Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018

A SIDE-BY-SIDE COMPARISON OF KEY PROVISIONS FROM THE PROPOSED AND FINAL RULES FOR CY 2018

HHS | Hart Health Strategies Inc.

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Overview

On November 2, 2017, the Centers for Medicare and Medicaid Services (CMS) released the CY 2018 Medicare Physician Fee Schedule Final Rule. This major final rule addresses changes to the Physician Fee Schedule and other Medicare Part B payment policies to ensure that CMS' payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in statute. This final rule also includes final policies related to the Medicare Shared Saving Program and the Medicare Diabetes Prevention Program model.

Addenda and other detailed downloads related to this final rule are available here.

Hart Health Strategies, Inc. has prepared the below "side-by-side" comparison of the proposed and final provisions with the goal of helping organizations better understand how CMS modified its proposals in response to stakeholder feedback. Page numbers and hyperlinks refer to the display version of the final rule, which has been posted to our website.

The final rule will be published in the *Federal Register* on November 15, 2017 and the regulations are effective as of January 1, 2018. There is no comment period associated with this final rule.

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Determination of Practice Expense Relative Value Units (PE RVUs)		
Practice Expense Methodology: Allocation of PE to Services (PE RVU Methodology)	For codes with low Medicare service volume, CMS proposed to use the most recent year of claims data to determine which codes are low volume for the coming year (those that have fewer than 100 allowed services in the Medicare claims data). For codes that fall into this category, instead of assigning specialty mix based on the specialties of the practitioners reporting the services in the claims data, CMS proposed to instead use the expected specialty that it identifies on a list. For CY 2018, CMS proposed to use a list that was developed based on its medical review of the list most recently recommended by the RUC, in addition to its own proposed expected specialty for certain other low-volume codes for which CMS historically used expected specialty assignments. CMS would display this list as part of the annual set of data files it makes available as part of notice and comment rulemaking. CMS proposed to consider recommendations from the RUC and other stakeholders on changes to this list on an annual basis. CMS also proposed to apply these service-level overrides for both PE and MP, rather than one or the other category. CMS believes that this would simplify the implementation of service-level overrides for PE and MP, and would also address stakeholder concerns about the year-to-year variability for low volume services. Services for which the specialty is automatically assigned based on previously finalized policies under established methodology (for example, "always therapy" services) would be unaffected by this proposal.	***CMS is finalizing the proposal to use service-level overrides to determine the specialty mix for low volume procedures. CMS is also finalizing the use of service-level overrides to determine the specialty mix for no volume procedures. In addition, CMS is finalizing the proposed list of expected specialty overrides with modifications. CMS is finalizing the addition of certain CPT codes to the list and updated specialty assignments for certain CPT codes. (p. 37)***
Changes to Direct PE Inputs for Specific Services: PE Inputs for Digital Imaging Services	CMS seeks comments regarding whether or not the use of the professional PACS workstation would be typical in the following list of CPT and HCPCS codes: CPT codes 93880, 93882, 93886, 93888, 93890, 93892, 93893, 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93990, and 76706, and HCPCS code G0365.	***CMS is finalizing the addition of a professional PACS workstation to the 21 codes listed in Table 4 with the equipment time detailed. (p. 55)*** Equipment times for the professional PACS workstation in the non-facility setting are assigned according to the equipment time formula finalized in CY 2017. (p. 53)
Changes to Direct PE Inputs for Specific Services: Standardization of Clinical Labor Tasks (Preservice Clinical	CMS is seeking comment on the value and appropriate application of the standard in its review of RUC recommendations in future rulemaking. CMS is seeking comment specifically on whether the standard preservice clinical labor time of 0 minutes should be consistently applied for 0-day and 10-day global codes in future rulemaking.	***CMS does not believe that the standard preservice clinical labor time of 0 minutes should be consistently applied for 0-day and 10-day global codes in future rulemaking. (p. 60)*** CMS agrees with commenters who suggested that there is a need to identify circumstances where deviations from the standard clinical labor times would be appropriate and develop clear definitions and criteria for

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Labor for 0-Day and 10-Day Global Services)		these situations. If an increasingly large number of major procedures are performed using the 0-day and 10-day global periods, CMS believes that there will be a need for the establishment of new guidelines for the typical allotment of preservice clinical labor. CMS agrees with commenters that preservice clinical labor must be determined on an individual basis based on the resources typically required to furnish the service, but notes that the need for individual review of services does not preclude the development of standards, which helps to facilitate greater transparency of information and maintain consistency in review patterns over time. (p. 60)
Changes to Direct PE Inputs for Specific Services: Standardization of Clinical Labor Tasks (Obtain Vital Signs Clinical Labor)	CMS is proposing to assign 5 minutes of clinical labor time for all codes that include the "Obtain vital signs" task, regardless of the date of last review. CMS is proposing to assign this 5 minutes of clinical labor time for all codes that include at least 1 minute previously assigned to this task. CMS is also proposing to update the equipment times of the codes with this clinical labor task accordingly to match the changes in clinical labor time. CMS is proposing to adjust the equipment time of any equipment item that matched the clinical labor time of the full service period to match the change in the "Obtain vital signs" clinical labor time.	***CMS is not finalizing its proposal to establish 5 minutes as the new standard for the "Obtain vital signs" clinical labor task. However, since CMS continues to believe that the review standards associated with the clinical labor time for obtaining vital signs have changed over time, CMS will assign 5 minutes as the input for all codes that include the "Obtain vital signs" task for CY 2018, as proposed. (p. 64)*** For future rulemaking CMS will consider code-level recommendations that will help distinguish services that may require fewer or greater than 5 minutes for this activity. CMS believes that finalizing 5 minutes for the codes as proposed will serve to mitigate the detrimental impact of review standards shifting over time while preserving the principle that the number of minutes involved in obtaining vital signs may vary for different services. (p. 63)
Changes to Direct PE Inputs for Specific Services: Standardization of Clinical Labor Tasks (Establishment of Clinical Labor Activity Codes)	To facilitate the transition to the new clinical labor activity codes, CMS has developed a crosswalk to link the old clinical labor tasks to the new clinical labor activity codes assigned by the RUC. This crosswalk is for informational purposes only, and would not change either the direct PE input values or the PE RVUs for codes. For CY 2018 rulemaking, CMS is displaying two versions of the Labor Task Detail public use file: one version with the old listing of clinical labor tasks, and one with the same tasks as described by the new listing of clinical labor activity codes.	As noted in the proposed rule, CMS is posting these lists on the CMS website.
Changes to Direct PE Inputs for Specific Services: Equipment Recommendations for Scope Systems	CMS is seeking comment on several potential categories of scope system PE inputs. CMS is considering creating a single scope equipment code for each of the five categories detailed in this proposed rule: (1) a rigid scope; (2) a semi-rigid scope; (3) a non-video flexible scope; (4) a non-channeled flexible video scope; and (5) a channeled flexible video scope.	***CMS is not finalizing its proposal to create and price a single scope equipment code for each of the five categories identified. Instead, CMS is supportive of the recommendation from the commenters to create scope equipment codes on a per-specialty basis for these five, or potentially six, categories of scopes as applicable.*** CMS states that its goal is to create an administratively simple scheme that will be

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		easier to maintain and helps to reduce administrative burden. CMS looks forward to receiving detailed recommendations from expert stakeholders regarding the number of these scope equipment items that would be typically required for each scope category as well as the proper pricing for each scope. (p. 71)
	CMS is proposing to add an LED light source into the cost of the scope video system (ES031), which would remove the need for a separate light source in these procedures. CMS is also proposing an increase to the price of the scope video system of $1,000.00 to cover the expense of miscellaneous small equipment associated with the system that falls below the threshold of individual equipment pricing as scope accessories (such as cables, microphones, foot pedals, etc.).	***CMS is not finalizing its proposal to add an LED light source and an increase to the price of the scope video system of $1,000.00 to cover the expense of miscellaneous small equipment associated.*** CMS intends to address these changes for CY 2019 in order to incorporate the aforementioned feedback from expert stakeholders. (p. 71)
Changes to Direct PE Inputs for Specific Services: Clarivein Kit for Mechanochemical Vein Ablation	CMS is soliciting comment regarding the use of multiple kits during procedures described by the base and add-on codes to determine whether or not this supply should be included as a direct PE input for CPT code 36474 for CY 2018.	***CMS is not finalizing the addition of the Clarivein kit to CPT code 36474 at this time***, though CMS will review any recommendations received for consideration in future rulemaking. CMS believes that the decision on whether to include a Clarivein kit in CPT code 36474 should be made as part of a broader review of the direct PE inputs that are typically required to furnish the procedure. One commenter noted that the this issue would be reviewed by the RUC during the next two years. (p. 73)
Changes to Direct PE Inputs for Specific Services: Removal of Oxygen from Non-Moderate Sedation Post-Procedure Monitoring	CMS is proposing to remove the oxygen gas from the codes included on Table 5 that were previously valued with moderate sedation.	***CMS is finalizing its proposal to remove the oxygen gas from the codes listed in Table 5. (p. 74)***
Changes to Direct PE Inputs for Specific Services: Technical Corrections to Direct PE Input Database and Supporting Files	**CMS is proposing to correct several inconsistencies in the direct PE database**: • For CPT code 96416 (Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump) to improve payment accuracy, CMS is proposing to add 6 additional minutes of RN/OCN clinical labor (L056A), 4 minutes for the "Review charts by chemo nurse regarding course of treatment & obtain chemotherapy-related medical hx" task, and 2 minutes for the "Greet patient and provide gowning" task. CMS is proposing to add 1 quantity of the IV infusion set	***CMS is finalizing the corrections as proposed.*** These include the direct PE changes to CPT code 96416 as proposed, the correction to an anomaly in the postservice work time for CPT code 91200 as proposed, and the proposed changes to the direct PE database detailed in Table 6. (p. 84) In response to a comment that identified incorrect total times for 108 codes in the Physician Work time file that were previously finalized, ***CMS is finalizing a technical correction to the physician work time of***

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	supply (SC018) and to lower the quantity from 2 to 1 of the 20 ml syringe supply (SC053). CMS is proposing to add 1800 minutes for the new ambulatory IV pump equipment, and to increase the equipment time of the medical recliner chair (EF009) from 83 minutes to 89 minutes to match the increase in RN/OCN clinical labor. • For CPT code 91200 (Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report), CMS proposes to change the postservice work time from 5 minutes to 3 minutes, which also results in a refinement in the total work time for the code from 18 minutes to 16 minutes. • CMS is proposing the direct PE refinements the to codes found on Table 6, to address a series of discrepancies CMS identified between the finalized direct PE inputs and the values entered into the database from previous calendar years.	***these codes, as listed in Table 7.*** CMS notes that the technical correction to the total work time of these codes will not have a direct effect on the calculation of their individual RVUs, as changes to work time affect code valuation at the specialty level, not the service level, in the rate-setting methodology. (p. 82) In response to another comment identifying 7 additional codes with the need for technical correction, listed starting on p. 82, ***CMS is finalizing technical corrections to the work time file for 6 of the codes as detailed by the commenter. (p. 84)***
Changes to Direct PE Inputs for Specific Services: Updates to Prices for Existing Direct PE Inputs	For CY 2018, CMS is proposing to update the price of thirteen supplies and one equipment item in response to the public submission of invoices, as detailed in Table 14 of the proposed rule titled Invoices Received for Existing Direct PE Inputs. CMS is not proposing to update the price of the blood warmer (EQ072), the cell separator system (EQ084), or the photopheresor system (EQ206) equipment items as CMS was unable to verify the accuracy of the submitted invoice. CMS is also not proposing to update the price of the DNA image analyzer (ACIS) (EP001) equipment item, due to the inclusion of many components on the submitted invoice that are not part of the price of the DNA image analyzer; to price these equipment items accurately, CMS believes that CMS needs additional information. CMS is also proposing to change the name of the ED050 equipment from the "PACS Workstation Proxy" to the "Technologist PACS workstation" to alleviate potential confusion with the professional PACS workstation (ED053).	***CMS is finalizing the updated supply and equipment prices as detailed in Table 16: Invoices Received for Existing Direct PE Inputs***, which includes several changes from proposed: • CMS is finalizing updated prices for the blood warmer (EQ072), the cell separator system (EQ084), the photopheresor system (EQ206), and the DNA image analyzer (EP001) equipment items, in response to submission of invoices (p. 86), as well as a change in the name of the EP001 equipment from "DNA image analyzer" to "DNA/digital image analyzer" as requested by commenters. (p. 86) • CMS is finalizing the following two separate supply items rather than blending them together: UV goggles (SJ027) and the new patient/clinician goggles (SD326). CMS is also finalizing updated prices for these items. (p. 87) • CMS is finalizing an updated price for LMX 4% anesthetic cream (SH092) supply based on additional submitted invoices. • CMS is finalizing the addition of 1 quantity of the (cytology, preservative and vial (Preserv-cyt) SL040 supply to CPT code 88108 and the removal of the cytology, preservative and vial (cytospin) 88108 – 30 ml (SL501) supply from the database in response to comments. (p. 89)
Adjustment to Allocation of Indirect PE for Some Office-Based Services	CMS believes it would be appropriate to modify the existing methodology for allocating indirect PE RVUs in order to better reflect the relative indirect PE resources involved in furnishing these kinds of services in the nonfacility setting. Specifically, CMS identified HCPCS codes that describe face-to-face	***CMS is finalizing this policy as proposed. (p. 97)***

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	services, have work RVUs greater than zero, and are priced in both the facility and nonfacility setting. From among these codes, CMS further selected those with the lowest ratio of nonfacility PE RVUs for each work RVUs, specifying a ratio of less than 0.4 as an appropriate threshold based on several factors, including the range of nonfacility PE RVU to work RVU ratios among the codes identified. CMS proposes to set the nonfacility indirect PE RVUs for these codes using the indirect PE RVU to work RVU ratio for the most commonly furnished office-based, face-to-face service (CPT 99213) as a marker. Specifically, for each of these outlier codes, CMS proposes to compare the ratio between indirect PE RVUs and work RVUs that result from the preliminary application of the standard methodology to the ratio for the marker code, CPT code 99213. This proposed change in the methodology would then increase the allocation of indirect PE RVUs to the outlier codes to at least one quarter of the difference between the two ratios. In developing the proposed PE RVUs for CY 2018, CMS proposes to implement only one quarter of this proposed minimum value for nonfacility indirect PE for the outlier codes for this year. CMS is also proposing to exclude the codes directly subject to this proposed change from the misvalued code target calculation because the proposed change is a methodologic al change to address an anomaly produced by its indirect PE allocation process as opposed to a change to address misvalued codes.	
Determination of Malpractice Relative Value Units (MRVUs)		
MP Premium Data	To calculate the malpractice (MP) RVUs for paying physician fee schedule services, CMS relies on a methodology based on three factors: (1) Specialty-level risk factors derived from data on specialty-specific MP premiums incurred by practitioners; (2) Service level risk factors derived from Medicare claims data of the weighted average risk factors of the specialties that furnish each service; and (3) An intensity/complexity of service adjustment to the service level risk factor based on either the higher of the work RVU or clinical labor RVU	CMS reviewed the methodology in the final rule.

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	CMS uses MP premium data to update the MP GPCIs and the MP RVUs. In CY 2017, CMS utilized updated MP premium data to finalize the latest GPCI update (which was the 8th GPCI update). CMS, however, did not propose to use the updated MP premium data to propose updates for the specialty risk factors component of calculating MP RVUs. This was due to the fact that CMS has previously finalized a policy that would update the specialty-risk factor component once every 5 years. Statute, however, requires that the GPCI data be updated at least once every 3 years. Therefore, because both components rely on the use of MP premium data, CMS proposes to use the most recent data for MP RVUs for 2018 and to align the update of MP premium data and MP GPCIs to once every 3 years. CMS is also seeking comment on methodologies and sources it might use to improve the next update of the MP premium data.	***CMS did not finalize the incorporation of the most recent MP RVU data, and the CY 2018 MP RVUs will continue to be based on the premium data that was collected for the CY 2015 update*** (p. 117). CMS reiterated that the next MP premium data update must happen by CY 2020 but articulated a preference that "more frequent updates are optimal" and that it will pursue this in future rulemaking (p. 118). CMS reviewed many of the reasons provided for not including the current data which include (p. 109 – p. 110 unless otherwise noted): • Concerns about the proposed valuation changes not being indicative of what was occurring in the professional liability premium market • Insufficiency of the premium data collected, including lack of sufficient data from all states for common specialties • Concern about the changes in specialty premiums and risk factors • Concerns about using the data for the crosswalking process and believe that it would be better to obtain adequate premium data rather than have to crosswalk • Concern about the proposed Cardiology risk factor being a blend (rather than distinct surgical and non-surgical risk factors as in the past) • Concerns that moving from 5 year to 3 year updates will cause greater variation in MP RVU calculations. • Lack of transparency in the proposed changes (p. 113) • Concern about crosswalking non-physician specialties to the lowest *physician* risk factor specialty for which it has premium rates (Allergy/Immunology) (p. 113) • Concern that insufficient data was found for Hospice and Palliative Care (p. 115) While CMS agreed to delay the updates, CMS did, however, state that it believes that it is important to delineate why the data cause such substantial variations and it believes that the changes where in how the rate filings were classified by specialty "rather than inherent deficiencies in the raw rate filing data" (p. 110). This included highlighted that in the past, CMS was able to obtain data for a similar number of specialties (2018: 43 specialties; 2015: 41 specialties; 2010: 44 specialties) (p. 111). That said, CMS recognized that it needs to

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		"resolve differences regarding the variances in the descriptions on the raw rate filings as well as how these raw data were categorized to conform with CMS specialties" (p. 112; p. 118). The MP RVUs for CY 2018 are available in Addendum B
Methodology for Proposed Revision of Resource-Based Malpractice RVUs	CMS notes that for some specialties MP premiums were not available from the rate filings in at least 35 states (the threshold for which it will include the specialty specific data). In those instances were CMS did not have sufficient data for a specialty, CMS performed a crosswalk to a similar specialty for which it did have data. CMS seeks comment on the appropriateness of the crosswalks developed for use in calculating MP RVUs. **Index.** CMS uses these risk factors as an index that is calculated by dividing the national average premium for each specialty by the national average premium for the specialty with the lowers premiums for which it had sufficient and reliable data (which was allergy and immunology).	***CMS did not finalize the crosswalks proposed*** (p. 117). CMS received the following input on the crosswalks: • Concern about crosswalking non-physician specialties to the lowest *physician* risk factor specialty for which it has premium rates (Allergy/Immunology) (p. 113) • Concern that insufficient data was found for Hospice and Palliative Care (p. 115) (CMS stated that it believed that the data that it did have available is close to the cross-walked specialty of Allergy/Immunology) • Concern about the 35 state threshold for rating filings to avoid the crosswalk (p. 115) • Use of population count to weight geographic differences to calculate national average premiums rather than work RVUs (p. 116) Even though it was not finalized, CMS did state that its proposed crosswalks were reasonable (p. 114).
	Technical Component (TC) Only Services. CMS seeks comment on appropriate, comparable data sources for the broader set of technical component services. CMS also seeks comment on whether the data for IDTFs are "comparable and appropriate as a proxy for the broader set of TC services. CMS proposes to assign a TC risk factor of 1.0 (i.e. the lowest physician specialty risk factor).	CMS did not specifically address the issues related to TC only services.
	Low Volume Service Codes. CMS requests comment on the proposal to use the service-level overrides to determine specialty mix for low volume services and the list of overrides. **New and Revised Codes**. CMS proposes to eliminate the general use of an MP-specific specialty-mix crosswalk for new and revised codes.	***CMS finalized the proposal to use a list of expected specialties (instead of a claims-based specialty mix) for low volume/no volume codes in both MP and PE RVU calculations*** (p. 117). CMS did not revisit this issue. The final CY 2018 specialty risk factors can be found on the CMS Website in the file CY 2018 Final Rule Malpractice Risk Factors and Premium Amounts by Specialty.

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Medicare Telehealth Services		
Adding Services to the List of Medicare Telehealth Services	The following requests were received in CY 2016 for inclusion in 2018 organized by the two categories for telehealth services created by Medicare: **Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services**: • G0296 (*Counseling visit to discuss need for lung cancer screening using low dose ct scan (LDCT)(services is for eligibility determination and shared decision making)*): In response to a request that this code be added, CMS believes that the service described by this code is sufficiently similar to office visits currently on the telehealth list and that all components of the service can be furnished via interactive telecommunications technology. Therefore, CMS proposes to add G0296 to the list of Medicare telehealth service under Category 1. • CPT 90839 (*Psychotherapy for crisis; first 60 minutes)* and 90840 (*Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)*): In response to a request that these codes be added, CMS found these services similar to the psychotherapy services currently on the telehealth list even though the code describes patient in need of more urgent care. CMS did not that one element of the services in the CPT prefatory language might not be able to be furnished via telehealth: "mobilization of resources to defuse the crisis and restore safety." Therefore, CMS proposes to add CPT 90839 and 90840 to the list of Medicare telehealth service under Category 1 with the explicit condition of payment that the distant site practitioner be able to mobilize resources at the originating site to defuse the crisis and restore safety when applicable. CMS specifically seeks comment on whether its assumption that a remote practitioner is able to mobilize resources at the originating site to "defuse the crisis and restore safety" is valid. • CPT 90785 (*Interactive complexity (List separately in addition to the code for the primary procedure*): Based on CMS' own review, CMS proposes to add CPT 90785 to the list of Medicare telehealth services. • CPT 96160 (*Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument*) and 96161 (*Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument)*): Based	***CMS finalized the addition of this code to the Medicare telehealth list*** (p. 139). ***CMS finalized the addition of this code to the Medicare telehealth list*** (p. 139). ***CMS finalized the addition of this code to the Medicare telehealth list*** (p. 139). ***CMS finalized the addition of this code to the Medicare telehealth list*** (p. 139).

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	on CMS' own review, CMS proposes to add CPT 96160 and 96161 to the list of Medicare telehealth services. CMS notes that these services would only be considered Medicare telehealth services when billed with a based code that is also on the telehealth list. CMS notes that these services might not ordinarily be furnished in person with a physician or billing practitioner. CMS also notes that services that are not considered face-to-face do not need to be on the list of Medicare telehealth services. Therefore, CMS notes that these services would only be considered Medicare telehealth services when billed with a based code that is also on the telehealth list.	
	• G0506 (*Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)*): Based on CMS' own review, CMS proposes to add G0506 to the list of Medicare telehealth services. CMS notes that this service would only be considered Medicare telehealth services when billed with a based code that is also on the telehealth list.	***CMS finalized the addition of this code to the Medicare telehealth list*** (p. 139).
	Services that are not similar to the current list of telehealth services. CMS declined to add the following services to the list of telemedicine services:	
	• Physical and Occupational Therapy and Speech-Language Pathology Services (Deleted CPT 97001/New CPT 97161; Deleted CPT 97002/New CPT 97162; Deleted CPT 97003/New CPT 97165; Deleted CPT 97004/New CPT 97166; CPT 97110; CPT 97112; CPT 97116; CPT 97535; CPT 97750; CPT 97755; CPT 97761; CPT 97762)	***CMS declined adding these codes to the Medicare telehealth list*** (p. 141) CMS noted that it believed that adding therapy services delivered primarily by professionals that are not included on the statutory list of "distant site practitioners" would result in confusion about who is allowed to bill for those services when furnished via telehealth. They also note that many of the codes require physical manipulation (p. 141).
	• Initial Hospital Care (CPT 99221; CPT 99222; CPT 99223);	***CMS declined adding these codes to the Medicare telehealth list*** (p. 140). CMS received opposition to the proposal to not add the Initial Hospital Care codes to the Medicare telehealth list. CMS continues to decline to add these codes and also stated that the telehealth critical care consultation codes are not a fair comparison because those codes "describe the kind of services that can be furnished to patients via telehealth" and the initial hospital visit E/M codes require elements that can only be furnished in person (p. 140).
	• Online E/M By Physician/QHP (CPT 99444);	***CMS declined adding this code to the Medicare telehealth list*** (p. 141) CMS reiterated that this is a non-covered service so there is no

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		payment associated with it even if CMS added it to the Medicare telehealth list (p. 141). In addition, it is not a service "typically furnished in person" so it would not meet the statutory requirements for being added to the Medicare telehealth list (p. 142).
	• Monthly Capitation Payment (MCP) for ESRD-related services for home dialysis, by age (CPT 90963, and CPT 90967) CMS is interested in input about current clinically accepted care practices and to what extent telecommunications technology can be used to examine the access site (including frequency of the evaluation of the access site).	***CMS declined adding these codes to the Medicare telehealth list*** (p. 141)
Elimination of the Required Use of the GT Modifier	CMS current requires claims to include the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT (*via interactive audio and video telecommunications systems*). In CY 2017, CMS finalized a new place of service (POS) code describing services furnished via telehealth. CMS believes that the POS code and modifier requirement are redundant and, therefore, CMS proposes eliminate the required use of the GT modifier on professional claims.	***CMS finalized the proposal to eliminate required use of the GT modifier*** (p. 144). CMS clarified that this policy was limited to professional claims and therefore if it is needed in other instances (e.g. CAH Method II billing), the modifier will be retained (p. 144).
Comment Solicitation on Medicare Telehealth Services	CMS seeks input on how it might "further expand access to telehealth services within the current statutory authority and pay appropriately for services that take full advantage of communication technologies."	CMS thanked stakeholders for their comments (which included suggesting that CMS use its demonstration authority to waive portions of the statutory restrictions. CMS stated that it will review the suggestions for future rulemaking and subregulatory guidance (p. 146).
Comment Solicitation on Remote Patient Monitoring	CMS seeks comment on whether to make separate payment for CPT codes that describe remote patient monitoring. CMS notes that these would by definition not be Medicare telehealth services. Using the examples of physician interpretation of an actual electrocardiogram or electroencephalogram, these services "involved the interpretation of medical information without a direct interaction between the practitioner and the beneficiary" and are therefore paid the same as in-person services without additional requirements of originating sites and the use of the telemedicine POS code.	CMS received general support of CMS recognition of remote patient monitoring services (p. 148).
	CMS seeks specific comment on currently bundled code, CPT 99091 (Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time).	Based on public input, ***CMS finalized a policy to make separate payment for CPT 90991*** (p. 150). Based on this information, ***CMS also recognized that CPT 99091 was in need of code revisions given the general nature of the code***): • CMS will require that the practitioner obtain advance beneficiary consent for the service and document it in the

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		patient medical record (p. 150) • For new patients (or patients not seen by the billing practitioner within 1 year prior to billing 99091), CMS will require initiation of the service during a face-to-face visit with a billing practitioner (including Level 2-5 E/M visits (CPT 99212-99215) (p. 151). • CMS clarified that CPT 99090 "should be reported no more than once in a 30-day period to include the physician or other qualified health care professional time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to patient and/or caregiver, and associated documentation (p. 151). • CMS will allow CPT 99091 to be billed once per patient during he same service period as CCM codes and behavioral health integration (BHI) codes (p. 151).
	CMS also seeks input on other existing codes that describe extensive use of communications technology for consideration in future rulemaking, **,** including CPT 99090 (*Analysis of clinical data stored in computers (e.g., ECGs, blood pressures, hematologic data)*).	***CMS will maintain bundled status of CPT 99090*** (p. 150). CMS noted that commenters cited that CPT 99090 and 99091 did not need to be separately payable because there are more specific codes that describe these services: CPT 93297 (*(Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional)* and CPT 93228 (*External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional)*) (p. 149).
Proposed Potentially Misvalued Services Under the Physician Fee Schedule		
CY 2018 Identification and Review of Potentially Misvalued Services	**Public Nomination.** CMS reviewed its public nomination process for potentially misvalued codes. • Since the CY 2017 Medicare Physician Fee Schedule Final Rule, CMS received a nomination for one code: CPT 27279 (*Arthrodesis,*	***CMS agreed with commenters that CPT 27279 is potentially misvalued and warrants a comprehensive review*** (p. 162). CMS will wait to make

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	sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device). The request was received with supporting documentation requesting that the code value be increased to 14.23. CMS proposes to add this code as a potentially misvalued code.	changes after the code is reviewed by the RUC.
	• CMS previously requested input on the values for dialysis vascular access codes (CPT 36901 through 36909). CMS notes that stakeholders have presented concern about the "typical patient" included in the CY 2017 RUC recommendations. Therefore, CMS seeks additional input and data regarding the potentially misvalued work RVUs for CPT 36901-36909.	CMS agreed that the services were misvalued, and for CY 2018, ***CMS finalized the CY 2017 RUC-recommended wRVUs for CPT 36901-36909)*** (p. 164).
	• CMS notes that it has received conflicting data for Direct PE inputs for CPT 88184 (*Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker*) and 88185 (*Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)*). Therefore, CMS proposes CPT 88184 and 88185 as potentially misvalued codes. CMS notes that stakeholders have noted that previously finalized clinical labor and supplies are no longer accurate.	***CMS has reexamined the CY 2017 RUC-recommended direct PE inputs given comments submitted urging CMS to use the RUC recommendations for CY 2017 in developing final PE RVUs instead of recommending additional review*** (p. 164).
	• CMS has received input that the Work RVUs for ED visits may not reflect the full resources involved in furnishing these services and are undervalued "given the increased acuity of the patient population and the heterogeneity of the sites (e.g. freestanding and off-campus emergency departments). Therefore, CMS seeks input on whether CPT codes 99281-99385 (Emergency department visits for the evaluation and management of a patient) should be reviewed as misvalued codes.	***CMS stated that it believes these services may be potentially misvalued given the increased acuity of the patient population and the heterogeneity of the sites where ED visits are furnished. CMS stated it intends to review RUC recommendations regarding the appropriate valuation of these services for consideration in future rulemaking*** (p. 166). CMS noted the RUC's assent to adding the codes to the potentially misvalued list in the event CMS finalized the codes on the list (p. 165). CMS also noted that it received comments: • Encouraging the streamlining of the E/M process for documenting higher levels of care • Stating caution on revaluation if CMS is planning to revise the E/M documentation guidelines
	Code Screens. CMS does not propose any new screens for CY 2018. CMS seeks comment on the best approach for developing screens and new screens it might consider for use in future rulemaking.	CMS stated that it received a suggestion to revisit two recent reports by the Urban Institute and RAND for prioritization of codes for review under the misvalued code initiative (and pointed to the report

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		statements regarding the relationship between service time and work RVUs). CMS only stated that it will consider recommendations in future rulemaking (p. 167).
Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services		
General	The Consolidated Appropriations Act of 2016 reduces payment amounts under the PFS for the technical component (including the technical component of a global service) of imaging services that are X-rays taken using film by 20 percent effective for services furnished beginning January 1, 2017. CMS previously finalized Modifier FX to be reported on claims for imaging services that are X-rays taken using film beginning on January 1, 2017. The statute also provides for a 7 percent cut in payments for imaging services under the PFS that are X-rays using computed radiography technology (including the X-ray component of a packaged service) in CYs 2018, 2019, 2020, 2021, or 2022. The statute also provides for a 10 percent reduction for such imaging services taken using computed radiography technology in CY 2023 or a subsequent year. CMS proposes to establish a new modifier to be used on claims beginning January 1, 2018 for the technical component of X-rays (including the X-ray component of a packaged service) taken using computed radiography technology. This will allow CMS to implement the statutory 7 percent reduction for these services for CYs 2018-2022 and 10 percent reduction for CY 2023 or a subsequent year.	CMS again explained the statutory provisions that require the implementation of this policy. ***CMS finalized the proposal without modification*** (p. 172). CMS again denied a request to create a list of codes to which the policy applies as it believes "that the professionals who furnish and bill for these services are in the best position to determine whether a particular imaging service is appropriately described as X-rays taken using computer radiography" (p. 170). CMS also noted that it will provide education for use of the new modifier and acknowledged that the agency appreciates "the assistance from private, national organizations, such as medical specialty societies in educating their membership" (p. 171).
Proposed Payment Rates under the Medicare PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments		
Background	CMS continued to monitor concerns that the trends in hospital acquisition of physician practices and increased delivery of physician services in a hospital setting have led to total higher Medicare payments. When care is delivered in a hospital Provider Based Department (PBD), Medicare makes two payments: one for the facility fees (under the OPPS) and the other for the physician's professional services (under the Physician Fee Schedule). Medicare and other stakeholders have been concerned that the total of those two payments are higher for many services when billed out of a PBD than they were when they	CMS again reviewed the history of the policy and its intent to use the same basic mechanism going forward. CMS noted that while it currently lacks the data and infrastructure to require hospitals to bill for these services using a professional claim, CMS will explore changes that would be needed in order to do so in the future (p. 207).

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	were previously provided in the physician office setting. The Bipartisan Budget Act of 2015 included a provision that "applicable items and services"[1] furnished by certain off-campus outpatient departments of a provider on or after January 1, 2017, will not be considered OPD service . . . for purposes of payment under the OPPS and will instead be paid 'under the applicable payment system; under Medicare Part B." The statute defines "off-campus outpatient department of a provider" as "a department of a provider . . . that is not located on the campus of such provider, or within the distance from a remote location of a hospital facility." The statute also excepts from that definition "an off-campus PBD that was billing . . . with respect to covered OPD services furnished prior to" November 2, 2015." CMS previously finalized that the "applicable payment system" for the provisions covered by the Bipartisan Budget Act of 2015 would be the Medicare Physician Fee Schedule (MPFS). That is, most nonexcepted items and services furnished by off-campus PBDs will be paid under the MPFS. These provisions for 2017 were implemented as an interim final rule. CMS proposes to set the payment policies for 2018 in this year's proposed rule and states that it anticipates responding to public comments and "finalizing the CY 2017 interim final rule in future PFS rulemaking." CMS notes that the coding and billing mechanisms that make payments to hospitals for nonexcepted "items and services" furnished by nonexcepted off-campus PBDs are similar to those CMS already uses to pay for the Technical Component (TC) of services paid for under the MPFS. CMS proposes to maintain this mechanism in 2018.	
Establishment of Payment Rates	In creating the new payment mechanism, CMS sought to ensure that the relativity in OPPS payment rates was maintained under the relative payment system of the MPFS. Therefore, CMS had established a transitional policy of site-specific rates under the MPFS for the TC of nonexcepted "items and services" furnished by nonexcepted off-campus PBDs based on the OPPS payment for those services and scaled down by 50 percent ("the PFS Relativity Adjuster"). CMS proposes to revise the PFS Relativity Adjuster for nonexcepted "items and services" furnished by nonexcepted off-campus PBDs to 25 percent of the OPPS payment rate.	CMS received significant pushback against its proposal to reduce the PFS Relativity Adjuster from 50% to 25%. CMS considered a new approach where it integrated the policies that led to the selection of the 50% and 25% adjusters (p. 199). After review of the top 22 codes (see Table 10), CMS data suggested that the applicable payment

[1] The statutory definition of "applicable items and services" specifically excludes items and services furnished by a dedicated emergency department. Therefore, these items and services will continue to be paid under the OPPS.

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	CMS also seeks comment on whether it should adopt a different PFS Relativity Adjuster (e.g., 40%) to represent a middle ground between ensuring adequate hospital payments and ensuring that hospitals are not paid more than others paid through the PFS nonfacility rate.	amount under the PFS is 35 percent of the amount that would have been paid under the OPPS (p. 200). However, CMS believes that it has not yet been able to appropriately account for OPPS packaging in its comparison methodology. Therefore, instead of setting the PFS Relativity Adjuster at 35 percent, ***for CY 2018, CMS finalized a PFS Relativity Adjuster of 40 percent*** (p. 201; p. 204). CMS reminded stakeholders that the PFS Relativity Adjuster is designed to be an interim policy until a complete year of claims data from CY 2017 are available (p. 206). **340B Clarification**. CMS received inquiries highlighting that CMS did not specify whether it will reduce the payment for 340B drugs furnished in nonexcepted off-campus PBDs. CMS notes that drugs that are acquired under the 340B program and furnished by non-excepted off campus PBDs are paid under the PFS and are not subject to OPPS drug payment policies. Therefore, CMS did not propose to adjust payment for 340B-acquired drugs. CMS did state that it would monitor drug utilization in these settings, however (p. 202).
Valuation of Specific Codes		
Process for Valuing New, Revised, and Potentially Misvalued Codes	In this section, CMS describes the process for valuing new, revised and misvalued codes, providing a history of the prior 5-year review process and the transition to the new process finalized in CY 2015.	No change
Methodology for Establishing Work RVUs	For CY 2018, CMS generally proposed RUC-recommended work RVUs for new, revised, and potentially misvalued codes based on its understanding that the RUC generally considers the kinds of concerns the agency has historically raised regarding appropriate valuation of work RVUs. However, CMS did identify some concerns and has included descriptions of potential approaches it might have taken in developing work RVUs that differ from the RUC recommended values. CMS seeks comment on both the RUC-recommended values as well as the alternatives considered. Table 10 contains a list of codes for which CMS proposed work RVUs; this includes all codes for which CMS received RUC recommendations by February 10, 2017.	Several commenters generally support the proposed use of the RUC-recommended work RVUs, without refinement, with one commenter encouraging further collaboration between the RUC and CMS to improve the relativity within the payment system. CMS agreed that collaboration is a critical element in the establishment of work RVUs, but noted that it will continue to consider information from various public commenters, medical literature, the HCPAC, information provided by the RUC, Medicare claims data, and other relevant sources. (p. 220) Another commenter stated that it is open to supporting CMS' alternative methods of valuation if the methods are disclosed and there is ample time to review, comment, and iterate on suggestions, as is the case with the RUC process. Yet another commenter stated that while it appreciates CMS

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		providing stakeholders with discussion of alternative approaches that the agency might have used to reach a different value, rather than proposing those values, it believes many of these alternative methods could be raised during deliberations at RUC meetings when specialties and their expert physician advisors are available to engage in a dialogue with CMS representatives. The commenter stated that CMS representatives who attend the RUC meetings should engage more actively in discussion with society representatives about the agency's issues and concerns with work and direct PE inputs, rather than first sharing concerns in the proposed rule when dialogue is restricted due to the rulemaking process. While CMS agreed that the comment period does not provide for an iterative process, it does provide an opportunity for all interested parties to review and have an opportunity to comment on the proposals and alternative valuations considered. CMS also acknowledged that discussion and consideration of different valuations occur during the RUC process, but not all interested parties have the opportunity to participate. While CMS agreed that agency staff could offer useful perspectives by regularly attending and participating more fully in the RUC meetings, CMS did not feel it would be appropriate as participation in the RUC process cannot supplant the agency's obligation to establish through notice and comment rulemaking what it determines to be appropriate RVUs for each reviewed code. (p. 222) Table 12 contains a list of codes for which CMS proposed work RVUs; this includes all codes for which CMS received RUC recommendations by February 10, 2017. Table 12 also contains the CPT code descriptors for all proposed, new, revised, and potentially misvalued codes discussed in this section.
Methodology for the Direct PE Inputs to Develop PE RVUs	Table 11 details CMS' proposed refinements of the RUC's direct PE recommendations at the code-specific level.	Table 13 details CMS' refinements of the RUC's direct PE recommendations at the code-specific level. As stated in the proposed rule, nearly half of the refinements listed in Table 13 result in changes under the $0.30 threshold and are unlikely to result in a change to the RVUs.
Common Refinements		*New Supply and Equipment Items*. For CY 2018, CMS received invoices for several new supply and equipment items. Tables 13 and 14 detail the invoices received for new and existing items in the direct PE database. CMS encourages stakeholders to review the prices associated with these new and existing items to determine whether these prices appear to be

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		accurate. Where prices appear inaccurate, CMS encourages stakeholders to provide invoices or other information to improve the accuracy of pricing for these items in the direct PE database during the 60-day public comment period for this final rule. Invoices received outside of the public comment period would be submitted by February 10th of the following year for consideration in future rulemaking, similar to CMS' new process for consideration of RUC recommendations. (p. 233)
Valuation of Specific Codes for CY 2018	Appendix A highlights CMS' work and PE proposals and final values for selected codes.	Appendix A highlights CMS' work and PE proposals and final values for selected codes.
Evaluation and Management (E/M) Guidelines and Care Management Services		
E/M Guidelines	CMS seeks input from a broad array of stakeholders, including patient advocates, on the specific changes CMS should undertake to reform the guidelines, reduce the associated burden, and better align E/M coding and documentation with the current practice of medicine. CMS specifically seeks comment on how it might focus on initial changes to the guidelines for the history and physical exam, including whether it would be appropriate to remove its documentation requirements for the history and physical exam for all E/M visits at all levels. CMS also seeks comment on how such reforms may differentially affect physicians and practitioners of different specialties, including primary care clinicians, and how CMS could or should account for such effects as it examines this issue. CMS seeks comment on whether it should leave it largely to the discretion of individual practitioners to what degree they should perform and document the history and physical exam. CMS also welcomes comments on specific ideas that stakeholders may have on how to update medical decision-making guidelines to foster appropriate documentation for patient care commensurate with the level of patient complexity, while avoiding burdensome documentation requirements and/or inappropriate upcoding.	CMS received significant feedback from stakeholders on this issue, but there was no consensus on any of the topics raised in the solicitation. CMS is especially appreciative of the commitment from stakeholders to work with the agency on developing and implementing potential changes. CMS stated it is considering the best approaches for collaboration, and will take all comments into account as it considers the issues for future rulemaking. (p. 501) While comments were not specifically solicited, commenters also raised the issue of the E/M values themselves. CMS stated its belief that the public comments illustrate how difficult it is to utilize or rely upon such a relatively small set of codes to describe and pay for the work of a wide range of physicians and practitioners in many vastly different clinical contexts and that many of the issues with the E/M documentation guidelines are not simply a matter of undue administrative burden. According to CMS, the guidelines reflect how work was performed and valued a number of years ago, and are intimately related to the definition and description of E/M work as well as its valuation. As such, opinions on potential redefinition and revaluation of the E/M code set tend to differ by specialty, according to the type of work dominating each specialty (for example, primary care, so-called "cognitive" specialty work, or global procedures that have E/M visits bundled in rather than separately performed and documented). CMS expects to continue to work on all of these issues with stakeholders in future years though CMS is immediately focused on revision of the current E/M guidelines in order to reduce

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		unnecessary administrative burden. (p. 502)
Care Management Public Comment Solicitation	CMS seeks comment on ways it might further reduce burden on reporting practitioners for care management services, including through stronger alignment between CMS requirements and CPT guidance for existing and potential new codes.	CMS received many comments, including some that recommended ways in which the agency might better involve specialists in the provision of Chronic Care Management (CCM) or care management broadly (such as payment to emergency department physicians when they act as primary care practitioners, or payment to multiple practitioners involved in managing a given patient at a given time). CMS agreed there may be circumstances in which more than one practitioner expends resources managing or helping manage a CCM patient, therefore, the agency will continue to explore ways in which we might better identify and pay for costs incurred by multiple practitioners who coordinate and manage a patient's care within a given month. CMS remains interested in hearing more about the relevant circumstances, potential gaps in coding, and the exact nature of the work performed or costs incurred. (p. 509)
Outpatient Therapy Caps for CY 2018		
General	No discussion in proposed rule.	**General.** CMS highlights that the Balanced Budget Act of 1997 required the implementation of the "therapy caps." There is one therapy cap for outpatient occupational therapy; and a separate therapy cap for physical therapy (PT) and speech-language pathology (SLP) combined (p. 512). **Amounts**. The therapy cap amounts are updated annually based on the MEI. CMS states that the update methodology results in a CY 2018 therapy cap amount of $2,010 (p. 512). **Therapy Cap Exception**. An exceptions process for the therapy caps has been in place since 2006, facilitated by multiple legislative extensions. The most recent was in MACRA which extended the exceptions process to December 31, 2017 (p. 512). CMS tracks each beneficiaries incurred expenses and after they have been exceeded, providers use the KX modifier on claims for subsequent services to request an exception to the therapy caps (p. 513). **Manual Medical Review**. CMS is required by law to apply a manual review process for therapy claims when a beneficiary's incurred expenses for outpatient therapy services exceed a threshold amount of $3,700. MACRA amended this requirement so that CMS could perform more targeted reviews (e.g. targeting therapy providers with a high claims denial rate for

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		therapy services or those with aberrant billing practices) (p. 514). The manual medical review process expires at the same time as the exceptions process for therapy caps (December 31, 2017). ***CMS simply provides clarification that:*** • ***Absent Congressional action, the therapy caps exceptions process will expire on December 31, 2017*** • ***If this happens, beneficiaries will become financially liable for 100 percent of the expenses that exceed the therapy caps*** • ***The therapy caps will be applicable without any further medical review; and*** • ***The use of the KX modifier will have no effect*** (p. 514).

Other Provisions of the Proposed Rule for PFS

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New Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)		
Proposed Care Management Requirements and Payment for RHCs and FQHCs	To ensure that RHC and FQHC patients have access to new care management services in a manner consistent with the RHC and FQHC per diem payment methodologies, CMS proposed the establishment of two new G codes for use by RHCs and FQHCs. The first new G code, GCCC1, would be a General Care Management code for RHCs and FQHCs, with the payment amount set at the average of the national non-facility PFS payment rates for CCM (CPT codes 99490 and 99487) and general BHI[2] code G0507. The second new G code for RHCs and FQHCs, GCCC2, would be a Psychiatric collaborative care model (CoCM) code, with the payment amount set at the average of the national non-facility PFS payment rates for CPT codes G0502 and G0503 (note that GCCC1 and GCCC2 were placeholder codes and are replaced by G0511 and G0512, respectively, effective January 1, 2018).	***CMS finalized the revisions to CCM payment for RHCs and FQHCs and establishment of requirements and payment for general BHI and psychiatric CoCM services furnished in RHCs and FQHCs, beginning on January 1, 2018, as proposed, except that it is removing the requirement that the behavioral health care manager be available to contact the patient outside of regular RHC or FQHC hours as necessary to conduct the behavioral health care manager's duties.*** (p. 549) Table 20 compares the proposed and final HCPCS/CPT codes. The code changes will be effective January 1, 2018, and are used in the remainder of this rule. A discussion of comments received in response to these proposals begins on p. 539.

[2] BHI refers to care management services that integrate behavioral health services with primary care and other clinical services.

Proposed Establishment of General Care Management Code for RHCs and FQHCs. Effective for services furnished on or after January 1, 2018, CMS proposed to create General Care Management code GCCC1 for RHCs and FQHCs, with the payment amount set at the average of the 3 national non-facility PFS payment rates for the CCM and general BHI codes and updated annually based on the PFS amounts. The 3 codes are:

- CPT 99490 - 20 minutes or more of CCM services
- CPT 99487 - at least 60 minutes of complex CCM services
- HCPCS G0507 - 20 minutes or more of BHI services

RHCs and FQHCs could bill the new General Care Management code when the requirements for any of these 3 codes are met. The General Care Management code would be billed alone or in addition to other services furnished during the RHC or FQHC visit. This code could only be billed once per month per beneficiary, and could not be billed if other care management services (such as TCM or home health care supervision) are billed for the same time period. CMS notes that CPT code 99489 is an add-on code when CPT code 99487 is furnished, and is therefore not included as RHCs and FQHCs are not paid for additional time once the minimum requirements have been met.

The program requirements for RHCs and FQHCs furnishing CCM services were established in the CY 2016 PFS final rule with comment period (80 FR 71080) and revised in the CY 2017 PFS final rule (81 FR 80256). CMS did not propose any changes to these requirements at this time.

CMS proposed the following requirements for RHCs and FQHCs furnishing BHI services. To bill for this service using the proposed General Care Management Code for RHCs and FQHCs, 20 minutes or more of clinical staff time, directed by an RHC or FQHC practitioner, must be furnished per calendar month.

- Initiating Visit: An E/M, AWV, or IPPE visit with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) occurring no more than one-year prior to commencing BHI services. This could be the same initiating visit that is used for initiating CCM services, and would be billed separately as an RHC or FQHC visit (if the RHC or FQHC has not already billed for this visit).
- Beneficiary Consent: Documentation in the medical record that the beneficiary has consented to receive BHI services, given permission to consult with relevant specialists as needed, and been informed that there may be beneficiary cost-sharing, including deductible and coinsurance amounts as applicable, for both in-person and non-face-to-face services that are provided. The beneficiary consent process would also include informing the patient that only one

CMS finalized policies regarding the establishment of General Care Management Code for RHCs and FQHCs as proposed. A discussion about these policies starts on p. 524. Table 18 compares the proposed requirements for CCM and general BHI services. CMS believe that even though there are some differences in the requirements of CCM and general BHI, grouping them together will help to promote integrated care management services for Medicare beneficiaries who have either or both primary care and behavioral health needs. It will also result in the least amount of reporting burden for RHCs and FQHCs because once the 20-minute threshold is met for either CCM or general BHI, reporting and tracking of additional time increments is not required.

practitioner/facility can furnish and be paid for these services during a calendar month, and that the patient can stop care coordination services at any time (effective at the end of the calendar month). This could be obtained at the same time that beneficiary consent is obtained for CCM services. • Billing Requirements: At least 20 minutes of care management services per calendar month, furnished under the direction of the RHC or FQHC primary care physician, NP, PA, or CNM, and furnished by an RHC or FQHC practitioner, or by clinical personnel under general supervision. These are the same billing requirements as for CCM services. If both CCM and BHI services are furnished in the same month, the time would be combined and billed as one under the new care coordination code. • Patient Eligibility: One or more new or pre-existing behavioral health or psychiatric conditions being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC primary care practitioner, warrants BHI services. • Required Service Elements: An initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.	
Proposed Establishment of a Psychiatric CoCM Code for RHCs and FQHCs. Psychiatric CoCM is a defined model of care that integrates primary health care services with care management support for patients receiving behavioral health treatment, and includes regular psychiatric inter-specialty consultation with the primary care team, particularly regarding patients whose conditions are not improving. Effective for services furnished on or after January 1, 2018, CMS proposes to create a psychiatric CoCM code for RHCs and FQHCs, GCCC2, with the payment amount set at the average of the 2 national non-facility PFS payment rates for CoCM codes, to be updated annually based on the PFS amounts. The 2 codes are: • G0502 - 70 minutes or more of initial psychiatric CoCM services • G0503 - 60 minutes or more of subsequent psychiatric CoCM services RHCs and FQHCs could bill the new psychiatric CoCM code when the requirements for any of these 2 codes (G0502 or G0503) are met. The	***CMS finalized policies regarding the establishment of General Care Management Code for RHCs and FQHCs as proposed, except that it is removing the requirement that the behavioral health care manager be available to contact the patient outside of regular RHC or FQHC hours as necessary to conduct the behavioral health care manager's duties***. A discussion about these policies starts on p. 531. A summary of CMS' proposals related to the members of the psychiatric CoCM team, including the behavioral health care manager, can be found on p. 533. It can also be found in Table 19, which compares the proposed requirements for general BHI, which would be billed using the proposed General Care Management code GCCC1, and psychiatric CoCM services, which would be billed using the proposed psychiatric CoCM code, GCCC2.

	psychiatric CoCM code would be billed alone or in addition to other services furnished during the RHC or FQHC visit. To prevent duplication of payment, this code could only be billed once per month per beneficiary, and could not be billed if other care management services, including the proposed General Care Management code, are billed for the same time period. Note that G0504 is an add-on code when G0503 is furnished and is therefore not included as RHCs and FQHCs are not paid for additional time once the minimum requirements have been met. The psychiatric CoCM team must include the RHC or FQHC practitioner, a behavioral health care manager, and a psychiatric consultant. Proposed specific requirements of the psychiatric CoCM team are outlined in the rule.	
Implementation	If this proposal is finalized as proposed, RHCs and FQHCs would continue to receive payment for CCM when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim until December 31, 2017. Beginning on January 1, 2018, CMS proposes that RHCs and FQHCs must use the new General Care Management G code GCCC1 when billing for CCM or general BHI services, and the new psychiatric CoCM G code GCCC2 when billing for psychiatric CoCM services, either alone or with other payable services on an RHC or FQHC claim. Claims submitted using CPT 99490 on January 1, 2018, or after, will not be paid.	RHCs and FQHCs will continue to receive payment for CCM services when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim for dates of service on or before December 31, 2017. Beginning on January 1, 2018, RHCs and FQHCs must use the new General Care Management code **G0511** when billing for CCM or general BHI services, and the new psychiatric CoCM code **G0512** when billing for psychiatric CoCM services, either alone or with other payable services on an RHC or FQHC claim. Service lines submitted using CPT 99490 code for dates of service on or after January 1, 2018 will be denied. Both the current RHC and FQHC payment rate for CCM, and the proposed RHC and FQHC payment rates for General Care Management and Psychiatric CoCM codes, are based on the PFS national non-facility rates. The PFS rates are updated annually, and the new G codes for RHCs and FQHCs would be updated accordingly and finalized when the PFS rates are finalized for the year. No geographic adjustment will be applied to the General Care Management or Psychiatric CoCM G codes. RHCs and FQHCs are required to submit claims for care management services on an institutional claim and are not authorized to bill care management services separately to the PFS. Regulatory changes related to these new policies are outlined on p. 550.

Part B Drug Payment: Infusion Drugs Furnished through an Item of Durable Medical Equipment (DME)

General	Here, CMS proposes to revise §414.904(e)(2) to ensure the regulations conform with the new payment requirements in section 5004(a) of the	***CMS finalized its proposal to revise §414.904(e)(2) to conform with the statutory payment requirements of section 5004(a) of the Cures Act. It also finalized its***

	Cures Act as they pertain to section 1847A of the Act. Currently, this describes an exception to ASP-based payments and requires pricing DME infusion drugs at 95% of the 2003 AWP. Consistent with section 5004(a) of the Cures Act, the proposed revision limits the exception to infusion drugs furnished before January 1, 2017. In addition, CMS proposed at §414.904(e)(2) to delete the phrase "and is not updated in 2006." CMS believes this language is not relevant since the statutory language required that the pricing of DME infusion drugs be based on the October 2003 AWP. Therefore, there was no update for pricing DME infusion drugs in 2006, and the proposed revision will serve to simplify the language. Effective January 1, 2017, payment limits for these drugs are determined under section 1847A of the Act.	***proposal to revise §414.904(e)(2) to delete the phrase "and is not updated in 2006."*** (p. 552)

Solicitation of Public Comments on Initial Data Collection and Reporting Periods for Clinical Laboratory Fee Schedule

General	To better understand the applicable laboratories' experiences with the data reporting, data collection, and other compliance requirements for the first data collection and reporting periods, CMS is interested in public comments from applicable laboratories and reporting entities on the following questions: • Was the CMS data reporting system easy to use? Please describe your overall experience with navigating the CMS data reporting system. For example, describe the aspects of the CMS data reporting system that worked well for your reporting entity and/or any problems the reporting entity experienced with submitting applicable information to us. • Did the applicable laboratory (or its reporting entity) request and receive assistance from our Help Desk regarding the CMS data reporting system? Please describe your experience with receiving assistance. • Did the applicable laboratory (or its reporting entity) request and receive assistance from the CMS CLFS Inquiries Mailbox regarding policy questions? Please describe your experience with receiving assistance. • Did the applicable laboratory (or its reporting entity) use the subregulatory guidance on data reporting provided on the CMS CLFS website? If so, was the information presented useful? • Was the information that the applicable laboratory was required	A summary of comments received begins on p. 556. Some specific recommendations include: • Improving the accessibility of the CMS data reporting system, e.g., by removing certain security measures. • That CMS allow the reporting entity to aggregate applicable information for its components that are applicable laboratories, and enter the aggregated applicable information in the designated column on the CMS data reporting template since it is administratively burdensome for the reporting entity (i.e., the Taxpayer Identification Number (TIN)) to report applicable information individually for each of its component applicable laboratories. • Change the proportion of data that applicable laboratories are required to report; e.g., allow applicable laboratories to report 75 to 80% rather than 100%, of their applicable information. • Change the requirement that applicable laboratories must report data from claims that require manual remittance processes. • Streamline the identification of user formatting errors and permit real-time file edits in the CMS data reporting system. • Define terms used in the data reporting system; e.g., the term "CMS Certification Number (CCN)". CMS will consider this feedback for potential future rulemaking or publication of subregulatory guidance pertaining to the CLFS data collection and reporting

	to report readily available in the applicable laboratory's record systems? • Did the reporting entity have a manual, automated, or semi-automated remittance process for data reporting? • If the reporting entity used a manual or semi-automated remittance process for data reporting, what percentage of the process was manual? • How much time (hours) was required to assemble and report applicable information to CMS? • Is there any other information that will inform us regarding the reporting, recordkeeping, and other compliance requirements from the first data collection and reporting periods?	periods. No CLFS data collection or reporting changes are being proposed or finalized within this final rule. CMS notes that a hospital outreach laboratory, that is, a hospital based laboratory that furnishes laboratory tests to patients other than inpatients or outpatients of the hospital, could be an applicable laboratory if it meets the definition of an applicable laboratory in 42 CFR 414.502.

Payment for Biosimilar Biological Products under Section 1847A of the Act

General	Although CMS is not making any proposed changes to existing policies in this space, it requests comments regarding: • Its Medicare Part B biosimilar biological product payment policy; specifically new or updated information on the effects of the current biosimilar payment policy that is based on experience with the U.S. marketplace. • Data to demonstrate how individual HCPCS codes could impact the biosimilar market, including innovation, the number of biosimilar products introduced to the market, patient access, and drug spending. • Other novel payment policies that would foster competition, increase access, and drive cost savings in the biological product marketplace. These solutions may include legislation, demonstrations, and administrative options. CMS seeks to promote innovation, to provide more options to patients and physicians, and to encourage competition to drive prices down. Its goal for this comment solicitation is to further evaluate its policies to be sure they allow for market forces to provide a robust and comprehensive selection of choices for patients at a fair price.	***CMS finalized the policy to separately code and pay for biological biosimilar products under Medicare Part B; CMS is not changing regulation text at §414.904(j). Effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same HCPCS code.***[3] (p. 574) CMS will issue detailed guidance on coding, including instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers. Completion of these changes, which will require changes to the claims processing systems, is planned to occur as soon as feasible, but should not be expected to be complete by January 1, 2018. CMS anticipates that this will be done by mid-2018 and plans to issue instructions using subregulatory means, such as change requests/transmittals to contractors and the ASP website. A summary of comments received can be found starting on p. 563. According to CMS, comments received about the issue of grouping or separating payment for biosimilars of the same reference product were sharply divided, and information provided as support for a given position was also subject to interpretation. Nevertheless, based on comments received, CMS was persuaded that changing the Part B biosimilar payment policy to provide for the separate coding and payment for products approved under each individual abbreviated application, rather than grouping all biosimilars with a common reference product into codes, will meet its stated goal. CMS believes that this policy change will encourage

[3] CMS reminds readers that its preamble language in the CY 2016 PFS rule with comment period (80 FR 71096) indicated that policy changes could be forthcoming (80 FR 71098).

		greater manufacturer participation in the marketplace and the introduction of more biosimilar products, thus creating a stable and robust market, driving competition and decreasing uncertainty about access and payment. CMS anticipates that this policy change will provide physicians with greater certainty about biosimilar payment, which will affect utilization of these products, creating more demand that would help increase competition (compared to the policy that is currently in place). As a result of the policy change CMS anticipates greater access to biosimilar biological products and that more price competition between more products will occur because there will be more products available. The change in policy could lead to additional savings for Medicare and its beneficiaries over the long-term by increasing the utilization of products that are less expensive than reference biologicals. Further, carrying out this policy change as early as possible, rather than waiting, would maximize the benefits described in this paragraph and would bring more certainty to the new and developing marketplace promptly. CMS will continue to monitor Part B biosimilar payment and utilization, particularly as they relate to access, including the number of products available to beneficiaries with Part B and cost savings associated with Medicare and beneficiary payments. CMS also appreciated the comments on novel payment policies that would foster competition, increase access, and drive cost savings in the biological product marketplace.
Appropriate Use Criteria for Advanced Diagnostic Imaging Services		
Consultation by Ordering Professional and Reporting by Furnishing Professional	There are four major components of the AUC program under section 1834(q) of the Act, and each component has its own implementation date: 1. Establishment of AUC by November 15, 2015 2. Identification of Clinical Decision Support Mechanisms (CDSMs) for consultation with AUC by April 1, 2016 3. AUC consultation by ordering professionals of applicable imaging services, and reporting on the Medicare claim by furnishing professionals information about the ordering professional's AUC consultation by January 1, 2017. CMS proposes in this rule that ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services ordered on or after January 1, 2019. During this "testing period,"	In general, CMS recognizes that Section 1834(q) of the Act includes rapid timelines for establishing a Medicare AUC program for advanced diagnostic imaging services. The impact of this program is extensive as it will apply to every physician or other practitioner who orders or furnishes advanced diagnostic imaging services (e.g., magnetic resonance imaging (MRI), computed tomography (CT) or positron emission tomography (PET)). This crosses almost every medical specialty and could have a particular impact on primary care physicians since their scope of practice can be quite broad. ***In order to provide more time for ordering and furnishing professionals, qualified PLEs, qualified CDSMs, CMS and other stakeholders to prepare for and support successful participation in the Medicare AUC program, CMS finalized this policy with the following changes:***

ordering professionals would consult AUC and furnishing professionals would report AUC consultation information on the claim, but CMS would continue to pay claims whether or not they correctly include such information. The agency recognizes the complexity of this program and seeks additional comments related to whether the program should be delayed beyond the proposed start date of January 1, 2019 and/or whether the testing period should be longer than a year.

CMS also proposes to offer a voluntary reporting period to be available ahead of January 1, 2019, which is anticipated to begin July 2018, depending on CMS's readiness.

Consistent with the statute, CMS also proposes that furnishing professionals report the following information on Medicare claims for applicable imaging services ordered on or after January 1, 2019:

- Which qualified CDSM was consulted by the ordering professional;
- Whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered; and
- The NPI of the ordering professional (if different from the furnishing professional)

This information, to the extent feasible, is required across claim types (including both the furnishing professional and facility claims) and across all three applicable payment systems (PFS, hospital outpatient prospective payment system and ambulatory surgical center payment system). In other words, CMS would expect this information to be included on the practitioner claim that includes the professional component of the imaging service and on the hospital outpatient claim for the technical component of the imaging service.

Unless a statutory exception applies, an AUC consultation must take place for every order for an applicable imaging service furnished in an applicable setting and paid under an applicable payment system.

To implement this reporting requirement, CMS proposes to establish a series of HCPCS level 3 codes. These G-codes would describe the specific CDSM that was used by the ordering professional. CMS also proposes to establish a G-code to identify circumstances where there was no AUC consultation through a qualified CDSM.

- ***Extending the voluntary reporting period to 18 months starting July 2018 and continuing through CY 2019. During this time, early adopters can begin reporting limited consultation information on Medicare claims. During the voluntary period there is no requirement for ordering professionals to consult AUC or furnishing professionals to report information related to the consultation; and***
- ***Making the AUC consultation and reporting requirements effective for an educational and operations testing period beginning on January 1, 2020, instead of January 1, 2019 as proposed, to last through CY 2020. To clarify, ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2020, and furnishing professionals must report the AUC consultation information on the Medicare claim for these services ordered on or after January 1, 2020. During this time, CMS will continue to pay claims whether or not they correctly include such information.*** This educational and operations testing period will allow professionals to actively participate in the program while avoiding claims denials during the learning curve. It also gives CMS an opportunity to make any needed claims processing adjustments before payments are impacted. CMS does not expect to continue this educational and operations testing period beyond the first year of the AUC program; however, it will evaluate whether a second educational and operations testing year is necessary. (p. 590, p. 633)

In response to commenter concerns, CMS will not move forward with the G-code and modifier combinations for reporting which CDSM is consulted, adherence, non-adherence or situations where AUC are not applicable. Instead, CMS will work with stakeholder to further explore using a standardized unique AUC consultation identifier for reporting on Medicare claims, per commenter suggestions. CMS expects to conduct stakeholder outreach during 2018 to develop a standard taxonomy and better explore options of where to place such an identifier on practitioner and facility claims. CMS will discuss such changes in future rulemaking ahead of the 2020 consulting and reporting effective date. CMS does not anticipate including these identifiers on claims before then.

In regards to the voluntary reporting period (July 2018 and continuing through CY 2019), furnishing professionals and facilities opting to report AUC consultation information will have only one HCPCS modifier available to them to report on the line level with the CPT code for the advanced diagnostic imaging service. This modifier identifies only that AUC was consulted and not the result of the consultation since that is all that CMS will be able to accommodate by that

Each G-code would be expected, on the same claim line, to contain at least one new HCPCS modifier. CMS proposes to develop a series of modifiers to provide necessary information as to whether and when a CDSM is used to consult AUC:

- The imaging service would adhere to the applicable appropriate use criteria;
- The imaging service would not adhere to such criteria; or
- Such criteria were not applicable to the imaging service ordered

CMS also proposes to create additional modifiers to describe situations where an exception applies and a qualified CDSM was not used to consult AUC:

- Imaging service was ordered for a patient with an emergency medical condition; or
- The ordering professional has a significant hardship exception

Since CMS proposes in this rule for the program to start January 1, 2019, it anticipates that implementation of the prior authorization component for outlier professionals, expected to begin January 1, 2020 (as specified under section 1834(q)(6)), will be delayed. This policy applies only to identified priority clinical areas

time. However, CMS expects this type of limited reporting to be temporary.

Public Comments

Below is a summary of CMS' response to select public concerns:

- CMS agreed with commenters that the goals of the QPP are consistent with those of the AUC program; however, CMS is required by separate statutory authority provisions to implement the AUC program and the QPP.
- Although it recognized concerns about the undue burden placed on furnishing professionals since it is their claims that ultimately will not be paid if AUC consultation information is not included on the claim form, CMS clarified that it does not have discretion with respect to Section 1834(q) of the Act, which requires that AUC consultation information be included on the *furnishing* professional's claim in order for that claim to be paid.
- Other commenters raised questions about who is actually required to perform the AUC consultation (e.g., could a designee within an ordering professional's practice consult on behalf of the ordering professional?). CMS clarified that Section 1834(q)(4)(A)(i) of the Act requires an ordering professional to consult with a qualified CDSM, but because there were so many questions about this provision, it will consider developing policy to address this policy.
- In response to concerns, CMS is exploring claims-reporting options for situations when the imaging service is ordered before January 1, 2020 but furnished after January 1, 2020 and AUC consultation information is not available for inclusion on the claim.
- In response to commenter concerns, CMS clarified that in instances when the furnishing professional must update or modify the order for an advanced diagnostic imaging service, the AUC consultation information provided by the ordering professional with the original order should be reflected on the Medicare claim to demonstrate that the requisite AUC consultation occurred. In future rulemaking, CMS expects to establish a means to account for instances when the order must be updated or modified.
- In regards to which professional is actually responsible for the accuracy of reporting, CMS will continue to consider implementation of exceptions to AUC consultation during the voluntary reporting period and in response to stakeholder feedback.
- In response to public inquiries, CMS clarified that when the patient is in an inpatient setting and advanced diagnostic imaging services are paid under Medicare Part A, the physician's Part B professional claim would not require reporting of an AUC consultation. In other words, the

ordering practitioner would not be required to consult a qualified CDSM. Also, any advanced imaging service furnished within a CAH would not be subject to this requirement.

- In response to public requests, CMS plans to explore mechanisms for CMS and qualified CDSMs to share data.
- Some commenters requested prescriptive guidance on how AUC consultation information should be communicated between the ordering and furnishing professionals. If CMS adopts a policy to require reporting of the unique AUC consultation identifier on the furnishing professional's claim, then it would expect the ordering professional to include that identifier on the order for the advanced diagnostic imaging service. However, CMS believes that it first needs to establish a standardized taxonomy for the unique consultation identifier before it can determine the extent to which it will establish guidance.

Others public concerns that CMS will continue to monitor include:

- Potential unintended consequences:
  - For example, decreased patient access or choices, inappropriate underutilization of imaging studies and harm to patients because of such a reduction, inappropriate testing to avoid AUC requirements, delays in beneficiaries receiving needed tests or even denial of services by furnishing professionals and facilities if AUC is not consulted or information is not provided by the ordering professional, and healthcare rationing.
  - Shifts in referral patterns
  - Disruptions in physicians' practices and workflows and a reduction in patient facing time for providers.
  - Unwarranted financial penalties for imaging facilities and increases in the cost of tests as CDSMs may recommend higher cost imaging.
- Concerns related to the definition of "provider-led entities" qualified to offer AUC for purposes of this program:
- That the regulatory definition of certified "provider-led entity" should include organizations that develop AUC under the leadership of a structured group of providers who are actively engaged in the practice and delivery of healthcare.
- Concern that under the current regulatory definition, independent content developers and third party entities cannot participate in the AUC program. Although CMS believes that independent content developers, third parties or non-PLE authors can play a valuable role under the AUC program, it does not believe that AUC endorsed by any organization that could meet the definition of PLE should be considered specified AUC under this program.

		• Opposition to the transparency requirements for qualified PLEs codified at §414.94(c)(1), which commenters believe are inappropriate because they require developers to place their intellectual property in the public domain when the statute does not include such transparency requirements. CMS countered that to ensure all the statutory considerations are taken into account, transparency of the process is essential, which includes making publicly available the people, methodologies, and evidence used by developers. In general, CMS hopes to engage in continuous communications with stakeholders to address these and other questions/concerns that arise. CMS will continue to post information regarding the implementation of this program on its website and over the coming months, plans to pursue additional stakeholder engagement.
Alignment with Other Medicare Quality Programs	CMS proposes to develop a direct tie between MIPS and the AUC program by giving MIPS credit in the improvement activities performance category to ordering professionals for consulting specified AUC using a qualified CDSM as a high-weight improvement activity for the performance period beginning January 1, 2018 (82 FR 30484). Although CMS proposes that the AUC program consultation and reporting requirements would not officially begin until January 1, 2019, it is able to adopt this proposed improvement activity because the first qualified CDSMs were announced in conjunction with the 2018 PFS proposed rule; therefore, ordering professionals will be able to begin consulting specified, applicable AUC using those tools.	CMS finalized this improvement activity in the 2018 Updates to the QPP final rule. However, the description was updated such that clinicians attest that they are consulting specified applicable AUC through a qualified CDSM for all applicable imaging services furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2018. Public Comments Below is a summary of additional commenter suggestions for expanding the scope of the proposed AUC improvement activity: • Eligible clinicians could receive credit for AUC consultation through both the MIPS quality and improvement activities performance categories; • CMS should further incentivize the electronic ordering of advanced diagnostic imaging services; • Credit should be awarded if the rate of consultation with AUC is 60% for first year, or 75% for the second year similar to IA _PSPA _ 6 "Consultation of the Prescription Drug Monitoring program"; • CMS should award credit for consultation with AUC through CDSMs that have not been qualified; • CMS should provide credit to those eligible clinicians providing radiological consultative services; • Credit should be given for reporting of the AUC consultation by *furnishing* professionals; • MIPS credit should be awarded to those clinicians directly involved in AUC development; • By expanding certified EHR technology (CEHRT) requirements to include

		the requirement for CDSM functionality within computerized physician order entry modules, CMS could further reinforce alignment between the AUC program and the MIPS ACI performance category; • CMS could adopt a quality measure could assess whether a clinician consults specified, applicable AUC using a qualified CDSM or other tool (while other felt that creating such a quality measure would be moving closer to more directly tying AUC consultation to payment for the *ordering* professional, potentially through MIPS performance scoring, which runs contrary to the statutory requirement that the *furnishing* professionals' claims and payment are directly impacted); • CMS should offer optional quality measure or bonus points in MIPS if physicians provide feedback to PLEs and CDSMs about why they decided to proceed with ordering an applicable imaging service when it does not adhere to the specified applicable AUC consulted, thus enabling PLEs and CDSMs to learn from user experience; • CMS could achieve greater alignment between the two programs by recognizing Qualified Clinical Data Registries (QCDR) that incorporate CDSMs and report information on the physician's behalf; and • CMS can only achieve full alignment of the AUC program with the MIPS cost or quality performance categories through complete discontinuation of the AUC program and its regulatory burden. CMS recognizes that there are further opportunities for alignment between the AUC program and the QPP. However, since it did not propose any additional policies in rulemaking for 2018, it will consider these suggestions through future rulemaking.
Significant Hardship Exceptions to Consulting and Reporting Requirements	Section 1834(q)(4)(C) of the Act provides for certain exceptions to the AUC consultation and reporting requirements including in the case of certain emergency services, inpatient services paid under Medicare Part A, and ordering professionals who obtain an exception due to a significant hardship. In the 2017 PFS final rule (81 FR 80170), CMS identified the circumstances specific to ordering professionals under which consulting and reporting requirements are not required. These include orders for applicable imaging services: 1. For emergency services when provided to individuals with emergency medical conditions as defined in section 1867(e)(1) of the Act; 2. For an inpatient and for which payment is made under Medicare Part A; and 3. By ordering professionals who are granted a significant hardship exception to the Medicare EHR Incentive Program payment	***CMS did not finalize changes to the significant hardship exceptions in this final rule since public comments suggested that further evaluation is necessary before making changes to regulations.*** (pgs. 618, 623) As such, it will maintain its regulations at §414.94(i)(3), which provides exceptions from consulting and reporting requirements for orders for applicable imaging services made by ordering professionals who are granted a significant hardship exception to the Medicare EHR Incentive Program payment adjustment for that year. CMS intends to take into consideration public comments, as well as policies adopted for the 2018 QPP), and to address significant hardship exceptions for the AUC program in rulemaking for 2019. As noted earlier, CMS believes that during the voluntary reporting period it will continue to develop its understanding of the workflows of both ordering and furnishing professionals, and in particular how it can apply section 1834(q)(4)(C)(iii) of the Act to support those ordering professionals whose consultation would result in a significant hardship.

adjustment for that year under 42 CFR 495.102(d)(4) (described below), except for those granted such an exception under §495.102(d)(4)(iv)(C).[4]

In the 2017 PFS final rule, for purposes of the AUC program significant hardship exceptions, CMS included the following categories from §495.102(d)(4):

- Insufficient Internet Connectivity (as specified in §495.102(d)(4)(i));
- Practicing for less than 2 years (as specified in §495.102(d)(4)(ii));
- Extreme and uncontrollable circumstances (as specified in §495.102(d)(4)(iii));
- Lack of control over the availability of CEHRT (as specified in §495.102(d)(4)(iv)(A)); and
- Lack of face-to-face patient interaction (as specified in §495.102(d)(4)(iv)(B))

In addition, in the 2017 QPP final rule, CMS finalized a policy (81 FR 77240-77243) to reweight the advancing care information (ACI) performance category to zero in the MIPS final score for the year for MIPS eligible clinicians who meet the criteria in one of the listed categories of §495.102(d)(4), with the exception of the category for clinicians practicing for less than 2 years since clinicians enrolled in Medicare for their first year are not even required to participate in MIPS.

In the 2018 PFS proposed rule, CMS proposes to modify its policies related to significant hardship exceptions under the AUC program (§414.94(i)(3)) to reflect the conclusion of payment adjustments under the Medicare EHR Incentive Program and to substitute an alignment with the ACI performance category of MIPS:

- To remove the "practicing for less than 2 years" exception in recognition of the fact that first year Medicare enrollees are not eligible for MIPS, but to maintain the remaining exceptions for the AUC program;
- CMS proposes to amend the AUC significant hardship exception regulation to specify that ordering professionals who are granted re-weighting of the ACI performance category to 0% under MIPS due to the circumstances listed above for the EHR Incentive

Public Comments

Below are select public comments that influenced CMS' decision to not finalize its proposal:

- Concern that identifying ordering professionals with significant hardship exceptions creates challenging workflows for furnishing professionals.
- Concern that under the proposal, radiologists who meet the lack of face-to-face patient interaction threshold would be excepted from consulting AUC if they order applicable imaging services;
- Concern that certain hardships may justifiably last longer than 12 months and that circumstances leading to the initial request for a significant hardship may be uncontrollable by the physician. Those opposing the 12-month cap on hardship exemptions also felt that it would disproportionately affects rural providers;
- Concern that it's unreasonable to recognize clinicians who have their MIPS ACI performance category re-weighted to zero as a result of the ordering professional practicing at multiple locations, without also considering an exception for other practitioners that face challenges to controlling their CEHRT, such as ASC-based eligible clinicians;
- Concern that CMS must also include an exception for hospital-based physicians because emergency physicians and practitioners could not purchase a CDSM platform or adopt a free CDSM platform for implementation in the hospital because they do not have the appropriate authority to make such purchases or decisions in the hospital.
- Requests that CMS expand the scope of available significant hardship exceptions to recognize the following additional circumstances for which an ordering professional should be granted a significant hardship exception under the AUC program:
  - Imaging services ordered as part of clinical research;
  - Physicians nearing retirement or dealing with hardships who may not have data systems, capital, or the desire to invest in a qualified CDSM system necessary to consult AUC;
  - Any time when a PLE or CDSM is de-qualified;
  - For complex medical systems;
  - Any physician who does not have access to free integrated CDSMs;
  - Physicians whose EHR cannot integrate into an existing qualified registry
- Concern about the costs associated with integration of CDSMs and the

[4] §495.102(d)(4)(iv)(C) is defined as EPs whose primary specialty listed in PECOS as anesthesiology, radiology or pathology 6 months prior to the first date of the payment adjustments that would otherwise apply.

	Program (except for "practicing less than 2 years") would also be excepted from the AUC consultation requirement during the same year that the re-weighting applies for purposes of the MIPS payment adjustment; • Recognizing that there are timing difference between the MIPS and AUC program that there will be instances when a clinician who is not a MIPS eligible clinician will need to seek a significant hardship exception to the Medicare AUC program, CMS proposes that ordering professionals who have not received a reweighting to 0 for the MIPS ACI performance category for the year, but experience one of the circumstances listed above (except for "practicing less than 2 years"), may be granted an AUC significant hardship exception. CMS also clarifies here that section 1843(q)(4)(C)(iii) of the Act only allows the *ordering* professional to seek a significant hardship exception, not the *furnishing* professional.	fact that a free tool is an impractical solution for those practices focused on investing in upgrading to certified 2015 Edition EHR technology or unable to afford acquisition of a CDSM that integrates with an EHR system; • Concern that small, rural, and independent practices are not ready for AUC program implementation. • Consideration for exempting ordering professionals based on the MIPS low-volume threshold of services or instead, a threshold that more closely reflects advanced diagnostic imaging services and billing; and • Concern about challenges related to the communication about a significant hardship exception from an ordering professional, to which CMS noted its intent to explore opportunities to use a more automated process to facilitate such communication and make the information readily accessible.

Physician Quality Reporting System (PQRS) Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment

Proposed Modifications to the Satisfactory Reporting Criteria for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment	Responding to the clinician community's concerns that the 2016 PQRS requirements are too complex and need to better align with the Merit-Based Incentive Payment System (MIPS), CMS makes multiple proposed changes to the 2016 PQRS reporting requirements to ensure that clinicians can be assessed for purposes of the 2018 payment adjustment based on satisfactory reporting criteria that are simpler, more understandable, and more consistent with the beginning of MIPS. Table 18 in the proposed rule summarizes the previously finalized satisfactory reporting criteria for individual EPs at §414.90(j)(8) and §414.90(k)(5). Table 19 in the proposed rule summarizes the previously finalized satisfactory reporting criteria for group practices via the group practice reporting option (GPRO) at §414.90(j)(9) and §414.90(k)(5). Appendix B and Appendix C of this document summarize the modified reporting requirements proposed for the 2016 reporting year/2018	***CMS finalized these policies as proposed, and as summarized in Appendix B and Appendix C, including finalizing the revisions at §414.90(j)(8) and (k)(5) as proposed.*** (p. 640) Table 21 includes a summary of the individual reporting criteria finalized for the 2018 PQRS payment adjustment/2016 reporting year. Table 22 includes a summary of the group reporting criteria finalized for the 2018 PQRS payment adjustment/reporting year. In response to a request that CMS create a hardship exemption to relieve satisfactory reporters, of any number of measures, from the 2018 downward payment adjustment, CMS clarified that section 1848(a)(8), (k), and (m) of the Act, which directs it to create and implement the PQRS, does not provide for a hardship exemption process, nor did CMS propose to implement such a process.

	payment adjustment.	
Accountable Care Organization (ACO) Participants Who Report PQRS Quality Measures Separately During the Secondary Reporting Period	As discussed in the 2017 PFS final rule (81 FR 80441 through 80445), individual EPs and group practices who bill under the TIN of an ACO participant may report separately from the ACO, if the ACO failed to report on behalf of such individual EPs or group practices for the applicable reporting period, during the 2016 reporting period for purposes of the 2017 and 2018 PQRS payment adjustments, as applicable. In accordance with these previously established policies related to the ACO Secondary Reporting Period, CMS' proposed modifications to the satisfactory reporting criteria for individual EPs and group practices for the 2016 reporting period would apply to such individual EPs and group practices for purposes of the 2017 PQRS payment adjustment.	***In accordance with these previously established policies for the ACO Secondary Reporting Period, CMS' finalized modifications to the satisfactory reporting criteria for individual EPs and group practices for the 2016 reporting period would apply to such individual EPs and group practices for purposes of the 2017 PQRS payment adjustment.***
Physician Compare Downloadable Database – Addition of Value Modifier (VM) Data	Given the fact that VM data would be available for posting in the Physician Compare downloadable database for only one year (prior to the program ending) and that VM data may not reflect an EP or group's actual performance or payment adjustment given the proposed changes in this rule, CMS proposes to not move forward with publicly reporting VM data in 2017.	***CMS finalized this policy as proposed and will not be including VM data in the Physician Compare downloadable database related to the 2018 payment adjustment.*** (p. 650) CMS clarifies that all other previously finalized policies related to 2016 PQRS data available for public reporting on Physician Compare in late 2017 remain unchanged (80 FR 71116 through 71132). Also, for transparency purposes, these data are already available in a PUF that contains VM performance results of de-identified practices. Clinicians could use the PUF files to evaluate the tiering information as that is included and already public.

Clinical Quality Measurement for Eligible Professionals Participating in the Electronic Health Record (EHR) Incentive Program for 2016

General	CMS proposes to change the reporting criteria from 9 CQMs covering at least 3 NQS domains to 6 CQMs with no domain requirement for EPs and groups who, in 2016, chose to electronically report CQMs through the PQRS Portal for purposes of the Medicare EHR Incentive Program. Note that CMS does not propose any changes to the previously finalized requirements for CQM reporting in 2016 for eligible hospitals and CAHs or the previously finalized requirements for EPs who chose to report CQMs through attestation in 2016 for the Medicare EHR Incentive Program (80 FR 62888).	***CMS finalized this proposal in order to align with the finalized PQRS reporting requirements for 2016***. An EP or group who satisfies these revised reporting criteria (as well as other EHR Incentive Program requirements) may qualify for the 2016 incentive payment under section 1848(o) of the Act and may avoid the downward payment adjustment in 2017 and/or 2018 under section 1848(a)(7)(A) of the Act, depending on the EP or group's applicable EHR reporting period for the payment adjustment year. (p. 656)

	CMS does not propose to change the previously finalized requirements for 2016 for EPs participating in the Medicaid EHR Incentive Program due to the difficulty states might face implementing this policy for 2016 relative to the number of Medicaid EPs who might benefit.	***CMS did not receive any comments and is not changing the previously finalized CQM reporting requirements for 2016 for EPs participating in the Medicaid EHR Incentive Program***. (p. 658)

Medicare Shared Savings Program (MSSP)

Beneficiary Assignment Methodology	CMS reviewed the ACA requirement that CMS assign fee-for-service (FFS) beneficiaries to an MSSP ACO "based on the beneficiary's utilization of primary care services rendered by physicians participating in the ACO."	
	Special Assignment Conditions for RHCs an FQHCs. • Beginning in CY 2019, CMS proposes to remove the RHC and FQHC physician attestation requirement. CMS proposes to instead treat a service reported by on an RHC or FQHC institutional claim as "a primary care service furnished by a primary care physician."	***CMS finalized this proposal for CY 2019 and subsequent years*** (p. 669).
	• CMS proposes to adjust all ACO benchmarks at the start of the first performance year in which the new assignment rules are applied so that the ACO benchmarks reflect the use of the assignment rules as will apply in the performance year.	CMS restated the proposal (p. 667) and generally finalized its RHC and FQHC proposals (p. 669), although did not specifically mention the proposal to adjust the ACO benchmarks.
	Definition of "Primary Care Services." • CMS proposes the addition of the following codes to the definition of "primary care services" beginning in the 2018 for performance year 2019 and subsequent years:	
	Complex Chronic Care Management Codes: CPT 99487 and 99489; and add-on code G0506	***CMS finalized this proposal*** (p. 673). While CMS mostly received support for the inclusion of these codes as primary care services for purposes of attribution, CMS received input from one commenter stating that the value of CCM services is "highly disputed in the ACO community" and also that CCM services "are often provided by outside companies with little connection between the primary care provider and the beneficiary" (p. 672).
	Behavioral Health Integration (BHI) Codes: G0502, G0503, G0504, and G0507	***CMS finalized this proposal*** (p. 673).
	• CMS seeks input on whether there are additional existing	CMS received input that it should also include the Advance Care Planning codes

	HCPCS/CPT codes that it should add to the definition of "primary care services" for purposes of MSSP ACO beneficiary attribution in future rulemaking.	(CPT 99497 and 99498) in the definition of primary care services. CMS stated that it will consider this request in future rulemaking (p. 672).
ACO Quality Reporting	**CMS Web Interface Measures**. CMS highlights several of the changes it discussed in the CY 2018 QPP proposed rule to measures included in the CMS Web Interface. CMS reviewed that CY 2018 QPP CMS Web Interface-related proposals to determine whether the changes (if finalized) affect how the measures are used to assess ACO performance in the MSSP. After CMS review, CMS has determined that the proposed QPP changes to the CMS Web Interface measures do not require that CMS revert the measures to "pay-for-reporting" measures for the 2018 performance year for purposes of the MSSP. CMS will instead update the measures through subregulatory guidance and maintain the measure phase-in schedule as otherwise dictated under the MSSP	***CMS finalized this policy as proposed*** (p. 681). CMS received few comments on this proposal. CMS noted that its intent is "to revert measures to pay-for-reporting only in those rare circumstances where it is necessary to do so to assess ACO quality performance appropriately" (p. 680).
	Validation of ACO Quality Data Reporting. CMS previously finalized changes to its Quality Measures Validation audit policies including that the policies would apply to audited ACOs that result in an audit match rate that falls below 90 percent. Because CMS believes that a 90 percent threshold could inappropriately penalize ACOs that make quality data reporting errors that are unrelated to the actual care quality delivered, CMS proposes that it would adjust the ACO's overall quality score proportional to the ACO's audit performance only if the ACO has an audit match rate below 80 percent.	***CMS finalized its proposal*** (p. 689). CMS noted that it would periodically review the audit match threshold and increase the match rate over time (p. 687).
	CMS proposes that for each percentage point difference between the ACO's match rate the match rate considered "passing the audit," the ACO's overall quality score would be adjusted downward by 1 percent.	***CMS finalized its proposal*** (p. 689)
SNF 3-Day Rule: Waiver Application Requirements	While CMS believes the current SNF waiver requirements are generally reasonable, there are two requirements that it believes can create an unnecessary burden on applicants	
	• CMS proposes to remove the requirement where the ACO applicants must submit a narrative describing any financial relationships between the ACO, SNF affiliate, and acute care hospitals.	***CMS finalized this policy as proposed*** (p. 695).
	• CMS proposes to eliminate the documentation requirement regarding the SNF 3 star or higher rating.	***CMS finalized this policy as proposed*** (p. 695). CMS reiterated that it is not removing or modifying the requirement that SNF affiliates must have and maintain an overall rating of 3 in the 5-star Quality Rating System to remain an

		eligible partner with an ACO for purposes of the SNF 3-day waiver rule, only the documentation requirement for the ACOs (p. 694).
MSSP Initial Application	CMS proposes to remove the requirement to submit supporting documents or narratives and instead will add that CMS can request these materials as needed in order to "fully assess the ACO's application" before a decision is made to approve or deny the application.	***CMS finalized this as proposed*** (p. 708). CMS acknowledged the comment received in opposition to eliminating the need for the ACO to provide a narrative on how it would distribute shared savings. CMS replied that it continues to believe that ACOs have the freedom to choose how to distribute or use any shared savings (within the confines of the agreements they set with their participants) (p. 708). CMS also noted that they are maintaining the requirement that ACOs publicly report how they use and distribute shared savings.
ACO Participant TIN Exclusivity Requirement	CMS proposes that if during a benchmark or performance year (including the 3 month claims run out period) an ACO participant TIN that participates in more than one ACO begins billing for services that would be used in assignment: • CMS would not consider any services billed through that TIN when performing beneficiary assignment for the applicable benchmark or performance year • The ACOs in which the overlapping TIN is an ACO participant may be subject to compliance action (including requiring that each ACO that includes the TIN as an ACO participant to submit a corrective action plan explaining how the ACO plans to work with the overlapping ACO participant to resolve the overlap) • If the overlap remains unresolved (by the date specified by CMS), CMS would remove the overlapping ACO participant TIN from the ACO participant list of each ACO for the subsequent performance year.	***CMS finalized these polices as proposed*** (p. 716).
Individually Beneficiary Identifiable Payments Made Under a Demo, Pilot, or Time Limited Program	The MSSP holds ACOs accountable for total Parts A and B spending under Medicare, including "individually beneficiary identifiable non-claims based payments made under a demonstration, pilot or time limited program" (i.e. payments made outside the Medicare fee-for-service claims system). CMS tracks these payments through "a separate CMS system that receives and stores these non-claims based payments made from the Medicare Trust Funds under a demonstration, pilot or time limited program." However, because of the different rules and processes used for each various program, CMS has included interim payments under these programs that will "undergo subsequent reconciliation to determine the final payment amount" and this might or might not occur on the same operational schedule as the MSSP. CMS and stakeholders are concerned about the fluctuation in interim payments, and therefore, CMS proposes that it would only include "final individually beneficiary identifiable	***CMS finalized this as proposed (with a minor technical correction)*** (p. 721).

payments made under a demonstration, pilot or time limited program" in financial calculations for establishing and updating MSSP benchmarks and for determining MSSP performance year expenditures for the 2018 performance year and subsequent performance years. CMS also makes a proposal to address this issue for ACOs who are in the middle of an agreement period when this policy takes effect.

Value-Based Payment Modifier and Physician Feedback Program

Provisions in the Final Rule

In the interest of program alignment and providing a smooth transition between the VM and MIPS, as well as aligning with the proposed changes to the PQRS in this rule, CMS proposes the following modifications to the VM policies for the CY 2018 payment adjustment period:

- Reduce the automatic downward adjustment for groups and solo practitioners in Category 2 (those who do not meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50% of the group's EPs meet the criteria as individuals) to 2.0% for groups with 10 or more EPs and at least one physician, and -1.0% for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs.
- Hold all groups and solo practitioners who are in Category 1 (those who meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50% of the group's EPs meet the criteria as individuals) harmless from downward performance-based payment adjustments under quality tiering for the last year of the program.
- To provide a smoother transition to the MIPS, to align incentives across all groups and solo practitioners, and to account for CMS's proposed reduction in downward adjustments under this budget neutral program, CMS also proposes to reduce the maximum upward adjustment under the quality-tiering methodology to two times an adjustment factor (+2.0x) for groups with 10 or more EPs. This is the same maximum upward adjustment under the quality-tiering methodology that CMS finalized and will maintain for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-

CMS finalized these policies as proposed and will make conforming revisions to §§414.1270, and 414.1275(c)(4) and (d)(3) to reflect the policies described in this section. (pgs. 735 and 742)

Table 23, included below, displays the final 2018 VM adjustments under the quality-tiering methodology, for groups and solo practitioners in Category 1 (i.e., those who meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50% of the group's EPs meet the criteria as individuals).

TABLE 23: Final CY 2018 VM Amounts Under the Quality-Tiering Approach for Physicians, PAs, NPs, CNSs, and CRNAs Who Are Solo Practitioners and Those in Groups of Any Size

Cost/quality	Low quality	Average quality	High quality
Low cost	+0.0%	+1.0x*	+2.0x*
Average cost	+0.0%	+0.0%	+1.0x*
High cost	+0.0%	+0.0%	+0.0%

* Under existing policy, these groups and solo practitioners are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor.

Tables 24, 25, and 26 illustrate how the final policies differ from the previously-finalized policies for each group size and composition.

As a side note, CMS also clarifies on p. 1169 that under the quality-tiering methodology, for groups and solo practitioners that participated in a Shared Savings ACO that successfully reported quality data for CY 2016, the cost composite will be classified as "Average" and the quality of care composite will continue to be based on ACO-level quality measures. For groups and solo practitioners that participate in a Shared Savings Program ACO that did not

	physician EPs. CMS seeks comment on whether it has appropriately balanced the interests of high and low-performing groups and solo practitioners through these proposed changes to policy. CMS does not propose any change to the existing policy (80 FR 71291) that groups and solo practitioners that are eligible for upward adjustments under the quality-tiering methodology and have average beneficiary risk score that is in the top 25% of all beneficiary risk scores will earn an additional upward adjustment of one times an adjustment factor (+1x). CMS also does not propose any changes to the existing policy (81 FR 80520 through 80524) related to clinicians who are in Category 1 as a result of reporting outside of their Shared Savings Program ACO during the ACO Secondary Reporting Period because their ACO failed to successfully report on their behalf to avoid the PQRS payment adjustment for 2017 and/or 2018.	successfully report quality data for CY 2016 and are Category 1 as a result of quality data reported to the PQRS outside of the ACO, the quality and cost composites will continue to be classified as "Average". CMS acknowledges in this section the fairness concerns raised by commenters who had not support these proposals. However, CMS' intent is not to penalize groups that had high performance based on the previously finalized policy. Instead, CMS was concerned that the 2018 VM adjustment factor could potentially be higher than the 2017 VM adjustment factor, which could result in a high upward payment adjustment under the VM in 2018 followed by a significantly lower payment adjustment under MIPS in 2019. CMS believes that finalizing these proposals will have the intended consequence of lowering the maximum upward adjustment in 2018 as a result of a lower adjustment factor and thus ensuring a smoother transition from the VM adjustment in 2018 to the positive MIPS adjustments in 2019.

MACRA Patient Relationship Categories and Codes

Operational List of Patient Relationship Categories	Section 101(f) of MACRA amended section 1848 of the Act to create a new subsection (r) entitled Collaborating with the Physician, Practitioner, and Other Stakeholder Communities to Improve Resource Use Measurement. Section 1848(r)(2) of the Act requires the development of care episode and patient condition groups, and classification codes for such groups. To facilitate the attribution of patients and episodes to one or more clinicians, section 1848(r)(3) of the Act requires the development of patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. The categories shall include different relationships of the clinician to the patient and reflect various types of responsibility for and frequency of furnishing care. Pursuant to section 1848(r)(3)(E) of the Act, CMS posted the operational list of patient relationship categories on May 17, 2017, which is available here and listed below. Section 1848(r)(3)(F) of the Act requires that not later than November 1st of each year (begin with 2018), the Secretary shall, through rulemaking, make revisions to the operational list of patient	See next section for finalized policies.

	relationship categories and codes as the Secretary determines appropriate. In preparation for potential subsequent revisions by November 1, 2018, CMS sought comment on the following operational list of patient relationship categories • Continuous/Broad Services • Continuous/Focused Services • Episodic/Broad services • Episodic/Focused Services • Only as Ordered by Another Clinician	
Reporting of Patient Relationship Codes Using Modifiers	Section 1848(r)(4) of the Act requires that claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by the Secretary, include the applicable codes established for care episode groups, patient condition groups, and patient relationship categories under sections 1848(r)(2) and (3) of the Act, as well as the NPI of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner). Applicable practitioners are defined in section 1848(r)(9)(B) of the Act as a physician assistant, nurse practitioner, and clinical nurse specialist, and a certified registered nurse anesthetist, and beginning January 1, 2019, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary. In December 2016, when it solicited comments on the potential modifications to the patient relationship categories, CMS also sought comment on the use of Level II Healthcare Common Procedure Coding System (HCPCS) Modifiers for the patient relationship codes. Public comments indicated that Current Procedural Terminology (CPT) Modifiers would be the best way to operationalize the reporting of patient relationship codes. CMS submitted an application for the CPT modifiers for reporting of the patient relationship codes. The CPT Editorial Panel, at their June 2017 meeting determined that AMA would not include the modifiers in the CPT code set, pending future finalization of the modifiers by CMS, whereby CMS publishes the modifiers as Level II HCPCS Modifiers. Therefore, CMS proposed the following Level II HCPCS Modifiers as the patient relationship codes: Table 26. Patient Relationship HCPCS Modifiers and Categories	***CMS finalized its proposal to use the Level II HCPCS Modifiers in Table 26 of the proposed rule as the patient relationship codes, which CMS will add to the operational list of patient relationship categories available here.*** ***CMS also finalized its proposal that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include the aforementioned applicable HCPCS modifiers, as well as the NPI of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).*** ***CMS also finalized its proposal that for at least an initial period while clinicians gain familiarity, the HCPCS modifiers may be voluntarily reported, and the use and selection of the modifiers will not be a condition of payment (i.e., errors related to the use of these patient relationship codes will not have payment consequences). CMS believes this approach will allow it to gain information about the patient relationship codes, allow for a long period of education and outreach to clinicians on the use of the codes, and inform its ability to refine the codes as necessary.*** (p. 752) Public Comments Below is a summary of select comments: • CMS appreciated concerns raised about accurately identifying the correct clinician that took care of a patient during an episode of care (e.g., in the case of "incident to" billing provisions) and clarified that its approach would allow for multiple clinicians to code for their role in care during the episode. Also, information gathered during the voluntary period will help refine the patient relationship categories if necessary. • In response to concerns about the broadness and vagueness of the descriptors used in the five categories of the HCPCS modifiers and the fact that the categories may not be applicable to some specialties, CMS noted that its intent was to simplify the reporting burden for clinicians, as

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

CMS proposes that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include the applicable HCPCS modifiers listed above, as well as the NPI of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner). To allow clinicians time to gain familiarity with using these modifiers, CMS proposes that, at least for an initial period, clinicians may voluntarily report these codes on claims. In other words, the selection of the modifiers would not be a condition of payment and claims would be paid regardless of whether and how the modifiers are included.

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

well as allow for broad applicability of modifiers across all specialty settings. By allowing for voluntary reporting of the HCPCS modifiers for a period of time, CMS believes it will be able to examine trends in their use and further refine the modifiers if necessary.

- CMS acknowledged concerns about the administrative burden that may come with these modifiers. Again, CMS hopes the voluntary period will help it learn how to minimize burden for clinicians.
- CMS also recognized that additional information on cost measures would help commenters in evaluating the patient relationship categories. CMS notes that the patient relationship categories and codes can help as it defines cost measures in the future. However, CMS clarified that the current cost measures in MIPS and those in immediate development do not use these patient relationship codes. CMS believes additional experience and analysis will be needed before it can incorporate the codes into cost measures. CMS plans to engage clinicians in the use of these codes as it gains experience with their use and submission.

Medicare Diabetes Prevention Program

Proposed Changes to Effective Date of MDPP Services	CMS is proposing that MDPP services would be available on April 1, 2018, rather than January 1, 2018, as previously finalized.	***CMS is finalizing this policy as proposed.*** (p. 763) MDPP services will be available under the MDPP expanded model as a Part B item/service for eligible Medicare beneficiaries, in both Original Medicare and Medicare health plans, beginning on April 1, 2018. (p. 762) As a Part B service, Medicare health plans are required to provide beneficiaries with coverage of all MDPP services using medical necessity criteria that authorize coverage on at least the same terms as Original Medicare. (p. 760-761)
Proposed Changes to the Set of MDPP Services	CMS proposes to define a "set of MDPP services" as the series of MDPP sessions, composed of the following services offered over the course of the MDPP services period: core sessions; core maintenance sessions, and ongoing maintenance sessions. CMS proposes a total MDPP services period of up to 3 years, consisting of 6 months of core sessions, 6 months	***CMS will generally finalize all definitions as proposed with the exception of the MDPP Services Period, which CMS is finalizing as a 2-year MDPP services period, consisting of a core services period of 1 year and an ongoing maintenance services period of 1 year. (p. 772; p. 779)*** CMS also clarifies that monthly core maintenance sessions cannot begin prior to month 7 during the first 12 months; if

	of core maintenance sessions, and up to 2 years of ongoing maintenance sessions but solicits comment on alternatives considered. CMS also provides refinements to terminology used in describing the set of MDPP services.	core sessions are completed by month 4, the supplier will need to offer additional sessions during months 5 and 6 to avoid a 2-month break in service for the beneficiary before the supplier can offer monthly core maintenance sessions. (p. 767) ***CMS is also finalizing changes to the definition for "ongoing maintenance session interval" to align with the finalized MDPP Services Period. (p. 780)***
Proposed Changes Related to Beneficiary Eligibility	CMS proposes clarifications and changes to eligibility criteria previously finalized in the CY 2017 PFS for Medicare beneficiaries to have coverage of the set of MDPP services. For example, CMS: • Proposes that the finalized diabetes diagnosis eligibility exclusion only applies at the time of the first score session • Proposes that performance and attendance requirements would apply for beneficiaries to be eligible for ongoing maintenance sessions. • Suppliers may offer make-up sessions, including virtual make-up sessions subject to specific requirements.	***CMS is finalizing this policy as proposed. (p. 796)*** ***CMS is finalizing eligibility criteria for the ongoing services period as proposed. (p. 811) CMS is finalizing with modification its policy for ongoing maintenance session intervals such than an MDPP beneficiary must only attend 2 out of 3 ongoing maintenance sessions per ongoing maintenance session interval (and maintain 5 percent weight loss during at least one in-person session during the interval) to be eligible for subsequent ongoing maintenance session intervals after the first. (p. 819)*** ***CMS is finalizing its policies as proposed, with the exception of changes to reflect the shortening of the ongoing services period from 2 years to 1 year. (p. 832)*** In response to concerns about referral pathways, for which CMS did not propose changes or solicit comment, CMS notes that it is not finalizing changes to its previously finalized policies to allow self-referral, community-referral, or health care practitioner-referral. (p. 783) In response to concerns regarding inappropriate uptake of MDPP services, CMS details protections that exist within the program, but also note that CMS is establishing monitoring mechanisms that will identify inappropriate service delivery and allow CMS to take appropriate action. (p. 784) In response to concerns about CMS' previously finalized policy to only allow beneficiaries to receive MDPP services once per lifetime, CMS reiterates the rationale for the policy and flexibilities offered for beneficiaries, as well as supplier standards that CMS is finalizing in this rule. CMS also notes that it will monitor the once-per-lifetime limitation to consider whether an exceptions policy is necessary for beneficiaries who experience life-altering events. (p. 800)

Proposed Changes Related to Payment for MDPP Services	CMS proposes definitions for "performance goal" and "performance payment". CMS proposes that each performance payment made based on attendance of a specified number of core sessions, for a specific 3-month core maintenance or ongoing maintenance interval during the MDPP services period, or for achieving a weight loss performance goal, would only be made once per MDPP beneficiary.	***CMS is finalizing the proposals for the definitions of performance goal and performance payment without modification. (p. 845)***
	CMS proposes to pay for the set of MDPP services through a performance-based payment methodology that makes periodic performance payments to MDPP suppliers during the MDPP services period. The aggregate of all performance payments constitutes the total performance-based payment amount for the set of MDPP services. CMS proposes a maximum total performance payment amount per beneficiary for the set of MDPP services of $810. Performance payments would be made to MDPP suppliers periodically during the course of a beneficiary's MDPP services period based upon a number of factors, including the beneficiary's completion of a specified number of MDPP sessions and the achievement of the required minimum weight loss that is associated with a reduced incidence of type 2 diabetes. CMS details proposals related to payment for: • core sessions, which are capped at $105 and based on attendance only • core maintenance session intervals, which are capped at $120 and based on attendance alone, or attendance and weight loss achievement • ongoing maintenance session intervals, which are capped at $400 and based on attendance and weight loss achievement • one-time performance payments capped at $185 for achieving specified levels of weight loss	***CMS is finalizing proposals for the maximum total performance payment amount and the distribution of performance payments for MDPP services across the set of MDPP services with modifications. (p. 862-863)*** The maximum total performance payment amount for the set of MDPP services is $670 (versus $810). Payments will be distributed as follows: • Core sessions will be capped at $165 • Core maintenance session intervals will be capped at $120 • Ongoing maintenance session intervals will be capped at $200 • Performance payments for weight loss capped at $185 These amounts are displayed in Table 29 (p. 863) and account for increases in certain payment amounts for core sessions and core maintenance session intervals, as well as for the shorter MDPP Services Period. ***Proposals for the performance payments are also finalized as proposed. (p. 911)*** ***CMS is finalizing with modification its performance-based incentive structure, such that attendance goals are reduced from 3 sessions, as proposed, to 2 sessions, to receive payment for each core maintenance session interval (p. 894) and ongoing maintenance session interval. (p. 902)***
	Table 32 of the proposed rule summarizes proposed performance payments for the set of MDPP services noted above.	Table 39 summarizes all of the final performance payments for the set of MDPP services.
	CMS proposes to update payment amounts each year based on the CPI-U. CMS also proposes requirements for billing and payment for MDPP services, including requirements to accept payment on an assignment-related basis, requirements to include the National Provider Identifier of the MDPP coach on a claim, and expectations around billing instructions. Additionally, CMS proposes payment policies when a beneficiary changes MDPP suppliers, including a proposal to provide a one-time $25 bridge payment to an MDPP supplier for furnishing its first MDPP services session	***CMS is finalizing the following proposals, without modification:*** • to update payment amounts by the CPI-U without modification. (p. 922) • to make performance payments and bridge payments to MDPP suppliers on an assignment-related basis. (p. 925) • to require the beneficiary to assign the claim for MDPP services to the MDPP supplier in order for assignment to be effective. (p. 925) • conditions for payment of performance payments and bridge payments

	to an MDPP beneficiary who has previously received services from a different supplier and proposals around transferring MDPP records. CMS also proposes to establish 19 G-codes to submit claims for payment (see Table 33 of the proposed rule).	to MDPP suppliers (p. 929) • to require reporting the coach NPI as the rendering provider on session line-items included on claims for performance payments and bridge payments to MDPP suppliers. (p. 953) • policies regarding bridge payments. (p. 973) ***CMS is finalizing with modification its proposal to establish new HCPCS G-codes for reporting MDPP services under the MDPP expanded model. Due to the shortened MDPP Services Period that CMS is finalizing, CMS is adopting 15 (out of 19 proposed) new HCPCS G-codes, effective April 1, 2018, for the MDPP expanded model. In addition, the descriptions of the HCPCS G-codes for core maintenance and ongoing maintenance session interval performance payments have been modified to reflect the final attendance performance goal of 2 sessions for each interval.*** (p. 946) The final HCPCS G-codes, long descriptors, indication of whether or not each code may be reported with modifier VM as a virtual make-up session, and their payment amounts are displayed in Table 41. Table 42 summarizes the final set of MDPP services and payments.
Supplier Enrollment and Compliance	To address the time required to achieve full DPRP recognition, CMS proposes an MDPP interim preliminary recognition standard for organizations with pending CDC recognition, and that organizations that meet this standard would also be eligible to enroll as an MDPP supplier if it also meets all other conditions for enrollment. CMS also includes specific proposals related to the enrollment application and application requirements, as well to the effective date of MDPP suppliers' billing privileges. CMS also proposes supplier standards that build on conditions for enrollment, as well as existing requirements that apply to all Medicare suppliers and providers. CMS also proposes additional standards specific to MDPP suppliers, including standards related to suppliers' individual coaches, to establish program integrity safeguards, as well as to support program evaluation. In addition, CMS proposes a new revocation authority to revoke an MDPP supplier for knowingly using an ineligible coach to furnish MDPP services.	***CMS is finalizing its proposals, without modification, for MDPP preliminary recognition under the MDPP expanded model. (p. 992)*** ***CMS is finalizing policies on the following topics as proposed:*** • the MDPP supplier enrollment start date (p. 994) • the effective date for billing privileges (p. 996) • creation of an MDPP supplier specific enrollment application (p. 1000) • timelines under which MDPP suppliers must update their enrollment applications (p. 1007) • establishment of supplier standards (p. 1015) and to prevent MDPP suppliers from having previous terminations or exclusions from State Medicaid agencies (p. 1016) • coach eligibility, including revocation authority for knowingly allowing an ineligible coach to furnish MDPP services (p. 1031) • beneficiary complaints (p. 1058) • requirements for model evaluation compliance (p. 1062) ***CMS is finalizing with slight modifications its proposals:*** • on information required on enrollment applications, to include minor

		amendments to the definition of an administrative location to provide greater clarity. (p. 1004, p. 1006) • to amend the definition of institutional provider to include MDPP suppliers such that MDPP suppliers would be subject to enrollment and revalidation fees, with technical clarifications regarding references to application forms (p. 1009-1010) • on provisions to ensure that MDPP suppliers are legitimate, operational organizations. While CMS is finalizing policies to require MDPP suppliers to have at least one administrative location at an appropriate site, policies regarding telephone requirements, and policies against knowingly selling or allowing another individual or entity to use its supplier billing number, CMS is modifying proposals to provide increased flexibility for signage requirements. (p. 1038) • regarding beneficiary access, to clarify that an MDPP supplier may deny access to a beneficiary if the MDPP supplier lacks the self-determined and publicly-posted capacity. Beneficiary access policies regarding prevention of undue coercion on beneficiaries' decisions to change or not change to a different MDPP supplier and requirements that MDPP suppliers furnish all services for which the beneficiary is eligible are generally finalized as proposed, with a slight modification to align with the shortened availability of ongoing maintenance sessions for only one year. (p. 1053) • on disclosure requirements, with a modification to specifically highlight that detailed information about the set of MDPP services not only includes eligibility and supplier standards, but also minimum coverage requirements (p. 1055)
	CMS finalized that newly enrolling MDPP suppliers would be identified as high categorical risk in the CY 2017 PFS final rule. CMS is proposing that MDPP suppliers would revalidate, however, under a moderate risk level every three years. CMS also proposes documentation and record retention requirements for MDPP suppliers.	***CMS is finalizing with modification its supplier revalidation policies. To make MDPP supplier risk levels more clear, CMS is adding Prospective (newly enrolling) MDPP suppliers to high categorical risk and revalidating MDPP suppliers to the moderate risk level. CMS is also finalizing that MDPP suppliers must revalidate every five years, versus three years as proposed. (p. 1065-1066) CMS is also finalizing the proposals regarding documentation and record retention with a modification to clarify that MDPP suppliers must maintain and handle any beneficiary information related to MDPP, including PII and PHI, as would be required under HIPAA, other applicable state and federal privacy laws, and CMS standards. (p. 1074)***
Beneficiary Engagement Incentives under the MDPP	CMS proposes to establish rules governing the furnishing of beneficiary engagement incentives to MDPP beneficiaries under the MDPP expanded model. These rules cover timing of potential incentives, types and value limits of incentives, conditions for financing and furnishing incentives,	***CMS is finalizing policies under this section as proposed. (p. 1079, p. 1101, p. 1112, p. 1114, p. 1121) CMS is also adding another condition for provision of beneficiary engagement incentives that specifies that the cost of the item or service must not be shifted to an MDPP beneficiary. (p. 1101)***

Expanded Model	prohibition on advertising, and documentation requirements.	
Additional Provisions	*Fraud and Abuse:* The Secretary will consider whether waivers of certain fraud and abuse laws are necessary for the MDPP expanded model. *Virtual DPP*: CMS does not propose to include virtual DPP services, except for a limited number of virtual make-up sessions. Instead, CMS notes that it is considering a separate model under CMS' Innovation Center authority to test and evaluate virtual DPP services, and intends that any separate model of virtual DPP services would run in parallel with the MDPP expanded model	No waivers of any fraud and abuse authorities are being issued in this final rule. (p. 1122) While CMS did not propose to include virtual DPP services, CMS intends to utilize the comments received, as appropriate, to inform the development of any virtual model test that occurs as part of broader CMS efforts to promote expanded access to remote and telehealth services. In response to comments, CMS also clarifies that MA plans will not be able to provide fully virtual MDPP services to enrollees as a means to satisfy the requirement that an MA plan provide basic benefit MDPP services to its enrollees. However, CMS notes that MA plans may continue to offer coverage of fully virtual MDPP-like services to enrollees as a supplemental benefit. (p. 1126)

Physician Self-Referral Law: Annual Update to the List of CPT/HCPCS Codes

General	CMS does not address this policy in the proposed rule.	Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare or billing the beneficiary or any other entity for Medicare DHS that are furnished as a result of a prohibited referral. The entire scope of four DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS Level II publications. ***The updated, comprehensive Code List effective January 1, 2018, is available on the CMS website. (p. 1132)*** Additions and deletions to the Code List conform it to the most recent publications of CPT and HCPCS Level II and to changes in Medicare coverage policy and payment status. Table 44 and Table 45 identify the additions and deletions, respectively, to the comprehensive Code List that become effective January 1, 2018. They also identify the additions and deletions to the list of codes used to identify the items and services that may qualify for exceptions related to outpatient prescription drugs furnished in or by an ESRD facility preventive screening tests, immunizations, and vaccines.

Collection of Information Requirements

Topic	Final Rule
General	In this section, CMS discussed each of the following information collection requirements (ICRs): • Medicare Diabetes Prevention Program (MDPP) Expanded Model • Appropriate Use Criteria for Advanced Diagnostic Imaging Services • Medicare Shared Savings Program

Regulatory Impact Analysis

Topic	Final Rule
Changes in Relative Value Unit (RVU) Impacts for the PFS	*Background.* The annual update to the PFS conversion factor (CF) was previously calculated based on a statutory formula (79 FR 67741 through 67742). Section 101(a) of the MACRA repealed that formula and amended section 1848(d) of the Act to specify the update adjustment factors for calendar years 2015 and beyond. For CY 2018, the specified update is 0.5% before applying other adjustments. Section 220(d) of the PAMA added a new paragraph at section 1848(c)(2)(O) of the Act to establish an annual target for reductions in PFS expenditures resulting from adjustments to relative values of misvalued codes. Under section 1848(c)(2)(O)(ii) of the Act, if the net reduction in expenditures for the year is equal to or greater than the target for the year, reduced expenditures attributable to such adjustments shall be redistributed in a budget-neutral manner within the PFS in accordance with the existing budget neutrality requirement under section 1848(c)(2)(B)(ii)(II) of the Act. Section 1848(c)(2)(O)(iii) of the Act specifies that, if the estimated net reduction in PFS expenditures for the year is less than the target for the year, an amount equal to the target recapture amount shall not be taken into account when applying the budget neutrality requirements specified in section 1848(c)(2)(B)(ii)(II) of the Act. *2018 Impact.* ***CMS estimates the CY 2018 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.41%.*** Since this amount does not meet the 0.5% target under section 1848(c)(2)(O)(v) of the Act, payments under the fee schedule must be reduced by the difference between the target for the year and the estimated net reduction in expenditures, known as the target recapture amount. ***As a result, CMS estimates that the CY 2018 target recapture amount will produce a reduction to the conversion factor of -0.09%.*** ***As such, CMS estimates the CY 2018 PFS conversion factor to be 35.9996.*** Table 48 illustrates the calculation of the final CY 2018 conversion factor. ***CMS estimates the CY 2018 anesthesia conversion factor to be 22.1887***. Table 49 illustrates the calculation of the final CY 2018 anesthesia conversion factor. ***Table 50 shows the CY 2018 estimated payment impact on total allowed charges by specialty based on the proposals contained in this final rule***. A table showing the estimated impact of all of the changes on total payments for selected high volume procedures is available under "downloads" on the CY 2018 PFS final rule website. The most widespread specialty impacts of the final RVU changes are generally related to the changes to RVUs for specific services resulting from the Misvalued Code Initiative, including finalized RVUs for new and revised codes. Also, the estimated impacts for many specialties are increases relative to the rates published in the proposed rule due to the decision to retain the professional liability premium data (from CY 2015) that was used for CY 2017, as opposed to utilizing the updated data for CY 2018 that were used to calculate the rates in the proposed rule.
Effects of	In this rule, CMS adds several new codes to the list of Medicare telehealth services. Although these changes are expected to have the potential to

Topic	Final Rule
Changes Related to Telehealth	increase access to care in rural areas, CMS estimates there will only be a negligible impact on PFS expenditures from the proposed additions. For example, for services already on the list, they are furnished via telehealth, on average, less than 0.1% of the time they are reported overall. In this rule, CMS also makes CPT code 99091 separately payable for CY 2018. This change will be implemented in a budget neutral manner and is estimated to have a negligible impact on PFS expenditures from making this code separately payable.
Effect of Changes to Payment to Provider-Based Departments (PBD) of Hospitals Paid Under the PFS	For CY 2018, CMS finalized a PFS Relativity Adjuster of 40%, meaning that nonexcepted items and services furnished by nonexcepted off-campus PBDs would be paid under the PFS at a rate that is 40% of the OPPS rate. CMS estimates that this change will result in total Medicare Part B savings of $12 million for CY 2018 relative to maintaining the CY 2017 PFS Relativity Adjuster for CY 2018.
Other Provisions of the Proposed Regulation	**New Care Coordination Services and Payment for RHCs and FQHCs** (p. 1156). In this rule, CMS finalized the establishment of two new G codes for use by RHCs and FQHCs. Establishment of the RHC and FQHC General Care Management code, which includes all levels of CCM and general BHI services, is projected to increase Medicare spending by $2.2 million in CY 2018 and by $25.5 million over 10 years. Establishment of the RHC and FQHC Psychiatric CoCM code, which includes all levels of psychiatric CoCM services, is projected to increase Medicare spending by approximately $100,000 in CY 2018 and $4.0 million over 10 years. The combined increase in Medicare spending for both new G codes is estimated to be approximately $2.2 million in 2018, and approximately $29.5 million over 10 years. Table 51 illustrates the CY 2018-2027 projected spending impact of new General Care Management and Psychiatric CoCM Codes for RHCs and FQHCs. **Payment for DME Infusion Drugs** (p. 1158). In this rule, CMS finalized its proposal to transition payment for DME infusion drugs from AWP-based pricing to the ASP-pricing methodology on January 1, 2017. Table 52 shows the effect of changes in drug payments to DME suppliers. CMS estimates adoption of the ASP+6 pricing methodology will result in total Medicare Part B savings ranging over the 10-year period from $40 million in FY 2017 to $110 million in FY 2026 with a 10-year total Medicare Part B savings of $960 million. Payment for Biosimilar Biological Products under Section 1847A of the Act (p. 1159). In this rule, CMS finalized the policy to separately code and pay for biological biosimilar products under Medicare Part B. Effective on January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. With limited data, CMS is not able to quantify with certainty the potential savings or costs to Medicare Part B from changes to current policy. It also is not able to quantify the impact, if any, on physician offices that administer biosimilar biological products or the costs to beneficiaries. CMS presents a hypothetical example starting at the bottom of p. 1160 to illustrate what would need to occur in the market for this policy change to achieve cost savings for Medicare. Table 53 is intended to illustrate that at year 10 compared to current policy, separate codes are anticipated to decrease reference product prices (or at least keep them stable) and increase the number of products and uptake of biosimilars at year 10. The data presented assumes that payment amounts would remain stable. However, over the long term, if the policy leads to greater competition and more products in the marketplace, CMS believes that it is reasonable to anticipate that the higher initial payments will be offset by savings. Savings could also occur from lower payment amounts due to increased competition. CMS lists questions that could be a part of further analysis in this area, as the market develops, on p. 1162. **Appropriate Use Criteria for Advanced Diagnostic Imaging Services** (p. 1163). CMS finalized the effective date of January 1, 2020 on which the AUC

consulting and reporting requirements will begin, and extended the voluntary consulting and reporting period to 18 months. Since these updates will not result in claims denials in CY 2018, they would not impact CY 2018 physician payments under the PFS. The Congressional Budget Office (CBO) estimates that section 218 of the PAMA would save approximately $200 million over 10 years from FY 2014 through 2024, which could be the result of identification of outlier ordering professionals and also includes section 218(a) of the PAMA, which is a payment deduction for CT equipment that is not up to a current technology standard. Since CMS has not yet proposed a mechanism or calculation for outlier ordering professional identification and prior authorization, it is unable to quantify the impact of these policies at this time.

Physician Quality Reporting System Criteria for Satisfactory Reporting for Individual EPs (p. 1164) The policies finalized in this section would increase the amount of satisfactory reporters for the CY 2016 reporting period, which would decrease those subject to the 2018 PQRS payment adjustment. Using data from the CY 2015 reporting period, there were roughly 525,000 eligible professionals who failed the PQRS reporting requirements for the CY 2015 reporting period and received a downward payment adjustment in 2017. CMS estimates that, based on 2015 results, approximately 4.5% of EPs that received a downward payment adjustment would be found successful under the amended policy and would avoid the payment penalty. This equates to an estimated 23,625 EPs that would no longer be subject to the 2018 PQRS payment adjustment based on PQRS data for the CY 2015 reporting period.

Medicare EHR Incentive Program for EPs (p. 1165). The changes finalized for the Medicare EHR Incentive Program, which would reduce the reporting requirements for those EPs submitting CQMs electronically, would neither increase or decrease the number of successful meaningful EHR users in the Medicare EHR Incentive Program for EPs. Based on an analysis of data already reported for CY 2016, no additional EPs would have successfully demonstrated meaningful use.

Medicare Shared Savings Program (p. 1165). CMS finalized certain modifications to its rules regarding ACO assignment and financial calculations, quality measures and quality validation audits, TIN overlaps, and application requirements. Although CMS believes the final policies will reduce burden for participating ACOs and applicants, it does not anticipate any significant economic impact for these policies in terms of overall program costs or savings.

Value-Based Payment Modifier and the Physician Feedback Program (p. 1166). In this rule, CMS finalized policies to 1) reduce the 2018 VM payment adjustment amount for groups and solo practitioners in Category 2; 2) to hold groups and solo practitioners in Category 1 harmless from downward adjustments under quality-tiering for CY 2018; and 3) to reduce the maximum upward adjustment under the quality-tiering methodology in 2018. In September 2017, CMS made the 2016 Annual QRURs available to all groups and solo practitioners based on their performance in 2016. CMS also completed a preliminary analysis (based on results included in the 2016 Annual QRURs and prior to accounting for the informal review process) of the impact of the VM in 2018 on physicians, PAs, NPs, CNSs, and CRNAs in groups with 2 or more EPs and solo practitioners based on their performance in 2016. Table 55 shows the preliminary distribution of Category 1 TINs (and physicians, PAs, NPs, CNSs, and CRNAs in the TINs) under the 2018 VM. In early 2018, after the conclusion of the informal review period, CMS will release updates to the number of TINs receiving upward, neutral, and downward adjustments, along with the adjustment factor for the 2018 VM on the CMS website. Preliminary estimates indicate that the implementation of the finalized policies discussed above would reduce the adjustment factor to below 10%.

MACRA Patient Relationship Categories and Codes (p. 1173). CMS finalized that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should voluntarily include HCPCS modifiers to indicate their relationship to the care episode for purposes of more accurate cost of care analyses. Since CMS is not tying the collection of the codes with payment until it is sure clinicians have gained ample experience and education in using these modifiers, there is no impact to CY 2018 physician payments under the PFS.

Effects of Proposals Relating to the Medicare Diabetes Prevention Program Expanded Model (MDPP) (p. 1174) Table 57 shows the 10-year impact of the MDPP expanded model, net of payments to MDPP providers but gross of any other model costs, based on CMS' expected enrollment per year. The 10-year

impact is a savings to Medicare of $182 million. The estimate is expected to cross into a cumulative savings to Medicare in the sixth year of the MDPP expanded model. Since this is a new expanded model that was tested using a small percentage of the population, the estimated impact from the expanded MDPP model is very uncertain. To understand how various participation scenarios would affect the financial results, CMS presents estimates under two other participation scenarios. Table 58 shows the results if half of the beneficiaries shown in the best estimate participate, and Table 59 uses twice as many beneficiaries.

Appendices

APPENDIX A: Finalized Valuation of Specific Codes for CY 2018

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
Anesthesia Services for Gastrointestinal (GI) Procedures (CPT codes 00731, 00732, 00811, 00812, and 00813)	For CY 2018, CMS proposes the RUC-recommended base units without refinement for CPT codes 007X1 (5.00 base units), 007X2 (6.00 base units), 008X1 (4.00 base units), 008X2 (4.00 base units) and 008X3 (5.00 base units). CMS considered 3.00 base units (the 25th percentile survey result) for CPT code 008X2 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy), based on its comparison of the surveyed post-induction anesthesia-intensity allocation for CPT code 008X2 to codes with similar allocations (CPT code 01382 (Anesth dx knee arthroscopy)). CMS seeks comment on its proposed and alternative value for CPT code 008X2.	CMS reviewed additional information submitted by the RUC as part of its public comment, which included an analysis of new survey data. CMS was persuaded by the data and now believes that 3.00 base units better reflects the work of CPT code 00812. For CY 2018, ***CMS finalized 5.00 base units for CPT codes 00731, 6.00 base units for CPT code 00732, 4.00 base units for CPT code 00811, 3.00 base units for CPT code 00812, and 5.00 base units for CPT code 00813.***		
Muscle Flaps (CPT codes 15734, 15736, 15738, 15730, and 15733)	For CY 2018, CMS proposes the RUC-recommended work RVUs for CPT codes 15734 (a work RVU of 23.00), 15736 (a work RVU of 17.04), 15738 (a work RVU of 19.04), 157X1 (a work RVU of 13.50), and 157X2 (a work RVU of	***CMS finalized the work RVUs for the codes in the muscle flaps family as proposed.***	CMS considered refining the clinical labor time for "Check dressings & wound/home care instructions" for CPT code 157X1 from 10 minutes to 5 minutes. CMS seeks comment on the typical time input for checking dressings, and whether	***CMS finalized the direct PE inputs for the codes in the muscle flaps family as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	15.68). For CPT code 157X1, CMS considered a work RVU of 12.03, crosswalking to CPT code 36830 (Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)). CMS considered a potential crosswalk to another code in the same family, CPT code 36830, which also shares the same intraservice time with CPT code 157X1 but differs by only 8 minutes of total time. CMS seeks comment on whether the RUC recommendation is appropriate given the significant variation in intensity among these services. CMS considered a work RVU of 14.63 for CPT code 157X2 (survey 25th percentile), crosswalking to CPT code 36833 (Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)), which has the same intraservice time, 1 minute of additional total time, and a work RVU of 14.50. CMS seeks comment on the effect that an alternative work RVU of 14.50 would have on relativity among the codes in this family.		removing and replacing dressings, would typically take place during the intraservice or postservice period. CMS seeks comments regarding the use of the new "plate, surgical, mini-compression, 4 hole" (SD189) supply included in CPT code 157X1, including whether use of this supply would be typical, and if so, whether it should be included in the work description. CMS notes that SD189 is mentioned in the direct PE recommendations, but the supply does not appear in the work description. In the work description, the fixation screws are applied to the orbital rim and lateral nasal wall, not the surgical plate.	
Application of Rigid	For CY 2018, CMS proposes the	***CMS finalized the work RVUs for***	For the direct PE inputs, CMS	While one commenter disagreed

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
Leg Cast (CPT code 29445)	RUC-recommended work RVU of 1.78 for CPT code 29445.	***CPT code 29445 as proposed.***	proposes to refine the clinical labor time for "Check dressings & wound/home care instructions" from 5 minutes to 3 minutes, as the additional 2 minutes of clinical labor time that CMS proposes to remove would take place during the monitoring time following the procedure and be accounted for in that clinical labor time. CMS also considered refining the clinical labor time for "Remove cast" from 22 minutes to 11 minutes: 1 minute for room prep, 10 minutes for assisting the physician, and 0 minutes for the additional activities described in the RUC recommendations, which would have only taken place during the initial casting. CMS seeks comment on whether the initial application of a new cast would be typical for CPT code 29445. According to Medicare claims data for CPT code 29445, three or more castings took place for 52 percent of beneficiaries, which suggests that three or more castings may be the typical case. A single casting only took place for 30 percent of services reported with CPT code 29445.	with the proposal to refine the clinical labor time, they didn't provide a rationale. As such, ***CMS finalized the direct PE inputs for CPT code 29445 as proposed.***
Strapping Multi-Layer Compression (CPT codes 29580 and 29581)	For CY 2018, CMS proposes the RUC-recommended work RVUs for CPT code 29580 (a work RVU of 0.55) and CPT code 29581 (a work RVU of 0.60); however, CMS is concerned about the changes in	***CMS finalized the work RVUs for these services as proposed.***	CMS proposes to refine the L037D clinical labor time for "Provide pre-service education/obtain consent" from 3 minutes to 2 minutes to conform to the standard for this clinical labor activity. CMS also	***CMS finalized the direct PE inputs for these services as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	preservice time reflected in the specialty surveys compared to the RUC-recommended work RVUs. CMS is seeking comment on whether the alternative values considered would be more appropriate.		proposes to refine the recommended equipment times for the exam table (EF023) and exam light (EQ168) to conform to changes in clinical labor time. Thus, CMS proposes to refine the equipment times for EF023 and EQ168 to 34 minutes for CPT code 29580 and to 36 minutes for CPT code 29581, to reflect the service period time associated with these codes.	
Control Nasal Hemorrhage (CPT codes 30901, 30903, 30905, and 30906)	For CY 2018, CMS proposes the RUC-recommended work RVUs for CPT codes 30901 (a work RVU of 1.10), 30903 (a work RVU of 1.54), 30905 (a work RVU of 1.97), and 30906 (a work RVU of 2.45). For CPT code 30903 (Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method), CMS considered a work RVU of 1.30 (the 25th percentile survey result), which would have been further supported by CPT codes 36584 and 51710 which have similar service times to the median survey results. For CPT code 30905 (Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial), CMS considered a work RVU of 1.73. CMS seeks comment on whether a work RVU of 1.73 would potentially affect relativity among the codes in	***CMS finalized a work RVU of 1.10 for CPT code 30901, a work RVU of 1.54 for CPT code 30903, a work RVU of 1.97 for CPT code 30905, and a work RVU of 2.45 for CPT code 30906.***	CMS proposes to use the RUC-recommended direct PE inputs for CPT codes 30901, 30903, 30905, and 30906, with standard refinements to the equipment times to account for patient monitoring times. CMS noted that as part of its recommendation, the RUC informed the agency that the specialty societies presented evidence stating that the 1995 valuations for these services factored in excessive times, specifically to account for infection control procedures that were necessary at that time due to the prevalence of HIV/AIDS. The specialty societies also noted that increased availability and use of blood thinner medications compared to those available in 1995, has increased the difficulty and intensity of these procedures. CMS seeks additional information	***CMS finalized the direct PE inputs as proposed, with standard refinements to equipment times to account for patient monitoring times.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	this family. For CPT code 30906 (Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent), CMS considered a work RVU of 2.21. CMS seeks comment on whether a work RVU of 2.21 would potentially improve relativity among the codes in this family. While CMS proposes the RUC-recommended values, it seeks comment on whether its alternative values would be more appropriate.		regarding the presumption that the relative resource intensity of these services, specifically, would be affected by the commercial availability of additional blood thinner medications. Additionally, CMS seeks comments on the prevalence of HIV/AIDS and whether the work related to infection control procedures would be relative across many PFS services or specifically related to nasal hemorrhage control procedures.	
Tracheostomy (CPT codes 31600, 31601, 31603, 31605, and 31610)	CMS proposes the RUC-recommended work RVUs for all five codes in this family; a work RVU of 5.56 for CPT code 31600, a work RVU of 8.00 for CPT code 31601, a work RVU of 6.00 for CPT code 31603, a work RVU of 6.45 for CPT code 31605, and a work RVU of 12.00 for CPT code 31610. CMS considered a work RVU of 6.50 for CPT code 31601. CMS seeks comment on the effect that this alternative value would have on relativity compared to other PFS services, especially since the survey data does not suggest an increase in the time required to perform the procedure. CMS considered a work RVU of	***Given commenter support, CMS finalized the work RVUs and global periods for the codes in the tracheostomy family as proposed.***	CMS proposes the RUC-recommended direct PE inputs for all five CPT codes in this family without refinements, and seeks comment.	***CMS finalized the direct PE inputs for the codes in the tracheostomy family as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	4.77 for CPT code 31605. CMS seeks comments on the methodology used to determine the RUC-recommended work RVU and intraservice work time. CMS is concerned that the number of respondents (20) is below the threshold typically required for submission of a survey, and the effect of using survey results only from physicians who had personal experience performing the procedure (20 respondents). CMS seeks comment on the effect that an alternative work RVU of 4.77 would have on the relativity of this service compared to other services in this family of codes and compared to other PFS services, taking into account that CPT code 31605 describes a difficult and dangerous life-threatening emergency procedure. CMS considered a work RVU of 6.50 for CPT code 31610 based on a direct crosswalk to CPT code 31601 (Incision of windpipe). CMS seeks comment on whether the unusual volume of physician work time included in the postoperative visits for CPT code 31610 contributed to the negative derived intensity reported by the survey data. Considering that the other codes in this family have 0-day global periods, CMS considered and seeks comment on whether a 0-day global period should be			

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	assigned to CPT code 31610.			
Bronchial Aspiration of Tracheobronchial Tree (CPT codes 31645 and 31646)	For CY 2018, CMS proposes the RUC-recommended work RVU of 2.88 for CPT code 31645 and the RUC-recommended work RVU of 2.78 for CPT code 31646. CMS considered a work RVU of 2.72 for CPT code 31645, crosswalking to CPT code 45347 (Sigmoidoscopy, flexible; with placement of endoscopic stent). CMS has concerns regarding the decrease in intraservice and total time compared to the current values (it is important to note how these related codes have been affected by the creation of separately billable codes for moderate sedation). CMS agrees that CPT code 31645 should be valued at a higher work RVU than CPT code 31622, however, CMS seeks comment on whether the work of moderate sedation was inadvertently included in the development of the recommended work RVU. CMS notes that as part of the CY 2017 PFS final rule, it finalized separate payment for moderate sedation. Following the creation of separately billable codes for moderate sedation, CPT code 31622 is currently valued at a work RVU of 2.53, not 2.78 as it was previously valued, and CMS does	***CMS finalized the work RVUs for the codes in the bronchial aspiration of tracheobronchial tree family as proposed.***	For the direct PE inputs, CMS proposes to remove the oxygen gas (SD084) from CPT code 31645. This supply is included in the separately billable moderate sedation codes, and CMS proposes to remove the oxygen gas as recommended by the RUC PE Subcommittee as part of the removal of oxygen from non-moderate sedation post-procedure monitoring codes. CMS proposes to remove the equipment time for the IV infusion pump (EQ032) from CPT code 31645; infusion pump is contained in the separately reportable moderate sedation codes. CMS also proposes to remove the equipment time for the CO_2 respiratory profile monitor (EQ004) and the mobile instrument table (EF027) from CPT code 31645, as they are not contained in the current composition of the code, and there was no rationale provided in the RUC recommendations for their inclusion. CMS proposes to increase the equipment time for the flexible bronchoscopy fiberscope (ES017) for CPT code 31645 consistent with standard equipment times for scopes. CMS also proposes to increase the equipment time for the Gomco suction machine (EQ235) and the power table	***CMS finalized the direct PE inputs for the codes in the bronchial aspiration of tracheobronchial tree family as proposed, with the exception of the proposed removal of the oxygen gas and CO2 respiratory profile monitor. Instead, CMS finalized the inclusion of 175 liters of oxygen gas and 58 minutes of equipment time for the CO2 respiratory profile monitor for CPT code 31645.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	not believe it would be appropriate to continue to value CPT code 31645 as though moderate sedation was still an inherent part of the work of this service. As a result, CMS considered a direct crosswalk to CPT code 45347, which has the same intraservice time and 8 additional minutes of total time, at a work RVU of 2.72. CMS considered a work RVU of 2.53 for CPT code 31646, crosswalking to CPT code 31622 (Dx bronchoscope/wash). CMS agrees with the survey participants that these two codes are comparable to one another, but has concerns about valuation of CPT code 31646 using a cross reference to a code that included moderate sedation. CMS considered crosswalking CPT code 31646 (Bronchoscopy reclear airway) using the current CY 2017 valuation for CPT code 31622 (a work RVU of 2.53). For CY 2018, CMS proposes the RUC-recommended work RVUs for both codes in this family and are seeking comment on whether it should finalize refined values consistent with the implementation of separately billable codes for moderate sedation.		(EF031) consistent with standard equipment times for non-highly technical equipment. For CY 2018, CMS proposes the RUC-recommended work RVUs for both codes in this family and are seeking comment on whether it should finalize refined values consistent with the implementation of separately billable codes for moderate sedation.	
Cryoablation of	For CY 2018, CMS proposes the	***CMS finalized the work RVUs as***	For CPT codes 32998 and 32X99,	***In response to comments, CMS***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
Pulmonary Tumor (CPT codes 32998 and 32994)	RUC-recommended work RVUs for CPT codes 32998 (a work RVU of 9.03) and 32X99 (a work RVU of 9.03). However, CMS has concerns about the descriptions of the codes and the recommended valuations assuming that imaging guidance is inherent to the procedure. CMS' analysis of claims data from 2014 shows that existing CPT code 32998 is currently reported with one of the three imaging guidance codes (CPT codes 76940, 77013, or 77022) less than 50 percent of the time. CMS seeks comment on whether there is additional information that would help explain why the codes are being bundled despite what is reflected in the Medicare claims data. CMS considered a work RVU of 7.69 for CPT code 32998, that included approximately one half the value of the imaging guidance in the new codes that describe the work of both the procedure and the image guidance (that is, the sum of the current work RVU for CPT code 32998 and one-half of the work RVU for CPT code 77013 (the imaging guidance code most frequently billed with CPT code 32998 according to 2014 claims data)). CMS applied the same general rationale regarding the use of imaging guidance for new CPT code 32X99. Since the RUC	***proposed.***	CMS proposes to use the RUC-recommended direct PE inputs with standard refinements.	***stated that it applied the standard formulas for equipment times, and continues to believe that these refinements are reasonable for these codes. CMS finalized the direct PE inputs with standard refinements for these services, as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	recommended identical work RVUs for these codes, CMS also considered a work RVU of 7.69 for CPT 32X99.			
Artificial Heart System Procedures (CPT codes 33927, 33929, and 33928)	CMS proposes the RUC-recommended work RVU of 49.00 for CPT code 339X1, and proposes to assign contractor-priced status to CPT codes 339X2 and 339X3 as recommended by the RUC. CMS considered assigning contractor-priced status for CPT code 339X1 given concerns regarding the accuracy of the RUC-recommended work valuation, due to its low utilization and the resulting difficulties in finding enough practitioners with direct experience of the procedure for the specialty societies to survey. CMS seeks comment on the sufficiency of the survey data, especially since new technologies and those with lower utilization are typically contractor-priced. CMS seeks comment on alternative pricing for this CPT code 339X1.	***CMS finalized the work RVU of 49.00 for CPT code 33927 and finalizing contractor-priced status for CPT codes 33929 and 33928 as proposed.***	CMS does not proposes any direct PE inputs, given it did not receive RUC-recommended PE information for CPT codes 339X1, 339X2, and 339X3. These three codes will be placed on the RUC's new technology list and will be re-reviewed by the RUC in 3 years.	No comments were provided
Endovascular Repair Procedures (CPT codes 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34709, 34710, 34711, 34712, 34713, 34812, 34714, 34820, 34833, 34834, 34715, and 34716)	CMS proposes the RUC-recommended work RVUs for all 20 codes in this family; a work RVU of 23.71 for CPT code 34X01, a work RVU of 36.00 for CPT code 34X02, a work RVU of 26.52 for CPT code 34X03, a work RVU of 45.00 for CPT code 34X04, a work RVU of 29.58 for CPT code 34X05, a work RVU of	***Given the comments, CMS finalized the work RVUs for the codes in the endovascular repair procedures family as proposed.***	CMS proposes the RUC-recommended direct PE inputs without refinement for all 20 codes in the family.	***Given the comments, CMS finalized the direct PE inputs for the codes in the endovascular repair procedures family as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	45.00 for CPT code 34X06, a work RVU of 22.28 for CPT code 34X07, a work RVU of 36.50 for CPT code 34X08, a work RVU of 6.50 for CPT code 34X09, a work RVU of 15.00 for CPT code 34X10, a work RVU of 6.00 for CPT code 34X11, a work RVU of 12.00 for CPT code 34X12, a work RVU of 2.50 for CPT code 34X13, a work RVU of 4.13 for CPT code 34812, a work RVU of 5.25 for CPT code 34X15, a work RVU of 7.00 for CPT code 34820, a work RVU of 8.16 for CPT code 34833, a work RVU of 2.65 for CPT code 34834, a work RVU of 6.00 for CPT code 34X19, and a work RVU of 7.19 for CPT code 34X20. CMS considered a work RVU of 32.00 for CPT code 34X02 based on the survey 25th percentile, and further supported with a crosswalk to CPT code 48000 (Placement of drains, peripancreatic, for acute pancreatitis), which has the same intraservice time of 120 minutes and a work RVU of 31.95. CMS considered a work RVU of 40.00 for CPT code 34X04 based on the survey 25th percentile, crosswalking to CPT code 33534 (Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts) which has a work RVU of 39.88. CMS considered a work RVU of			

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	40.00 for CPT code 34X06 based on the survey 25th percentile. CMS considered a work RVU of 30.00 for CPT code 34X08 based on the survey 25th percentile and seek comment on whether a work RVU of 30.00 would improve relativity among the codes in this family. CMS notes that the RUC-recommended work RVU of 36.50 for CPT code 34X08 is higher than the RUC-recommended work RVU of 36.00 for CPT code 34X02. This is the inverse of the relationship between CPT codes 34X07 and 34X01, which describe the same procedures in a non-emergent state when a rupture does not take place. CMS seeks comment on whether the RUC-recommended work RVUs would create a rank order anomaly within the family by reversing the relationship between these paired codes when performed in an emergent state. CMS notes that if CPT codes 34X08 and 34X02 were valued at the survey 25th percentile, this potential rank order anomaly disappears; in this scenario, CMS considered valuing CPT code 34X08 at a work RVU of 30.00 and CPT code 34X02 at a work RVU of 32.00. CMS seeks comment on whether these alternative work values would improve relativity with the RUC-recommended work RVUs for CPT code 34X07 (22.28)			

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	and CPT code 34X01 (23.71), with an increment of approximately 1.50 to 2.00 RVUs between the two code pairs. For the eight remaining codes that describe endovascular access procedures, CMS considered assignment of a 0-day global period, instead of the RUC-recommended add-on (ZZZ) global period and subsequently adding back the preservice and immediate postservice work time, and increasing the work RVU of each code accordingly using a building block methodology. As add-on procedures, these eight codes would not be subject to the multiple procedure payment discount. CMS is concerned that the total payment for these services will be increasing in the aggregate based on changes in coding that alter MPPR adjustments, despite the information in the surveys that reflects a decrease in the intraservice time required to perform the procedures, and a decrease in their overall intensity as compared to the current values. CMS considered a work RVU of 3.95 for CPT code 34X13, based on the RUC-recommended work RVU of 2.50 plus an additional 1.45 work RVUs. This additional work results from the addition of 38			

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	total minutes of preservice work time and 30 minutes of postservice work time based on a crosswalk to CPT code 37224 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty) as valued by using the building block methodology. Using the same method, CMS considered a work RVU of: • 6.48 for CPT code 34812 based on maintaining the current 75 minutes of preservice work time and the current 30 minutes of postservice work time, with a total work RVU of 2.35, added to the RUC-recommended work RVU of 4.13; • 7.53 for CPT code 34X15 with the addition of 75 minutes of preservice work time and 27 minutes of postservice work time to match CPT code 34833; • 9.46 for CPT code 34820 based on maintaining the current 80 minutes of preservice work time and the current 30 minutes of postservice work time; • 10.44 for CPT code 34833 based on maintaining the current 75 minutes of preservice work time and			

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	the current 27 minutes of postservice work time; • 5.00 for CPT code 34834 based on maintaining the current 70 minutes of preservice work time and the current 35 minutes of postservice work time; • 8.35 for CPT code 34X19 with the addition of 70 minutes of preservice work time and 35 minutes of postservice work time to match CPT code 34834; and • 9.47 for CPT code 34X20 with the addition of 75 minutes of preservice work time and 27 minutes of postservice work time to match CPT code 34833.			
Selective Catheter Placement (CPT codes 36215, 36216, 36217, and 36218)	CMS proposes the RUC-recommended work RVUs for each code in this family as follows: a work RVU of 4.17 for CPT code 36215, a work RVU of 5.27 for CPT code 36216, a work RVU of 6.29 for CPT code 36217, and a work RVU of 1.01 for CPT code 36218. CMS considered refinements to the intraservice work time for CPT code 36217 from 60 minutes to 50 minutes, consistent with the RUC's usual use of the survey median intraservice work time.	***Given the comments, CMS finalized the work RVUs for the codes in the selective catheter placement family as proposed.***	For the direct PE inputs, CMS proposes to refine the clinical labor time for the "Post- procedure doppler evaluation (extremity)" activity from 3 minutes to 1 minute for CPT codes 36215, 36216, and 36217. CMS proposes to remove the equipment time for the mobile instrument table (EF027) from CPT codes 36215, 36216, and 36217.	***Despite commenter concerns, CMS was not persuaded, thus it finalized the direct PE inputs for the codes in the selective catheter placement family as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
Insertion of Catheter (CPT codes 36555, 36556, 36620, and 93503)	CMS proposes the RUC-recommended work RVUs for each code in this family as follows: a work RVU of 1.93 for CPT code 36555, a work RVU of 1.75 for CPT code 36556, a work RVU of 1.00 for CPT code 36620, and a work RVU of 2.00 for CPT code 93503.	***Despite commenter concerns, CMS finalized the work RVUs for the codes in the insertion of catheter family as proposed.***	CMS proposes to remove the clinical labor time for the "Monitor pt. following procedure" activity and the equipment time for the 3-channel ECG (EQ011) for CPT code 36555. CMS proposes to remove the direct PE inputs related to moderate sedation from CPT code 36555 as they would now be included in the separately reported moderate sedation services. CMS proposes to refine the equipment times for the exam table (EF023) and the exam light (EQ168) to reflect changes in the clinical labor time.	***Despite commenter concerns, CMS finalized the direct PE inputs for the codes in the insertion of catheter family as proposed.***
Insertion of PICC Catheter (CPT code 36569)	For CY 2018, CMS proposes the RUC-recommended work RVU of 1.70 for CPT code 36569.	***CMS finalized the work RVUs for the codes for CPT code 36569 as proposed.***	CMS proposes to remove the equipment time for the exam table (EF023), as this equipment item is a component part of the radiographic-fluoroscopic room (EL014) included in CPT code 77001 (Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal).	***CMS finalized the direct PE inputs for the codes for CPT code 36569 as proposed, with the exception of the change for the exam table. Specifically, CMS restored the exam table to CPT code 36569 at an equipment time of 32 minutes in accordance with its standard formula for non-highly technical equipment time.***
Esophagectomy (CPT codes 43107, 43112, 43117, 43286, 43287, and 43288)	CMS proposes the RUC-recommended work RVUs and work times for all six codes in the family as follows: a work RVU of 52.05 for CPT code 43107, a work RVU of 62.00 for CPT code 43112, a work RVU of 57.50 for CPT code 43117, a work RVU of 55.00 for CPT code 432X5, a work RVU of 63.00 for CPT code 432X6, and a work	***CMS finalized the work RVUs for the codes in the esophagectomy family as proposed.***	CMS proposes the RUC-recommended direct PE inputs for all six codes in the family without refinement. CMS considered changing the preservice clinical labor type for all six codes from an RN (L051) to an RN/LPN/MTA blend (L037D). CMS also considered removing the additional clinical labor time for the	***CMS finalized the direct PE inputs for the codes in the esophagectomy family as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	RVU of 66.42 for CPT code 432X7. CMS proposes the RUC-recommended work times for all six codes in this family, but considered removing 20 minutes from the preservice evaluation work time from all six of the codes in this family given concerns as to whether this additional evaluation time should be included for surgical procedures, due to the lack of evidence indicating that it takes longer to review outside imaging and lab reports for surgical services than for non-surgical services. CMS also considered refining the preservice positioning work time and the immediate postservice work time for all six of the codes in this family consistent with standard preservice and postservice work times allocated to other PFS services. CMS has concerns about the presence of two separate surveys conducted for the three new codes. The accompanying reference service list (RSL) is the main difference between the two surveys; the codes on the initial RSL had a median work RVU of 44.18, while the codes on the second RSL had a median work RVU of 59.64. This increase of 15.00 work RVUs between the two RSLs that accompanied the surveys appears to account for the increase in the work RVUs for the three new codes. The second survey may have overestimated the work required		"Additional coordination between multiple specialties for complex procedures (eg, tests, meds, scheduling)" activity, consistent with preservice standards for codes with 90-day global periods.	

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	to perform these procedures, despite no change in the median intraservice work time for CPT codes 432X5 and 432X6. Given these concerns, CMS considered a work RVU of 50.00 for CPT code 432X5, a work RVU of 60.00 for CPT code 432X6, and a work RVU of 61.00 for CPT code 432X7, by using the survey median work RVU from the first survey for the three new codes. CMS considered a work RVU of 45.00 for CPT code 43107 based on the intraservice time ratio with CPT code 432X5 and a work RVU of 55.00 for CPT code 43117 based on the intraservice time ratio with CPT code 432X6. CMS considered a work RVU of 58.94 for CPT code 43112 based on a direct crosswalk to CPT code 46744 (Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach). CMS seeks comment on whether the alternative work RVUs that it considered may reflect the relative difference in work more accurately between the six codes in the family. CMS notes, for example, that these valuations correct the rank order anomaly between CPT codes 43112 and 43121 as noted in the RUC recommendations.			
Transurethral Electrosurgical Resection of Prostate	For CY 2018, CMS proposes the RUC-recommended work RVU of 13.16 for CPT code 52601 and proposes to use the RUC-	***CMS finalized the work RVUs for CPT code 52601 as proposed.***	CMS proposes to use the RUC-recommended direct PE inputs without refinements.	***CMS finalized the direct PE inputs for CPT code 52601 as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
(CPT code 52601)	recommended direct PE inputs without refinements. CMS considered a work RVU of 12.29 for CPT code 52601 based on a direct crosswalk to CPT code 58541 (Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less), which is one of the reference codes. CMS seeks comment on whether this alternative value might better reflect relativity.			
Peri-Prostatic Implantation of Biodegradable Material (CPT code 55874)	For CY 2018, CMS proposes the RUC-recommended work RVU of 3.03 for CPT code 55X87. CMS considered a work RVU of 2.68 calculated based on the intraservice time ratio between the key reference code (CPT code 49411) and the RUC-recommended intraservice time, and multiplying that against the work RVU for CPT code 49411 (3.57). This would have been further supported by a bracket of two crosswalk codes, CPT code 65779 (Placement of amniotic membrane on the ocular surface; single layer, sutured) which has a work RVU of 2.50 and CPT code 43252 Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy), which has a work RVU of 2.96. Compared with CPT code 55X87, these codes have identical intraservice and similar	***CMS finalized the work RVUs for CPT code 55874 as proposed.***	CMS received invoices with pricing information regarding two new supply items: "endocavity balloon" and "biodegradeable material kit – periprostatic". For supply item "endocavity balloon," CMS proposes a price of $39.90. For the supply item "biodegradeable material kit – periprostatic," CMS proposes a price of $2850.00. For equipment item "endocavitary US probe", CMS proposes a per-minute price of $0.0639. CMS seeks public comments related to whether equipment item EQ250 (portable ultrasound) includes probes.	***CMS finalized the direct PE inputs for CPT code 55874 as proposed.*** ***CMS finalized the following supply and equipment prices: SD325, at a price of $39.90; SA126, at a price of $2850.00; and EQ386, at a price of $16,146.00 (a per-minute price of $0.0639).***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	total times. CMS seeks comment on whether these alternative values should be considered, especially given the changes in time reflected in the survey data.			
Colporrhaphy with Cystourethroscopy (CPT codes 57240, 57250, 57260 and 57265)	For CY 2018, CMS proposes the RUC-recommended work RVUs for CPT code 57240 (a work RVU of 10.08), CPT code 57250 (a work RVU of 10.08), CPT code 57260 (a work RVU of 13.25), and CPT code 57265 (a work RVU of 15.00). CMS considered a work RVU of 9.77 for CPT code 57240, crosswalking to CPT code 50590 (Lithotripsy, extracorporeal shock wave), which has similar service times. CMS seeks comment on whether CPT code 57250 would be a relevant comparator for CPT code 57240, based on the described elements of each service and existing or surveyed service times, compared to CPT code 57240. CMS considered a work RVU of 11.47 for CPT code 57265, crosswalking to CPT code 47563 (Laparoscopy, surgical; cholecystectomy with cholangiography) with similar service times. CMS seeks comment on how an alternative work RVU of 11.47 for CPT code 57265 would affect relativity among PFS services, and on whether CPT code 57260 is a relevant comparator for	***CMS finalized the work RVUs as proposed.***	CMS proposes the RUC-recommended direct PE inputs for CPT codes 57240, 57250, 57260 and 57265 without refinements.	***CMS finalized the proposed direct PE inputs for CPT codes 57240, 57250, 57260 and 57265, without refinement.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	CPT code 57265, considering differences in the described procedures and service times.			
CT Soft Tissue Neck (CPT codes 70490, 70491, and 70492)	For CY 2018, CMS proposes the RUC-recommended work RVUs of 1.28 for CPT code 70490, 1.38 for CPT code 70491, and 1.62 for CPT code 70492. For CPT code 70490, CMS considered a work RVU of 1.07 based on a crosswalk to CPT code 72125 (Computed tomography, cervical spine; without contrast material). CMS also considered work RVUs of 1.17 for CPT code 70491 and 1.41 for CPT code 70492. CMS seeks comment on how relativity among other CT services paid under the PFS would be affected by applying the alternative work RVUs described above for CPT codes in this family.	***CMS finalized the RUC-recommended work RVUs, as proposed.***		
Magnetic Resonance Angiography (MRA) Head (CPT codes 70544, 70545, and 70546)	CMS proposes the RUC-recommended work RVUs of 1.20 for CPT code 70544, 1.20 for CPT code 70545, and 1.48 for CPT code 70546.	***CMS finalized the RUC-recommended work RVUs, as proposed.***	CMS proposes the following refinements to the RUC-recommended direct PE inputs. For the service period clinical labor activity "Provide preservice education/obtain consent," CMS proposes 5 minutes for CPT code 70544, 7 minutes for CPT code 70545, and 7 minutes for CPT code 70546 so that the times for this activity are consistent with other magnetic resonance (MR) services performed without-contrast	***CMS finalized the PE refinements, as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			materials, with-contrast materials, and without-and-with contrast materials, respectively. For the clinical labor task "Acquire images," CMS proposes to use the RUC-recommended clinical time of 26 minutes for CPT code 70544. CMS considered proposing 20 minutes of clinical time to maintain the relativity among the three codes in this family and for consistency with other MRA and magnetic resonance imaging (MRI) codes, which do not typically assign more clinical labor time to this task for services without contrast material than for services with contrast material. CMS seeks comments as to the appropriate time value for this clinical labor task.	
Magnetic Resonance Angiography (MRA) Neck (CPT codes 70547, 70548, and 70549)	CMS proposes the RUC-recommended work RVUs of 1.20 for CPT code 70547, 1.50 for CPT code 70548, and 1.80 for CPT code 70549.	***CMS finalized the RUC-recommended work RVUs, as proposed.***	CMS proposes several refinements to the RUC-recommended direct PE inputs for these services. For the service period clinical labor activity "Provide preservice education/obtain consent", CMS proposes 5 minutes for CPT code 70547, 7 minutes for CPT code 70548, and 7 minutes for CPT code 70549 so that the times for this activity are consistent with other MR services performed without contrast material, with contrast material, and without-and-with	***For CPT codes 70547, 70548, and 70549, CMS finalized the PE refinements, as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			contrast material, respectively. For the intraservice clinical labor task "Acquire Images," for CPT code 70547, CMS proposes to use the RUC-recommended 26 minutes. CMS considered applying 20 minutes to this clinical labor task, which would have maintained consistency with the 20 minutes recommended by the RUC for CPT code 70548 (the service that includes with-contrast material). CMS seeks comment as to the appropriate time value for this clinical labor task.	***CMS finalized the RUC-recommended time value for this clinical labor task, as proposed.***
CT Chest (CPT Codes 71250, 71260, and 71270)	CMS proposes the RUC-recommended work RVUs of 1.16 for CPT code 71250, 1.24 for CPT code 71260, and 1.38 for CPT code 71270. For CPT code 71250, CMS considered maintaining the CY 2017 work RVU of 1.02. For CPT code 71260, CMS considered proposing a work RVU of 1.10 by applying the RUC-recommended increment between CPT code 71250 and 71260 (0.08) to CPT code 71260. For CPT code 71270, CMS considered a work RVU of 1.24 by applying the RUC-recommended increment between CPT codes 71260 and 71270 (0.22) to CPT code 71270.	***CMS finalized the RUC-recommended values as proposed.***		

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	CMS seeks comment on whether its alternative values would improve relativity.			
MRI of Abdomen and Pelvis (CPT codes 72195, 72196, 72197, 74181, 74182, and 74183)	CMS proposes the RUC-recommended work RVUs of 1.46 for CPT code 72195, 1.73 for CPT code 72196, 2.20 for CPT code 72197, 1.46 for CPT code 74181, 1.73 for CPT code 74182, and 2.20 for CPT code 74183.	***CMS finalized the RUC-recommended work RVUs as proposed.***	CMS proposes the RUC-recommended direct PE inputs. However, CMS considered 30 minutes for clinical labor task "Acquire images" for CPT codes 74181 and 74182, which appears to be more consistent with the codes in this family and more consistent with other MR codes. CMS seeks comments on whether using a structure that matches other MR code families would be more appropriate to value these clinical labor times.	***CMS finalized the RUC-recommended PE inputs as proposed.***
MRI Lower Extremity (CPT codes 73718, 73719, and 73720)	CMS proposes the RUC-recommended work RVUs of 1.35 for CPT code 73718, 1.62 for CPT code 73719, and 2.15 for CPT code 73720.	***CMS finalized the RUC-recommended work RVUs as proposed.***	CMS proposes the following refinements to the RUC-recommended direct PE inputs. For the service period clinical labor activity "Provide preservice education/obtain consent," CMS proposes 5 minutes for CPT code 73718, 7 minutes for CPT code 73719, and 7 minutes for CPT code 73720. Likewise, for the service period task "Prepare room, equipment, supplies," CMS proposes 3 minutes for CPT code 73718, 5 minutes for CPT code 73719, and 5 minutes for CPT code 73720.	***CMS did not finalize its proposed time values for this activity, and instead finalized the RUC-recommended values of 5 minutes, 7 minutes, and 7 minutes for CPT codes 73718, 73719, and 73720, respectively, to maintain consistency among similar services.***
Abdominal X-ray (CPT Codes 74022, 74018, 74019, and 74021)	For CY 2018, CMS proposes the RUC-recommended work values for CPT codes 74022, 740X1, 740X2,	***CMS finalized the RUC-recommended work RVUs as proposed, and noted that its***		

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	and 740X3. For purposes of calculating the proposed RVUs, CMS used an even distribution of services previously reported as CPT codes 74010 and 74020 to CPT codes 740X2 and 740X3 instead of the RUC-recommended distribution because CMS thinks that the services previously reported with codes 74010 and 74020 will be reported in equal volume between the code representing two views and the code representing three views. CMS seeks comment on information that would help the agency improve on this distribution for purposes of developing final RVUs, including rationale for the distribution reflected in the RUC's utilization crosswalk.	***utilization assumptions do not determine the valuation of work RVUs, which will be incorporated into overall budget neutrality calculations.***		
Angiography of Extremities (CPT codes 75710 and 75716)	CMS proposes the RUC-recommended work RVUs of 1.75 for CPT code 75710 and 1.97 for CPT code 75716.	***CMS finalized the RUC-recommended work RVUs, as proposed.***	CMS proposes to use the RUC-recommended direct PE inputs for both CPT codes 75710 and 75716, with the following refinements. For the clinical labor task "Technologist QC's images in PACS, checking for all images, reformats, and dose page," CMS proposes refinements consistent with the standard clinical labor times for tasks associated with the PACS Workstation. CMS also proposes to refine the clinical labor by removing the 2 minutes associated with the task	***CMS finalized the PE refinements, as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			"prepare room, equipment, and supplies."	
Ultrasound of Extremity (CPT Codes 76881 and 76882)			CMS proposes the RUC-recommended inputs with refinements. Specificially, CMS proposes to remove 1 minute from the clinical labor task "Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue," because this code does not include any equipment time for the PACS workstation proxy or professional PACS workstation. CMS notes that the RUC-recommended inputs shift the general ultrasound room from the PE inputs for CPT code 76881 to the PE inputs for CPT code 76882. CMS proposes to make this change, consistent with the RUC recommendations; however, CMS seeks comment on whether a portable ultrasound unit would be a more accurate PE input for both codes, given that the dominant specialty for both of these services is podiatry, based on available 2016 Medicare claims data. CMS proposes that these codes would not be subject to the phase-in of significant RVU reductions given the significance of this shift of resource costs between codes in the same family and seeks	***CMS finalized the RUC-recommended direct PE inputs with refinements for CPT code 76881 as proposed.*** ***For CPT code 76882, CMS did not finalize its proposal to include an ultrasound room, and instead finalized the RUC-recommended equipment, with the exception of the ultrasound room, which CMS replaced with a portable ultrasound unit.*** ***CMS did not finalize its proposal to exempt these codes from the phase-in, and the reduction in the PE for CPT code 76881 will thus be limited to 19 percent for the first***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			comment on this proposed application of the phase-in policy.	***year. This transition period will allow CMS to obtain more stakeholder input on the appropriate PE inputs and specialty assumptions for these services, and CMS expects to consider this input for future rulemaking.***
Radiation Therapy Planning (CPT codes 77261, 77262, and 77263)	For CY 2018, CMS proposes the RUC-recommended work RVUs of 1.30 for CPT code 77261, 2.00 for CPT code 77262, and 3.14 for CPT code 77263. For CPT code 77263, CMS considered a work RVU of 2.60 based on a crosswalk to CPT code 96111 (Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report), which has an identical intraservice time, and similar total time to the RUC-recommended time values for CPT code 77263. CMS considered using a work RVU of 2.60 for CPT code 77263 as a base for alternative valuations for CPT codes 77261 and 77262 by applying the ratio of the crosswalk work RVU of CPT code 96111 (Developmental test extend) to the RUC-recommended work RVU of CPT code 77263 (that is, 2.60/3.14=0.83) to the RUC-	***CMS finalized the RUC-recommended work RVUs as proposed.***		

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	recommended work RVU for CPT code 77261 (that is, 0.83 x 1.30=1.08) and CPT code 77262 (that is, 0.83 x 2.0=1.66), which would have resulted in work RVUs of 1.08 for CPT code 77261 and 1.66 for CPT code 77262. CMS seeks comments on whether the alternative valuation would be more appropriate for these codes.			
Flow Cytometry Codes (CPT codes 88184 and 88185)			CMS has received conflicting information about the direct PE inputs for CPT codes 88184 (Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker) and 88185 (Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker). As a result, CMS proposes these codes as potentially misvalued so that they can be reviewed again because some stakeholders have suggested the clinical labor and supplies that were previously finalized are no longer accurate.	***Persuaded by commenters, CMS finalized a clinical labor time of 15 minutes for the "Instrument start-up, quality control functions..." clinical labor activity for CPT code 88184.*** ***Persuaded by commenters, CMS finalized a clinical labor time of 10 minutes for the "Load specimen into flow cytometer..." clinical labor activity for CPT code 88184.*** ***Persuaded by commenters, CMS finalized a supply quantity of 1.6 for the flow cytometry antibody in these two CPT codes.*** ***CMS increased the finalized equipment time to the RUC-recommended 5 minutes for CPT code 88184 and 2 minutes for CPT code 88185.***
Pathology Consultation during Surgery (CPT codes	CMS proposes the RUC-recommended work RVU of 1.20 for CPT code 88333 and the RUC-recommended work RVU of 0.73	***CMS finalized the work RVUs for the codes in the pathology consultation during surgery family as proposed.***	For the direct PE inputs, CMS proposes to remove the clinical labor for the "Prepare room. Filter and replenish stains and supplies	***CMS finalized that it will assign 2 minutes for room preparation and equipment setup for CPT code 88333, continuing to believe that***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
88333 and 88334)	for CPT code 88334.		(including setting up grossing station with colored stains)" activity from CPT code 88333. CMS proposes to refine the clinical labor time for "Clean room/equipment following procedure" activity for CPT code 88333, consistent with the standard clinical labor time assigned for room cleaning when used by laboratory services. CMS seeks comments related to the equipment time assigned to the "grossing station w-heavy duty disposal" (EP015) for both CPT codes 88333 and 88334.	***the replenishing of stains and supplies constitutes a form of indirect PE.*** CMS does not agree that clinical labor time should be allocated for this task. ***CMS continues to believe that the standard clinical labor time of 1 minute for room and equipment cleaning in laboratory services should be applied to CPT code 88333, and finalized it as such.*** ***CMS has no reason to believe that the recommended equipment time is incorrect, it was simply unclear how this equipment time was derived.*** ***Due to a technical error, a global period of XXX was incorrectly assigned to this code in the proposed rule. CMS finalized a global period of ZZZ for CPT code 88334 as the RUC recommended.***
Tumor Immunohistochemistry (CPT codes 88360 and 88361)	CMS proposes the RUC-recommended work RVU of 0.85 for CPT code 88360 and the RUC-recommended work RVU of 0.95 for CPT code 88361.	***CMS finalized the work RVUs for the codes in the tumor immunohistochemistry family as proposed.***	CMS proposes to refine the clinical labor time for the "Enter patient data, computational prep for antibody testing, generate and apply bar codes to slides, and enter data for automated slide stainer" activity for both codes, consistent with the standard time for this clinical labor activity across different pathology services. For CPT code 88361, CMS proposes	***Despite commenter concerns, CMS finalized a clinical labor time of 1 minute for "Enter patient data, computational prep for antibody testing, generate and apply bar codes to slides, and enter data for automated slide stainer" for CPT 88360 and 88361.*** ***Despite commenter concerns, CMS finalized the removal of 1 minute***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			to remove the 1 minute of clinical labor time from the "Performing instrument calibration, instrument qc and start up and shutdown" and the "Gate areas to be counted by the machine" activities. CMS proposes to remove the clinical labor time for "Clean room/equipment following procedure" for CPT codes 88360 and 88361. CMS also proposes to remove the clinical labor time for the "Verify results and complete work load recording logs" and the "Recycle xylene from tissue processor and stainer" activities for CPT codes 88360 and 88361. CMS proposes to refine the equipment time for the "Benchmark ULTRA auto slide prep & E- Bar Label system" (EP112) from 18 minutes to 16 minutes for both codes. CMS proposes to add 1 minute over the current value of 15	***of clinical labor time from the "Performing instrument calibration, instrument qc and start up and shutdown" and the "Gate areas to be counted by the machine" activities from CPT code 88361 as proposed.*** ***CMS agreed with the commenters that the clinical labor is not duplicative of the 4 minutes of clinical labor assigned to "Clean equipment and work station in histology lab", and finalized the restoration of 1 minute of clinical labor time, as recommended.*** ***With commenter support, CMS finalized its proposal to remove the clinical labor time for the "Verify results and complete work load recording logs" and the "Recycle xylene from tissue processor and stainer" activities for CPT codes 88360 and 88361.*** CMS continues to believe that both of these clinical labor activities are already included in the allocation of indirect PE consistent with its established methodology. ***Persuaded by the commenters that slide labeling would indeed take the full 3 minutes of additional time previously assigned to EP113, rather than the 1 minute that CMS proposed to assign for this task, CMS finalized a change to the equipment time for CPT codes 88360 and 88361,***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			minutes to the EP112 equipment time to reach the aforementioned 16 minutes. For CPT code 88361, CMS proposes to maintain the current price of $195,000.00 for the DNA image analyzer (EP001) equipment. CMS considered refining the equipment time for the DNA image analyzer from 30 minutes to 5 minutes. CMS seeks comments on additional pricing information for the EP001 DNA image analyzer equipment, specifically invoices solely for this equipment containing a rationale for each component part, as well as the appropriate equipment time typically required for use in CPT code 88361.	***along with a correction to the total equipment time reclassified as EP112 for the other three codes mentioned by commenters (CPT 88341, 88342, and 88344), as described in Table 11.*** ***CMS finalized its proposed equipment time of 30 minutes instead of the alternative equipment time. CMS finalized a price of $248,946.30 for this equipment, based on the submitted price of $258,042.30 minus the price of the user training ($6,800.00), the instructor-led online training ($646.00) and the shipping and handling costs ($1,650.00). These costs are allocated through the indirect allocation under the established PE methodology. CMS also finalizedthe name change to the EP001 equipment, as requested by the commenters.***
Cardiac Electrophysiology Device Monitoring Services (CPT codes 93279, 93281, 93282, 93283, 93284, 93285, 93286, 93287, 93288, 93289, 93290, 93291, 93292, 93293, 93294, 93295, 93296, 93297, 93298, and 93299)	For CY 2018, CMS proposes the RUC-recommended work RVUs for the 19 CPT codes in this family that are valued with physician work as follows: 0.65 for CPT code 93279, 0.77 for CPT code 93280, 0.85 for CPT code 93281, 0.85 for CPT code 93282, 1.15 for CPT code 93283, 1.25 for CPT code 93284, 0.52 for CPT code 93285, 0.30 for CPT code 93286, 0.45 for CPT code 93287, 0.43 for CPT code 93288, 0.75 for CPT code 93289, 0.43 for CPT code 93290, 0.37 for CPT code 93291,	***After reviewing the range of current prices established by MACs, CMS agreed with concerns that the proposed rate of 0.77 RVUs corresponds to a low reimbursement relative to the range of payments across localities and states. CMS concurred with commenters that there is no need, at this time, to establish a national rate, and will defer to individual MACs to set a reimbursement rate for this CPT code that reflects local***	CMS proposes the RUC-recommended direct PE inputs with the following refinements. CMS proposes to remove 2 minutes for "review charts" from CPT codes 93279, 93281, 93282, 93283, 93284, 93285, 93286, 93287, 93288, 93289, 93290, 93291, and 93292 to maintain relativity since it is not typically incorporated for similar PFS codes. CMS also proposes removing 2 minutes for "complete diagnostic forms, lab & X-ray requisitions" for	***Except for CPT 93299, which will remain contractor-priced, CMS finalized the RUC-recommended direct PE inputs with refinements, as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	0.43 for CPT code 93292, 0.31 for CPT code 93293, 0.60 for CPT code 93294, 0.74 for CPT code 93295, 0.52 for CPT code 93297, and 0.52 for CPT code 93298. For CPT code 93293, CMS considered a work RVU of 0.91 and seeks comment on whether this alternative work RVU for this service would better maintain relativity between single and dual lead pacemaker systems and cardioverter defibrillator services. CMS considered reducing the work RVU for CPT code 93282 by 0.11 work RVUs and seeks comments on whether this alternative value would better reflect relativity between the single and dual lead systems that exist within pacemaker services and within cardioverter defibrillator services. CMS considered a proportionate reduction for CPT code 93289 to a work RVU of 0.69. For CPT code 93283, CMS considered a work RVU of 0.91 and seeks comment on whether this value would improve relativity. CMS considered an alternative crosswalk for CPT code 93293 (Pm phone r-strip device eval) (5 minutes intraservice time and 13 minutes total time) to CPT code 94726 (Pulm funct tst plethysmograp), which has 5 minutes intraservice time and 15	***populations, supply costs, and practice patterns. CMS did not finalize its proposal with respect to CPT code 93299, and this code will remain contractor-priced.*** ***CMS finalized a work RVU of 0.74 for CPT code 93295, as proposed, as well as work RVUs for the remainder of the CPT codes in this family as proposed.***	the labor category "med tech/asst" (L026A). CMS seeks comment regarding whether this row was included in error. Also for the same group of CPT codes, CMS proposes standard refinements for the time for equipment items EF023 and EQ198. CMS proposes to use the RUC-recommended direct practice expense inputs and times for all other CPT codes in this family (CPT codes 93293, 93294, 93295, 93296, 93297, 93298, and 93299) without refinement.	

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	minutes total time and a work RVU of 0.26. CMS seeks comment its proposed and alternative valuations for this code. For CPT code 93294, CMS considered a work RVU of 0.55 and seeks comment on whether it would better align with the RUC-recommended service times, and whether its alternative value would better reflect the time and intensity involved in furnishing this service. For CPT code 93295, CMS considered a work RVU of 0.69, crosswalking to CPT code 76586, and seeks comment on whether its alternative value would better reflect the time and intensity involved in furnishing this service. CMS considered a work RVU of 0.37 for CPT code 93297. CMS also considered a work RVU of 0.37 for CPT code 93298 based on a crosswalk to CPT code 96446. CMS seeks comment on its proposed valuation and whether its alternative valuation would be more appropriate for this code.			
Transthoracic Echocardiography (TTE) (CPT codes 93306, 93307, and 93308)	For CY 2018, CMS proposes the RUC-recommended work RVUs for CPT codes 99306 (a work RVU of 1.50), 99307 (a work RVU of 0.92), and 99308 (a work RVU of 0.53). For CPT code 93306	***CMS finalized a work RVU of 1.50 for CPT code 93306, a work RVU of 0.92 for CPT code 93307, and a work RVU of 0.53 for CPT code 93308, as proposed.***	CMS proposes the RUC-recommended direct PE inputs for CPT codes 93306, 93307, and 93308 without refinement.	***CMS finalized the proposed direct PE inputs without refinement for all codes in this family.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	(Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography), CMS considered maintaining the CY 2017 work RVU of 1.30. For CPT code 93307 (Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography), CMS considered a work RVU of 0.80, crosswalking to services with similar service times (CPT codes 93880 (Extracranial bilat study), 93925 (Lower extremity study), 93939, 93976 (Vascular study), and 93978 (Vascular study)). For CPT code 93308 (Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study), CMS considered a work RVU of 0.43, crosswalking to CPT code 93292 (Wcd device interrogate) based on similar service times. For CY 2018, CMS proposes the RUC-recommended work RVUs for CPT codes 93306, 93307, and			

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	93308 and seek comments on whether its alternative values would better reflect the time and intensity of these services.			
Stress Transthoracic Echocardiography (TTE) Complete (CPT codes 93350 and 93351)	For CY 2018, CMS proposes the RUC-recommended work RVUs for CPT codes 93350 (a work RVU of 1.46) and 93351 (a work RVU of 1.75).	***CMS finalized work RVUs for these two codes, as proposed.***	CMS proposes the following refinements to the RUC-recommended direct PE inputs for CPT codes 93350 and 93351. For both codes, CMS applied the standard formula in developing the minutes for equipment item ED053 (professional PACS workstation), which results in 18 minutes for CPT code 93350 and 25 minutes for CPT code 93351. CMS also proposes standard clinical labor times for providing preservice education/obtaining consent. CMS did not propose to include clinical labor time for the task setup scope since there is no scope used in the procedure and CMS does not agree with the RUC's statement that this replicates 5 minutes in CPT code 93015 when the RN prepares patients for 10-lead ECG. CMS proposes refinements to the equipment time for ED050 (PACS workstation proxy) for CPT code 93351, consistent with its standard equipment times for PACS Workstation Proxy.	***CMS finalized the PE inputs and refinements for CPT 93350 and 93351 as proposed.***
Percutaneous Allergy Skin Tests (CPT code 95004)	For CY 2018, CMS proposes the RUC-recommended work RVU of 0.01 for CPT code 95004.	***CMS finalized the work RVUs for CPT code 95004, as proposed, and assured commenters they are subject to the phase-in.***	Regarding direct PE inputs, CMS proposes to refine the equipment times for exam table (EF023) and mayo stand (EF015) to 79 minutes	***CMS finalized the PE inputs for CPT code 95004, as proposed, and assured commenters they are subject to the phase-in.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			each to account for clinical 1:4 patient monitoring time. CMS also proposes a price of $0.03 per test for supply item SH101 and a price of $0.13 per test for supply item SH102.	
Patient, Caregiver-Focused Health Risk Assessment (CPT codes 96160 and 96161)			The RUC recommended 7 total minutes of clinical staff time, and CMS proposes to adopt this number of minutes in valuing the services. The PE worksheet included several distinct tasks with minutes for each; however, in keeping with the standardization of clinical labor tasks, CMS proposes to designate all 7 minutes under "administration, scoring, and documenting results of completed standardized instrument" rather than dividing the minutes into the four categories as shown in the RUC recommendations.	***CMS finalized the direct PE inputs for CPT codes 96160 and 96161, as proposed.***
Chemotherapy Administration (CPT codes 96401, 96402, 96409, and 96411)	For CY 2018, CMS proposes the RUC-recommended work RVUs for CPT code 96401 (a work RVU of 0.21), CPT code 96402 (a work RVU of 0.19), CPT code 96409 (a work RVU of 0.24) and CPT code 96411 (a work RVU of 0.20).	***CMS finalized the work RVUs for CPT codes 96401, 96402, 96409, and 96411, as proposed.*** Given comments regarding acuity adjustments for chemotherapy or infusion services, CMS stated it will consider whether to propose such adjustments in future notice and comment rulemaking. CMS will also continue to carefully consider the impact that its valuation of these services will have on beneficiary access to care.	For CPT code 96402, CMS proposes the RUC-recommended equipment times with refinements for the biohazard hood (EP016) and exam table (EF023) from 31 minutes to 34 minutes to reflect the service period time associated with this code. CMS proposes the RUC-recommended direct PE inputs for CPT codes 96401, 96409, and 96411 without refinements.	***CMS finalized the PE inputs for CPT codes 96401, 96402, 96409, and 96411, as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
Photochemotherapy (CPT code 96910)			CMS proposes to refine the clinical labor time for the "Provide preservice education/obtain consent" from 3 minutes to 1 minute for CPT code 96910. CMS proposes to remove the 2 minutes of clinical labor for the "Complete diagnostic forms, lab & X-ray requisitions" activity, as this item is considered indirect PE consistent with its established methodology. CMS proposes to create a new supply code (SB054) for the sauna suit, and proposing to price at $9.99 based on the submitted invoice. CMS proposes to adjust the equipment times to reflect changes in the clinical labor for CPT code 96910. CMS proposes the RUC-recommended clinical labor time of 15 minutes for the "Prepare and position patient/monitor patient/set up IV" activity, the RUC-recommended clinical labor time of 16 minutes for the "Monitor patient during procedure" activity, and the RUC-recommended clinical labor time of 15 minutes for the "Clean room/equipment by physician staff" activity, but seeking additional information regarding the rationale for these values. Given the lack of explanation, CMS considered using the current clinical labor time of 7 minutes for the "Prepare and position	***CMS finalized the direct PE inputs for CPT code 96910 as proposed, with the exception of the change to the "Provide preservice education/obtain consent" clinical labor activity. Specifically, CMS finalized a clinical labor time of 3 minutes for the "Provide preservice education/obtain consent" clinical labor activity for CPT code 96910.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			patient/monitor patient/set up IV" activity, the current clinical labor time of 4 minutes for the "Monitor patient during procedure" activity, and the current clinical labor time of 10 minutes for the "Clean room/equipment by physician staff" activity. CMS seeks comment on whether maintaining the current values would improve relativity. CMS considered removing the "Single Patient Discard Bag, 400 ml" (SD236) supply and replacing it with the "biohazard specimen transport bag" (SM008). CMS seeks comments on its proposed and alternative values for these direct PE inputs.	
Photodynamic Therapy (CPT codes 96567, 96573, and 96574)	For CY 2018, CMS proposes the RUC-recommended work RVUs for CPT code 96X73 (a work RVU of 0.48) and CPT code 96X74 (a work RVU of 1.01).	***CMS finalized the RUC recommended work RVUs for 96573 and 96574 CPT codes.***	CMS proposes the RUC-recommended PE inputs with refinements. First, CMS proposes to add assist physician clinical staff time to CPT codes 96X73 (10 minutes) and 96X74 (16 minutes). For both CPT codes 96X73 and 96X74, CMS proposes a reduction from 35 minutes to 17 minutes for clinical activity in the postservice time. For CPT codes 96X73 and 96X74, CMS proposes to refine equipment formulas for two items: power table (EF031) and LumaCare external light with probe set (EQ169), consistent with standards for nonhighly technical equipment.	***CMS finalized the RUC recommended PE clinical labor times for 96573 and 96574 CPT codes. CMS also finalized its proposal to refine equipment formulas for EF031 and EQ169 for these two CPT codes, in accordance with formula standards. CMS appreciated commenters for calling attention to discrepancies in the the rule.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			CMS proposes to set the price of supply item SH092 to $0.78 per gram. Other CPT codes affected by the proposed change in the price of supply item LMX 4 percent cream (SH092) are: CPT code 46607 (Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple), CPT code 17000 (Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion), CPT code 17003 (Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)), and CPT code 17004 (Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions)). CMS proposes a price of $4.10 for supply item SJ027 (the average of the two prices for this supply item ($2.30 + $6.00)/2=$4.10)). Other CPT codes affected by the proposed change in the price of	***CMS finalized its proposed refinement for this and two other equipment items for CPT 96573 and 96574.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			supply item UV-blocking goggles (SJ027) are: CPT code 36522 (Photopheresis, extracorporeal), CPT code 96910 (Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B), CPT code 96912 (Photochemotherapy; psoralens and ultraviolet A (PUVA)), and CPT code 96913 (Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)), CPT code 96920 (Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm), CPT code 96921 (Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm), and CPT code 96922 (Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm). CMS seeks comments on its proposed PE refinements, including its proposed supply item prices.	
Physical Medicine and Rehabilitation (PM&R) (CPT codes 97012, 97016, 97018, 97022, 97032, 97033, 97034, 97035, 97110, 97112, 97113, 97116, 97140,	For CY 2018, CMS proposes the HCPAC recommendations for CPT code 97014, HCPCS code G0283, and HCPCS code G0281. For CY 2018, CMS proposes the HCPAC's recommended work RVUs for CPT codes 97012, 97016,	***CMS finalized the HCPAC-recommended work RVUs, including the times, for all 19 PM&R codes as proposed.***	CMS proposes to maintain the existing CY 2017 PE inputs for all 19 codes and seeks comments on whether there is an alternative approach that would avoid duplicative downward payment adjustments while still allowing for	***Persuaded by the HCPAC's reassurance that the PE Subcommittee took the 50 percent MPPR into consideration during its deliberative process and that the forwarded recommendations reflect the therapy MPPR policy,***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
97530, 97533, 97535, 97537, 97542, and HCPCS code G0283)	97018, 97022, 97032, 97033, 97533, 97034, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, 97542, and G0283 (97014). For supervised modality services reported with CPT codes 97012, 97016, 97018, and 97022, and HCPCS code G0283 (97014), CMS considered maintaining the current values for these codes rather than the HCPAC recommendations. CMS seeks comments on whether maintaining the current times would better reflect the work times for these services.		the direct PE inputs to be updated to better reflect current practice.	***CMS did not finalize its proposal to maintain the existing direct PE inputs for therapy codes; instead, CMS accepted accept the HCPAC recommendations for the direct PE inputs for the 19 PM&R codes in this section and the three codes discussed below for services related to orthotics and prosthetics management and/or training.***
Management and/or Training: Orthotics and Prosthetics (CPT codes 97760, 97761, and 977X1)	For CY 2018, CMS proposes the HCPAC recommended work RVU of 0.5 for CPT code 97760, a work RVU of 0.5 for CPT code 97761, and a work RVU of 0.48 for CPT code 977X1. For CPT code 977X1, CMS considered a work RVU of 0.33, crosswalking to CPT code 92508 (Speech/hearing therapy). CMS seeks comments on the HCPAC one-to-one utilization crosswalk recommendations for all three codes in this family since the utilization assumptions are potentially flawed when viewed in the context of the new CPT code descriptors. CMS seeks comments on its proposed and alternative values for CPT code 977X1. CMS is	***After consideration of the public comments, CMS finalized its proposal to accept the HCPAC recommended work RVUs for CPT codes 97760, 97761, and 97763.***	CMS proposes to maintain the current PE inputs for CPT codes 97760, 97761, and 977X1. CMS proposes the current direct PE inputs for CPT code 97762 and for new CPT code 977X1, and seeks comment as to whether or not a different crosswalk or other adjustment would be appropriate given the change in code descriptor.	***Given these codes are subject to the same MPPR policy as the 19 PM&R codes discussed above, CMS did not finalize its proposal to retain the existing PE inputs for these three codes. CMS stated it was persuaded by the HCPAC that the PE Subcommittee took into account the 50 percent MPPR policy when developing the PE inputs for these codes.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	also interested in receiving comments from stakeholders and clinicians with expertise in furnishing these orthotic management and/or prosthetics training services about the utilization and types of services that would be furnished under the new CPT coding structure, particularly those of the newly created CPT code 977X1 and how these services differ from the services reported with the predecessor CPT code 97762.			
Physician Coding for Insertion and Removal of Subdermal Drug Implants for the Treatment of Opioid Addiction (HCPCS codes G0516, G0517, and G0518)	For CY 2018, CMS proposes to make separate payment for the insertion, removal, and removal with reinsertion of Buprenorphine subdermal implants using HCPCS G codes: • HCPCS code GDDD1: Insertion, non-biodegradable drug delivery implants, 4 or more. • HCPCS code GDDD2: Removal, non-biodegradable drug delivery implants, 4 or more. • HCPCS code GDDD3: Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more. CMS proposes a work RVU of 1.82	***With support of commenters, CMS finalized separate payment for insertion, removal, and removal with reinsertion of Buprenorphine subdermal implants using HCPCS codes G0516, G0517, and G0518, and the valuation for HCPCS codes G0516, G0517, and G0518, as proposed.***	CMS proposes to use the direct PE inputs for HCPCS codes GDDD1, GDDD2, and GDDD3, which are reflected in the Direct PE Inputs public use files for clinical labor, supplies, and equipment, available on the CMS website. In addition to seeking comment on the proposal to make separate payment for these services using HCPCS G codes, CMS also seeks comment on the appropriateness and accuracy of its proposed work RVUs and direct PE inputs.	***With support of commenters, CMS finalized separate payment for insertion, removal, and removal with reinsertion of Buprenorphine subdermal implants using HCPCS codes G0516, G0517, and G0518, and the valuation for HCPCS codes G0516, G0517, and G0518, as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	for HCPCS code GDDD1, which is supported by a direct crosswalk to CPT code 64644 (Chemodenervation of one extremity; 5 or more muscles). For HCPCS code GDDD2, CMS proposes a work RVU of 2.10, which is supported by a direct crosswalk to CPT code 96922 (Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm). For HCPCS code GDDD3, CMS proposes a work RVU of 3.55, which is supported by a direct crosswalk to CPT code 31628 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe).			
Superficial Radiation Treatment Planning and Management (HCPCS code GRRR1)	CMS proposes to make separate payment for the professional planning and management associated with SRT using HCPCS code GRRR1 (Superficial radiation treatment planning and management related services, including but not limited to, when performed, clinical treatment planning (for example, 77261, 77262, 77263), therapeutic radiology simulation-aided field setting (for example, 77280, 77285, 77290, 77293), basic radiation dosimetry calculation (for example, 77300), treatment devices (for	***CMS did not finalize its proposal to make separate payment for the planning and management services associated with SRT using HCPCS code GRRR1. CMS will continue a dialogue with stakeholders to address appropriate coding and payment for professional services associated with SRT.*** ***Further, CMS did not propose to value CPT code 77401, but looks forward to addressing potential coding gaps in future rulemaking.***	To develop the proposed direct PE inputs for this code, CMS proposes to use the RUC-recommended direct PE inputs from the aforementioned codes with several adjustments. CMS proposes to apply the staff type "RN/LPN/MTA" for all of the clinical labor inputs for this code and seeks comments as to the appropriateness of the staff type "RN/LPN/MTA" for this SRT-related service. CMS proposes to remove the supply items "gown, patient" and "pillow case" that are associated	***CMS did not finalize its proposal to make separate payment for the planning and management services associated with SRT using HCPCS code GRRR1. CMS will continue a dialogue with stakeholders to address appropriate coding and payment for professional services associated with SRT.*** ***Further, CMS did not propose to value CPT code 77401, but looks forward to addressing potential coding gaps in future rulemaking.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	example, 77332, 77333, 77334), isodose planning (for example, 77306, 77307, 77316, 77317, 77318), radiation treatment management (for example, 77427, 77431, 77432, 77435, 77469, 77470, 77499), and associated evaluation and management per course of treatment). For CY 2018, CMS proposes a work RVU of 7.93 for HCPCS code GRRR1.		with CPT code 77280. CMS does not propose to include the equipment items “radiation virtual simulation system,” "room, CT" and "PACS Workstation Proxy" that are associated with CPT code 77280. Instead, CMS includes additional time for the capital equipment used in delivering SRT in the proposed direct PE inputs. For “radiation dose therapy plan,” CMS proposes to apply the clinical labor time that is associated with CPT code 77300 to HCPCS code GRRR1 for purposes of developing a proposed value, but seeks comments as to whether the clinical staff would typically perform the radiation dose therapy planning for this service, or if the physician would perform this and/or other tasks, and, in the case of the latter, what the appropriate physician time would be. Likewise, CMS seeks comment as to whether the clinical labor associated with the teletherapy isodose plan would be performed by the physician. CMS proposes to assign 14 minutes each to the equipment items “radiation therapy dosimetry software (Argus QC)”, “computer workstation”, and “3D teletherapy treatment planning”. CMS does not propose to include inputs related to radiation physics consultation, and seeks comment as to whether inputs associated	

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
			with this code or other inputs used in furnishing analogous services should be included. CMS does not propose to include the post-operative office visits included in the valuation of CPT code 77427, but seeks comment regarding the amount of face-to-face time typically spent by the practitioner with the patient for radiation treatment management associated with SRT. CMS proposes to exclude HCPCS code GRRR1 from the misvalued code target.	
Payment Accuracy for Prolonged Preventive Services (HCPCS codes G0513 and G0514)	CMS proposes to make payment for prolonged preventive services using two new HCPCS G codes that could be billed along with the Medicare-covered preventive service codes, when a clinician provides a prolonged Medicare-covered preventive service. • GYYY1: Prolonged preventive service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (List separately in addition to code for preventive service)), and • GYYY2: Prolonged preventive service(s)	***CMS finalized its proposal for prolonged preventive services using HCPCS codes G0513 and G0514 with the work RVUs, work times and requirements for these codes as proposed.*** In response to commenter requests that CMS clarify whether it would be able to bill the prolonged preventives codes if the additional time was distributed across multiple services performed on a single encounter, CMS noted it believes that it would be appropriate to bill the prolonged preventive services if all of the services performed are un-timed preventive services with no beneficiary cost-sharing.	CMS proposes to use one half of the direct PE inputs for CPT code 99354, which results in a proposal of 7 minutes of clinical labor type L037D (RN/LPN/MTA) and 15 minutes for equipment type EF031 (table, power) for HCPCS code GYYY1 and HCPCS code GYYY2.	***CMS finalized its proposal for prolonged preventive services using HCPCS codes G0513 and G0514 with the direct PE inputs for these codes as proposed.***

Service(s)	Proposed Work Valuation	Finalized Work Valuation	Proposed PE Valuation	Finalized PE Valuation
	(beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for preventive service)). CMS proposes a work RVU of 1.17 and 30 minutes of total work time for HCPCS codes GYYY1 and GYYY2.			

APPENDIX B: Summary of Proposed and Finalized Modifications to the Requirements for the 2018 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs

Reporting Period	Measure Type	Reporting Mechanism	Proposed Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2016)	Individual Measures	Claims	Report at least 6 measures, AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. If less than 6 measures apply to the EP, the EP must report on each measure that is applicable, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
12-month (Jan 1–Dec 31, 2016)	Individual Measures	Qualified Registry	Report at least 6 measures, AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. If less than 6 measures apply to the EP, the EP must report on each measure that is applicable, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
12-month (Jan 1–Dec 31, 2016)	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report at least 6 measures. If an EP's direct EHR product or EHR data submission vendor product does not contain patient data for at least 6 measures, then the EP must report all of the measures for which there is Medicare patient data. An EP must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2016)	Measures Groups	Qualified Registry	No proposed changes
12-month (Jan 1–Dec 31, 2016)	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	QCDR	Report at least 6 measures available for reporting under a QCDR AND report each measure for at least 50% of the EP's patients seen during the reporting period to which the measure applies. If less than 6 measures apply to the EP, the EP must report on each measure that is applicable, AND report each measure for at least 50% of the EP's patients.

APPENDIX C: Summary of Proposed and Finalized Modifications to the Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Proposed Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2016)	25+ EPs	Individual GPRO measures in the Web Interface	Web Interface	No proposed changes
12-month (Jan 1–Dec 31, 2016)	25+ EPs that elect CAHPS for PQRS	Individual GPRO Measures in the Web Interface + CAHPS for PQRS	Web Interface + CMS-Certified Survey Vendor	No proposed changes
12-month (Jan 1–Dec 31, 2016)	2+ EPs	Individual measures	Qualified Registry	Report at least 6 measures, AND report each measure for at least 50% of the group's Medicare Part B FFS patients seen during the reporting period to which the measure applies. If less than 6 measures apply to the group, the group must report on each measure that is applicable, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
12-month (Jan 1–Dec 31, 2016)	2+ EPs that elect CAHPS for PQRS	Individual measures + CAHPS for PQRS	Qualified Registry + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. In addition, the group practice must report at least 3 additional measures using the qualified registry AND report each measure for at least 50% of the group's Medicare Part B FFS patients seen during the reporting period to which the measure applies. If less than 3 measures apply to the group practice, the group practice must report on each measure that is applicable, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
12-month (Jan 1–Dec 31, 2016)	2+ EPs	Individual measures	Direct EHR Product or EHR Data Submission Vendor Product	Report 6 measures. If the group practice's direct EHR product or EHR data submission vendor product does not contain patient data for at least 6 measures, then the group practice must report all of the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2016)	2+ EPs that elect CAHPS for PQRS	Individual measures + CAHPS for PQRS	Direct EHR Product or EHR Data Submission Vendor Product + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. In addition, the group practice must report at least 3 additional measures using the direct EHR product or EHR data submission vendor product. If less than 3 measures apply to the group practice, the group practice must report all of the measures for which there is patient data. Of the additional 3 measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, a group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2016)	2+ EPs	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	QCDR	Report at least 6 measures available for reporting under a QCDR AND report each measure for at least 50% of the group practice's patients seen during the reporting period to which the measure applies. If less than 6 measures apply to the group practice, the group practice must report on each measure that is applicable, AND report each measure for at least 50% of the group practice's patients.