute physician is providing services in place of the departed physician in the departed physician’s former medical group, while the departed physician is also providing services to beneficiaries following departure from the former group. CMS noted the continued use of a departed physician’s NPI to bill for services furnished to beneficiaries by a substitute physician raises program integrity issues, particularly if the departed physician is unaware of his or her former medical group or employer’s actions.

The ACR commented in the proposed rule that there are a number of different ways that temporary substitute physicians are used in radiology practices, and restricting the use of these substitute physicians could present significant challenges, especially for practices in smaller and rural locales.

CMS also noted it is concerned that the substitute physician may not be enrolled in the Medicare program. Without being enrolled in Medicare, CMS does not know whether the substitute physician has the proper credentials to furnish the services being billed under section 1842(b)(6)(D) of the Act or if the substitute physician is sanctioned or excluded from Medicare. The importance of enrollment and the resulting transparency afforded the Medicare program and its beneficiaries was recognized by the Congress when it included in the Affordable Care Act a requirement that physicians and other eligible non-physician practitioners (NPPs) enroll in the Medicare program if they wish to order or refer certain items or services for Medicare beneficiaries. This includes those physicians and other eligible NPPs who do not and will not submit claims to a Medicare contractor for the services they furnish. CMS solicited comments regarding how to achieve similar transparency in the context of substitute physician billing arrangements for the identity of the individual actually furnishing the service to a beneficiary.
In the comment letter, the ACR acknowledged CMS’ concerns about identifying the rendering physician in a substitute billing arrangement and ensuring that the rendering physician is eligible to provide services under the Medicare program. Should CMS require enrollment of locum physicians, it is imperative that CMS and commercial insurers offer an expedited online enrollment process for locum physicians so practices may bill for the services provided by these physicians and minimize payment delays.

CMS noted that any regulations would be proposed in a future rulemaking with opportunity for public comment. The comments received on the issues raised in this solicitation will be considered in any future rulemaking on this subject.

**Improving the Valuation and Coding of the Global Package (p. 127)**

Since the inception of the MPFS, CMS has valued and paid for certain services, such as surgery, as part of global packages that include the procedure and the services typically provided in the periods immediately before and after the procedure. The three primary categories of global packages labeled based on the number of post operative days included in the global period are 0-, 10-, and 90-day. CMS notes that the global surgical codes were established several decades ago when surgical follow-up care was far more homogenous than today and despite changes in practice patterns, the basic structures of the global surgery packages are the same as the packages that existed prior to the creation of the resource-based relative value system (RBRVS) in 1992.

CMS proposed to retain global bundles for surgical services, but to refine bundles by transitioning - over several years - all 10- and 90-day global codes to 0-day global codes. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure. CMS proposes to make this transition for current 10-day global codes in CY 2017 and for the current 90-day global codes in CY 2018, pending the availability of data on which to base updated values for the global codes.

As CMS transitions these codes, they would need to establish RVUs that reflect the change in the global period for all the codes currently valued as 10- and 90-day global surgery services. CMS seeks comments on the most efficient means of acquiring accurate data regarding the number of visits and other services actually being furnished by the practitioner during the current post-operative periods. CMS does not believe that survey data reflecting assumptions of the “typical case” meets the standards required to measure the resource costs of the wide range of services furnished during the post-operative periods. CMS believes that collecting information on these services through claims submission may be the best approach and they would propose such a collection through future rulemaking.
After consideration of all the comments received regarding this proposal, CMS will finalize the proposal to transition and revalue all 10- and 90-day global surgery services with 0-day global periods, beginning with the 10-day global services in CY 2017 and following with the 90-day global services in CY 2018. CMS believes this transformation to 0-day global codes is the most straightforward way to improve the accuracy of valuation for the various components of global surgical packages, including pre- and post-operative visits and performance of the surgical procedure.

Reports of Payments or Other Transfers of Value to Covered Recipients

Since the publication and implementation of the “Open Payments” rule on February 1, 2013, various stakeholders have provided feedback to CMS regarding certain aspects of the reporting requirements. Many commenters recommended that accredited or certified continuing education payments to speakers should not be reported because there are safeguards already in place, and they are not direct payments to a covered recipient. Section 403.904(g)(1) states that payments or other transfers of value provided as compensation for speaking at a continuing education program need not be reported if the following three conditions are met:

- The event at which the covered recipient is speaking/serving as faculty meets the accreditation or certification requirements and standards for continuing education of one of the following:
  - The ACCME;
  - The American Academy of Family Physicians;
  - The American Dental Association’s Continuing Education Recognition Program;
  - The American Medical Association;
  - The American Osteopathic Association
- The applicable manufacturer does not pay the covered recipient directly
- The applicable manufacturer does not select the covered recipient or provide a third party (i.e., a continuing education vendor) with a distinct, identifiable set of individuals to be considered as faculty for the continuing education event

The ACR commented in the proposed rule that it supports the original decision by CMS in the February 2013 final rule, that indirect payments made to faculty at continuing medical education (CME) activities are not indirect payments or other transfers of value for the purpose of the Open Payment program and, therefore, do not need to be reported when the specified conditions are met. The ACR also noted in its comments that the proposed decision by CMS to delete 42 CFR 403.904(g), in part because the agency considers it redundant with the exclusion in 403.904(i)(1), is seriously flawed. While there may be overlap between the two sections, they are not the same. Section 403.904(i)(1) excludes “indirect payments” or other transfers of
value where the applicable manufacturer is “unaware” of the covered recipient’s identity during the reporting year, and for two quarters thereafter. Physician faculty and attendees at accredited CME events are not reportable under the Open Payments program because of the firewall created through their strict adherence to the Standards for Commercial Support (SCS), not by the timing of when an applicable manufacturer may discover their identity.

The ACR also recognizes that while leaving both Sections 403.904(g) and (i)(1) in place creates some overlap or redundancy, but no additional confusion or adverse consequences, removing Section 403.904(g) in favor of Section 403.904(i)(1) would be replacing the more certain provision with a more problematic and confusing one. The ACR urged CMS to modify, rather than eliminate, Section 403.904(g) so that this section exempts only CME activities that bear credit from a national credit system and/or are offered by an organization that has strict policies in place to ensure adherence to the SCS. In the final rule, CMS stated it believes in creating consistent reporting requirements for all continuing education events. Removing the language in Section 403.904(g) in its entirety will provide enhanced regulatory clarity for stakeholders. Manufacturers reporting compensation paid to physician speakers may opt to distinguish if the payment was provided at an accredited or certified continuing education program versus an unaccredited or non-certified continuing education program by selecting the appropriate nature of payment category at Section 403.904(e). CMS moved forward with removing the language in Section 403.904(g) and finalizing the provisions to be adopted without change, as proposed.


Physician Compare

- In addition to previously finalized Physician Quality Reporting System (PQRS) quality measure data to be publicly reported beginning in 2012 (indication of satisfactory reporting under PQRS, a selection of Group Practice Reporting Option (GPRO) web interface measures), CMS finalized inclusion on Physician Compare in 2016 (2015 data collection year) quality data for:
  - All PQRS GPRO measures considered by CMS to be suitable for public reporting
  - All PQRS measures reported by individual eligible professionals (EP)s through registry, electronic health record (EHR) or claims and considered by CMS to be suitable for public reporting
  - All Qualified Clinical Data Registry data at individual EP level
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS, CAHPS for Accountable Care Organization (ACOs)
- CMS considers measures suitable if they are deemed to be comparable, reliable, and valid
- Newly available, “first year” measures will not be publicly reported for reporting under PQRS.
Physician Quality Reporting System

Reporting criteria for avoiding the 2017 PQRS payment adjustment

- Requirements to avoid the 2017 payment adjustment (-2.0%), based on 2015 reporting, are the same as for gaining the 2014 incentive with several additional requirements as identified below.

- **Individual EP reporting requirements** - 9 measures across 3 National Quality Strategy domains, for 50% of Medicare Part B FFS patients relevant to reported measures (or for 50% of ALL patients when using a Qualified Clinical Data Registry (QCDR)), or, using a qualified registry, report 1 measures group for at least 20 patients (majority should be Medicare Part B FFS patients) with the following additional requirements:
  - Claims or qualified registry reporting: of the measures reported, report on at least one “cross-cutting” measure if the individual EP has seen at least one Medicare patient in a face-to-face encounter.
  - QCDR reporting: report at least 2 outcome measures (vs 1 outcome in 2014) or if 2 are not available, report 1 outcome measure and at least 1 resource use, patient experience of care, efficiency/appropriate use or patient safety measure.
  - No additional requirements for EHR reporting (cross-cutting measure or outcome measure reporting not required.

- **GPRO reporting requirements** - 9 measures across 3 National Quality Strategy domains, for 50% of Medicare Part B FFS patients relevant to reported measures (does not pertain to GPRO web interface reporting) with the following additional requirements:
  - Qualified registry reporting, groups of 2-99 EPs: of the measures reported, report on at least one “cross-cutting” measure if any individual EP in the group has seen at least one Medicare patient in a face-to-face encounter.
  - Groups of 2-99 also have the option to report all CAHPS for PQRS survey measures using a certified CMS survey vendor and at least 6 additional measures covering at least 2 National Quality Strategy domains using a qualified registry, with the same requirement to report one “cross-cutting” measure, or report 6 additional measures through EHR.
- Groups of 100+ EPs: must report all the CAHPS for PQRS survey measures using a CMS certified survey vendor and at least 6 additional measures covering at least 2 National Quality Strategy domains using a qualified registry with the same requirement to report one “cross-cutting” measure, or report 6 additional measures through EHR.

- CMS will post additional information on the PQRS website as to specific codes that are considered face-to-face encounters.

- Measure applicability validation process remains in place to determine successful reporting if less than the required 9/3 measures, for both individual EPs when reporting using claims or qualified registries, or for GPROs reporting using registries. Also, if an individual EP or GPRO using an EHR does not have 9 measures for which there is patient data, then they must report the measures for which there is patient data.

PQRS Measure Changes

- CMS proposed to remove but did not finalize removal of the following measures reportable by diagnostic and/or interventional radiologists:
  - # 21-23 Perioperative care measures
  - #146 Inappropriate use of BIRAD3 Assessment Category on Screening Mammography
  - #147 Correlation of bone Scintigraphy exams

- CMS did finalize removal of measure #20, Perioperative care – timing of antibiotic

- CMS also finalized its proposals to remove the option for claims reporting for a number of measures, including #102 and #104 – two prostate cancer measures potentially reportable by radiation oncologists.

- There are no new individual measures or measures groups relevant to radiology.

Changes related to the Qualified Clinical Data Registry (QCDR)

- Changes to requirements for QCDR entities include:
  - QCDR must possess at least 2 outcome measures, or in lieu of 2 outcome measures, at least 1 outcome measure and 1 resource use, patient experience of care, efficiency/appropriate use, or safety measure.
  - An increase in the number of “non-PQRS” measures that QCDRs can report from 20 to 30.
  - Beginning with 2015 reporting period, QCDRs will be required to publicly report quality measures data for which its EPs report, including
measure title and description of measures for PQRS and the performance results for each measure the QCDR reports, with the exception for new measures (both PQRS and non-PQRS measures) that are in their first year of reporting by a QCDR under the PQRS.

- The QCDR can determine its method of public reporting including on the Physician Compare website, specialty website, dashboards or announcements.

- CMS defers to the QCDR to determine if performance results are posted at the individual EP level or aggregated to a group practice, however if performance results are posted on Physician Compare, the data must be posted at the individual EP level.

- QCDR self-nomination must state whether the QCDR will post quality data on Physician Compare (PC) or on own site and allow link from PC. On PC all measure data may be downloadable, but only those measures that have been deemed valid, reliable, and accurate will be publicly reported on the website. Deadline for reporting data publicly for 2015 reporting is the same as posted for Physician Compare – 2016.

- Payment adjustment informal review period changed to requests for review to be submitted within 60 days of the release of the PQRS feedback reports.

**Value-based Payment Modifier and Physician Feedback Program**

- CMS finalized its proposal to apply the VM to all physicians in groups with two or more eligible professionals and to solo practitioners starting in CY 2017, and to all nonphysician eligible professionals in groups with two or more eligible professionals and to solo practitioners starting in CY 2018.

- CMS estimates that their final policy to apply the VM to all physicians in groups with two or more eligible professionals and to all physicians who are solo practitioners in CY 2017 would affect approximately 900,000 physicians.

- Quality-tiering will be mandatory for groups and solo practitioners within Category 1 (successfully meeting CY 2015 PQRS requirements) for the CY 2017 VM. Solo practitioners and groups of 2-9 EPs would be subject only to any upward or neutral adjustment and held harmless from a downward adjustment at determined under the quality-tiering methodology.

- CMS will maintain the policy that a group or solo practitioners will have a cost composite score of “average” under quality-tiering if they do not have at least one cost measure with at least 20 patient cases.
• Beginning with the CY 2017 payment adjustment period, CMS will begin
applying the VM to physicians in groups with two or more eligible professionals
and physicians who are solo practitioners that participate in an ACO under the
Shared Savings Program.

• For purposes of the VM, EPs and groups participating in an ACO under the
Shared Savings Program will be classified as “average cost” to avoid confusion
and prevent conflicting incentives for these providers.

• For purposes of the VM, EPs and groups participating in an ACO under the
Shared Savings Program during the applicable performance period will
have a quality of care composite score calculated using the ACO-level quality
data from the performance period, regardless of whether the group or solo
practitioner participates in a Shared Savings Program ACO during the payment
adjustment period. The same quality composite score will be applied to all of the
groups and solo practitioners, as identified by TIN, under that ACO.

• Consistent with CMS policy for other groups subject to the VM, CMS will
not “track” or “carry” an individual professional’s performance from one TIN to
another TIN.

• For the CY 2017 payment adjustment period CMS will apply a -4.0% VM
(increased from – 2.0%) to groups with 10 or more EPs and to apply a -2.0% VM
to groups with two to nine eligible professionals and solo practitioners who have
not successfully met PQRS requirements.

• For the CY 2017 payment adjustment period, under quality tiering for groups
and solo practitioners who successfully participate in PQRS, CMS will apply a
maximum – 4.0% downward adjustment/maximum 4.0x upward adjustment to
groups with 10 or more EPs; and a maximum -2.0% downward
adjustment/maximum 2.0x upward adjustment to groups of 2-9 and solo
practitioners (as illustrated in tables below).
TABLE 88: Final CY 2017 VM Payment Adjustment Amounts for Groups with Two to Nine Eligible Professionals and Solo Practitioners

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low quality</th>
<th>Average quality</th>
<th>High quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost</td>
<td>+0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average cost</td>
<td>+0.0%</td>
<td>-0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High cost</td>
<td>+0.0%</td>
<td>-0.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

* Groups and solo practitioners eligible for an additional +1.0x if reporting measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where ‘x’ represents the upward payment adjustment factor.

TABLE 89: Final CY 2017 VM Payment Adjustment Amounts for Groups with Ten or More Eligible Professionals

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low quality</th>
<th>Average quality</th>
<th>High quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost</td>
<td>+0.0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td>Average cost</td>
<td>-2.0%</td>
<td>-0.0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>High cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

* Groups eligible for an additional +1.0x if reporting measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where ‘x’ represents the upward payment adjustment factor.