The Centers for Medicare and Medicaid Services (CMS) released the review copy of the 2014 Medicare Physician Fee Schedule (MFS) proposed rule on July 8, 2013. The American College of Radiology (ACR) will be submitting comments to CMS addressing issues of concern by the deadline in early September. Following are highlights of the proposed rule.

### A. Conversion Factor and Impacts (page 584)

The calendar year (CY) 2013 conversion factor (CF) is $34.023. For 2014, the proposed conversion factor based on the sustainable growth rate (SGR) formula mandated by law is $25.7109, representing a -24.4% update. CMS states that the actual values used to compute physician payments for CY 2014 will be based on later data and are scheduled to be published by November 1, 2013 as part of the PFS final rule.

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.

Below is an excerpt from Table 71 on page 587: 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>Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Radiology</td>
<td>2%</td>
<td>-6%</td>
<td>-4%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>2%</td>
<td>-1%</td>
<td>1%</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>1%</td>
<td>-6%</td>
<td>-5%</td>
</tr>
<tr>
<td>Radiology</td>
<td>2%</td>
<td>-3%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

CMS explains that the most widespread specialty impacts of the relative value unit (RVU) changes are generally related to two major factors. The first factor is the proposal to cap the payments for certain nonfacility services at the facility rate plus the lower of the hospital outpatient prospective payment system (OPPS) or ambulatory surgical center (ASC) payment. The second factor is the proposal to revise the Medicare Economic Index (MEI) and adjust the
RVUs to match the new weights for work, PE, and MP. In addition, a number of other changes contribute to the impacts shown in Table 71. These 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, proposals to update direct practice expense inputs and proposals to adjust time for some services.

Table 72 on page 590 outlines the estimated impacts of selected proposals on total allowed charges by specialty (not considering the negative conversion factor updated required by statute). Following is an excerpt from the table:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Impact of 2012 Claims Data, 90% utilization assumption, ultrasound changes, and other minor changes</th>
<th>Impact of OPPS/ASC Cap</th>
<th>Impact of Medicare Economic Index (MEI) Revision</th>
<th>Total Cumulative Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Radiology</td>
<td>-1%</td>
<td>-2%</td>
<td>-1%</td>
<td>-4%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>1%</td>
<td>-4%</td>
<td>-2%</td>
<td>-5%</td>
</tr>
<tr>
<td>Radiology</td>
<td>-1%</td>
<td>0%</td>
<td>0%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

B. Multiple Procedure Payment Reduction (Page 92)

CMS is not proposing any new multiple procedure payment reduction (MPPR) policies for CY 2014. They note that although they are not proposing 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 36)

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 currently used an equipment utilization rate assumption of 75 percent. 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 (PE RVUs) for expensive diagnostic imaging equipment, the Secretary shall use a 90 percent assumption.
Therefore, CMS proposes to 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. These CPT codes (mainly CT and MR) are listed in Table 3 on page 37 of the proposed rule.

D. Interest Rate (Page 39)

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 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 OPPS and ASC Rates in Developing Practice Expense (PE) Relative Value Units (RVUs) (Page 52)

CMS is proposing 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 are proposing to use the current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services under the PFS.

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 is proposing 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.

CMS is proposing the following exemptions from the proposed policy:

1) Services without separate OPPS payment rates
2) Codes subject to the Deficit Reduction Act (DRA) imaging cap (as well as screening and diagnostic mammography)
3) Codes with low volume in the OPPS or ASC (5% or less of the total number of services are provided in the OPPS setting relative to the total number of PFS/OPPS allowed services)

4) Codes with ASC rates based on the PFS payment rates (ASC services subject to the “office-based” procedure payment policies for which payment rates are based on the MFS nonfacility PE RVUs)

5) Codes paid in the facility at nonfacility MFS rates (services paid at the facility setting at nonfacility payment rates)

6) Codes with PE RVUs developed outside of the PE methodology (services with PE RVUs established outside the PE methodology through notice and comment rulemaking)

The policy applies to all CPT codes, but only affects approximately 200 codes (rest of the codes are not impacted due to either exempted based on the above or the nonfacility PE payment is lower compared to the OPPS rate). CMS has not yet posted the list of impacted codes, but does indicate the following impacts in Table 72 of the proposed rule (page 590):

- Radiology: 0%
- Radiation Oncology: -4%
- Interventional Radiology: -2%
- Nuclear Medicine: 1%

Independent laboratory has the highest impact at -25%, followed by radiation therapy centers at -8%, pathology at -6%, RO at -4%, etc.

ACR staff will continue to analyze the impacts of this proposed policy as additional information becomes available.

*Background*

When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (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 notes that they have 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 notes 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 goes 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.

F. Specific Practice Expense (PE) Calculations Recommendations

1. Changes to Direct PE Inputs for Specific Services

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 agrees with the commenters that the items should not be considered disposable supplies and that they are more appropriately
categorized as indirect PE costs. Therefore, CMS is proposing 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, cyclotron/accelerator, gammaknife, Lincac SRS system (SK107); fee, image analysis (SK110); and fee, licensing, computer, psychology (SK111).

CMS disagrees 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.

2. **Adjustments to Pre-Service Clinical Labor Minutes (Page 48)**

CMS is proposing to reduce pre-service clinical labor minutes for the following codes as per recommendations from the American Medical Association (AMA) Relative Value Update Committee (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>Proposed CL pre-service minutes (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 50)**

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’ 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. If the CY 2014 OPPS proposal is implemented, it would appear that there would no longer be a need for G-codes to describe robotic SRS treatment and delivery. 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 would be 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 is not proposing to replace the contractor-priced G-codes for PFS payment. CMS is seeking 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.*

4. **Ultrasound Room Equipment Recommendations (Page 59)**

CMS is seeking 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 seeking 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. Note that CMS is not proposing 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 addition to the concerns regarding the contents of the ultrasound “room” packages, CMS is also concerned about the pricing information submitted through the AMA RUC to support its recommendation to add equipment to the ultrasound room packages. They state 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.
At this time, CMS states that they are 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 is seeking comment on the appropriate price to use as the typical cost for portable ultrasound units. Again, CMS is not proposing to revise the equipment items, or to change the prices of items, included in these rooms. Instead, pending receipt and consideration of additional information, the proposed direct PE input database continues to include the current prices for the “room, ultrasound, general” (EL015), “room, ultrasound, vascular” (EL016), and “ultrasound unit, portable” (EQ250).

5. New Equipment Inputs and Price Updates

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

a. Ultrasound Unit, portable, breast procedures (page 63)

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 radionuclide 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 radionuclide application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance). CMS is proposing a price of $33,930, which reflects the price displayed on the submitted copy of the paid invoice.

b. Endoscopic Ultrasound Processor (page 63)

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 is creating 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 64)

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. Consequently, CMS is seeking copies of paid invoices for this equipment item so that they can price the item accurately in the future.

d. Endoscope, ultrasound probe, drive (ES015) (page 64)

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 is proposing to increase the price associated with ES015 to $13,256.25, which reflects the price documented on the submitted copy of the paid invoice.

6. Ultrasound Equipment Input Recommendations for Particular Services (Page 64)

The AMA RUC recommended changing the associated equipment inputs that appear in the direct PE input database for some CPT codes. Based on CMS’ review of these recommendations, they have generally agreed with the RUC regarding these recommended changes, and these changes are reflected in the proposed direct PE input database. Table 10 on page 66 of the proposed rule displays the codes with proposed changes to ultrasound equipment.

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 noted above, CMS is not proposing to create the “room, ultrasound, cardiovascular” and therefore will not propose to add this “room” an input for these services. However, CMS notes that the newly recommended equipment package incorporates many of the same kinds of items as the currently existing “room, ultrasound, vascular” (EL016). CMS agrees with the AMA RUC’s suggestion that the
existing equipment inputs for the relevant services listed in Table 10 (page 66) do not reflect typical resource costs of furnishing the services. Therefore, CMS believes that, pending further consideration of the ultrasound “room” equipment packages, it would be appropriate to use the existing “room, ultrasound, vascular” (EL016) as a proxy for resource costs for these cardiovascular services that include ultrasound technology. Therefore, the proposed direct PE input database reflects this proposed change.

In the case of CPT code 76942 (Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation), CMS agrees with the AMA RUC’s recommendation to replace the current equipment input of the “room, ultrasound, general” (EL015) with “ultrasound unit, portable” (EQ250). CMS notes 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 believes that the procedure time assumption currently used in establishing the direct PE inputs for this code (45 minutes) is inaccurate. They state that they have 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 is also proposing to change the procedure time assumption used in establishing direct PE inputs for the service from 45 to 10 minutes, based on our analysis of thirty needle placement procedures most frequently reported with CPT code 76942. CMS notes that this will reduce the clinical labor and equipment minutes associated with the code from 58 to 23 minutes. This change is reflected in the proposed direct PE input database. CMS also indicates that this code has been proposed as a potentially misvalued code.

G. Collecting Data on Services Furnished in Off-Campus Hospital Provider-Based Departments (Page 70)

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.

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, CMS is 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 has 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 notes 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 welcomes 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.**

**H. Misvalued Codes (Page 74)**

1. Validation Projects (Page 79)

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

CMS did not receive any publicly nominated potentially misvalued codes for inclusion in this proposed rule.
3. Contractor Medical Director (CMD) Identified Potentially Misvalued Codes (Page 82)

Tables 11 and 12 (pages 83 and 86) of the proposed rule are 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 is proposing 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). We are seeking public comment on including these codes as potentially misvalued codes. We are also seeking public comment on any similar codes that should be included on this list.**

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>
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I. Malpractice RVUs (Page 101)

For CY 2014, CMS will continue their current approach for determining malpractice RVUs for new/revised codes. We will publish a list of new/revised codes and the malpractice crosswalks used for determining their malpractice RVUs in the final rule with comment period. The CY 2014 malpractice RVUs for new/revised codes will be implemented in the CY 2014 PFS final rule with comment period. These RVUs will be subject to public comment. They will then be finalized in the CY 2015 PFS final rule with comment period.
J. Medicare Economic Index (Page 102)

For CY 2014, CMS is proposing 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 is proposing to implement 10 of the 13 recommendations made by the MEI TAP. These proposed changes only involve revising the MEI categories, cost shares, and price proxies. Again, CMS is not proposing to rebase the MEI at this time since the MEI TAP concluded that there is not a reliable, ongoing source of data to maintain the MEI. After acknowledging that there are no additional data to support further rebasing of the MEI at this time, the MEI TAP recommended that CMS’ Office of the Actuary (OACT) identify and evaluate additional data sources that may allow for more frequent updates to the MEI’s cost categories and their respective weights.

K. Geographic Practice Cost Indices (GPCIs) (Page 139)

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 is proposing to phase in 1/2 of the latest GPCI adjustment in CY 2014.

The 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.

The proposed 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 our 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/.

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, we 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 would result in a 17 percent increase in MP GPCI for the Puerto Rico payment locality under the proposed fully phased-in seventh GPCI update, which would be effective CY 2015.
CMS has historically updated the GPCI cost share weights to make them consistent with the most recent update to the MEI, and they propose to do so again for CY 2014. As a result, the cost share weight for the work GPCI (as a percentage of the total) in this proposal 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.

All of the proposed GPCIs for CY 2014 for the first and second year of the 2-year transition are displayed in Addenda D and E to the proposed rule available on the CMS website.

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.

L. Incident To (Page 199)

CMS is proposing 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 would 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.

M. Complex Care Management Services (Page 201)

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 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 seeks comment on potential care coordination standards and the work and practice expense that would be associated with these services.
They note that any regulatory changes will be addressed through separate notice-and-comment rulemaking.

N. Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) (Page 242)

CMS is proposing 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 proposed modification would allow coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the initial preventive physical examination (IPPE).

O. Liability for Overpayments to or on Behalf of Individuals including Payments to Providers or Other Persons (Page 262)

In accordance with the American Taxpayer Relief Act of 2012, CMS proposes 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.