

**Overview of Selected Provisions of the Medicare Physician Fee
Schedule Final Rule for Calendar Year 2017**

On November 2, 2016, the Centers for Medicare and Medicaid Services (CMS) released a final rule addressing revisions to payment policies under the Medicare Physician Fee Schedule (PFS) and other policy revisions under Part B for calendar year (CY) 2017 (the “Final Rule”). The Final Rule was published in the Federal Register on November 15, 2016.¹

Under the Final Rule, the cumulative effect on total Medicare payments to physicians involved in the provision of cancer care will be:²

Specialty	Allowed Charges (Millions)	Combined Impact
Hematology/Oncology	\$1,751	0%
Radiation Oncology	\$1,726	0%
Radiology	\$4,683	-1%
Radiation Therapy Centers	\$44	0%

Note that the addenda containing payment rates and other information referred to in this summary are available only on the CMS web site at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-f.html>.

CMS finalized changes in the following areas:

- (1) Conversion Factor
- (2) Practice Expense (PE) Relative Value Unit (RVU) Methodology: PE Inputs for Digital Imaging Services
- (3) Standard Times for Clinical Labor Tasks
- (4) Potentially Misvalued Codes
 - a. 0-Day Global Services Typically Billed with an Evaluation and Management (E/M) Code with Modifier 25
 - b. Revaluation of 10-Day and 90-Day Global Services
- (5) Care Management and Collaborative Care
- (6) Misvalued Code Target
- (7) Phased-in Reduction of Code Values
- (8) Payment Incentive for Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services

¹ Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Pricing Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model, CMS-1654-F, 81 Fed. Reg. 80170 (Nov. 15, 2016) available at <https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf>. (hereinafter “Final Rule”).

² 81 Fed. Reg. at 80455.

- (9) Multiple Procedure Payment Reduction (MPPR)
- (10) Medicare Payment for Certain Radiation Treatment Services
 - a. Current Procedural Terminology (CPT®)³ Codes 77778 and 77790
 - b. CPT Codes 77332, 77333, and 77334
 - c. CPT Code 77470
- (11) Changes to Medicare Payment for Mammography – Computer Aided Detection (CAD) Bundling
- (12) Medicare Telehealth Services
 - a. New CPT codes for End Stage Renal Disease (ESRD) services added to the list of eligible telehealth services
 - b. Addition of advance care planning services
 - c. Telehealth consultations for critically ill patients
 - d. Establishment of a place of service (POS) code
- (13) Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging
- (14) Medicare Shared Savings Program (MSSP)

No substantive changes were made for the following:

- (a) Open Payments. With respect to drug and device manufacturers' obligation to report payments to physicians and teaching hospitals under the Federal Open Payments program, CMS made no new proposals and finalized no changes to the reporting requirements. CMS requested comment on a number of issues in the Proposed Rule, however, and the Final Rule notes that CMS received comments focusing on:
 - Expanding or clarifying certain nature of payment categories listed in the Open Payments rule;
 - Changing the ongoing reporting obligation to a specific period of time, such as five years after the payment or transfer of value was made;
 - Streamlining the registration process and maintaining voluntary registration for applicable manufacturers who do not report;
 - Requiring manufacturers to “pre-vet” their data with covered recipients before reporting to the government;
 - Clarifying the regulatory definition of a teaching hospital;
 - Adding a new non-public data element to allow teaching hospitals to more easily verify payments reported for them;
 - Expanding the timeframe in which the Open Payments system can accept data submissions from manufacturers, e.g., multiple submission windows;
 - Implementing flexible reporting requirements to allow manufacturers to properly and easily disclose to CMS mergers and acquisitions and other business dealings;
 - Clarifying the definition of physician-owned distributors (PODs) and how the reporting requirements apply to PODs.⁴
- (b) Value-Based Payment Modifier (VBPM). CMS did not propose any significant changes to the VBPM methodology for CY 2017, which will be calculated based on eligible

³ CPT is a trademark of the American Medical Association (AMA).

⁴ Final Rule at 80428-429.

professionals' performance in CY 2015. But CMS finalized as proposed certain adjustments to the calculation methodology where informal review of the VBPM uncovers data integrity issues or other problems with the calculation.⁵ The VBPM, similar to the Physician Quality Reporting System (PQRS) and the incentive for meaningful use of Electronic Health Records (EHR), will sunset after CY 2018 and will be replaced by the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Details about each of the finalized changes are provided below.

(1) Conversion Factor

CMS finalized a conversion factor for CY 2017 of \$35.8887, reflecting the 0.5 percent annual increase specified by the Protecting Access to Medicare Act (PAMA) following elimination of the sustainable growth rate (SGR) formula, but also partially offsetting *decreases* mandated by statute that are described further below.⁶

(2) PE RVU Methodology: PE Inputs for Digital Imaging Services

Beginning with CY 2015, CMS created a new equipment item (ED050) for a specified list of digital imaging services to describe the Picture Archiving and Communication System (PACS) used by clinical staff to acquire and store digital images. In the CY 2016 final rule, CMS established a price for ED050 of \$5,557 based on invoice information, and the Final Rule maintains this price for this “technical” workstation.

For CY 2017, CMS also finalizes its proposal to add the cost of the “professional” PACS workstation (ED053) used by physicians to interpret digital images as a direct PE input for the global and technical component of a specified list of Healthcare Common Procedure Coding System (HCPCS) codes. The PACS workstation will be priced at \$14,616.93, based on invoices submitted by stakeholders. The professional PACS workstation will not be added as an input for add-on codes, for non-diagnostic services, or for image guidance codes where the dominant provider is not a radiologist. CMS finalized adding the professional PACS workstation to many of the therapeutic codes requested by commenters listed outside of the 7000 series, but within the 7000 series, CMS only added CPT code 73562.

For diagnostic codes with a service period time breakdown, CMS assigned equipment minutes equal to half the pre-service physician work time and the full intraservice physician work time. For the diagnostic codes without a service period time breakdown, CMS assigned equipment time equal to half of the total physician work time. For therapeutic codes, CMS assigned equipment minutes equal to half the pre-service physician work time and half the post-service physician work time for the second group.⁷

⁵ *Id.* at 80517, 80520.

⁶ *Id.* at 80543.

⁷ *Id.* at 80180-184.

(3) Standard Times for Clinical Labor Tasks

In the CY 2016 final rule, CMS revised the direct PE input database for certain digital imaging services by adding a standard number of minutes for four clinical labor tasks associated with those services.

In the CY 2017 Proposed Rule, CMS proposed a range of standard minutes for the clinical labor task “Technologist’s QC images in PACS, checking for all images, reformats, and dose page.” CMS also proposed that two minutes would be the standard for simple cases (X-rays), three minutes for intermediate cases (CTs and MRIs), and four minutes for complex cases.

CMS finalized time ranges as proposed, with the addition of a five minute category for highly complex cases. CMS is seeking recommendations from the RUC and other stakeholders to assist in identifying the specific basis used to distinguish the complex (4 minutes) and highly complex (5 minutes) categories. In the meantime, CMS will consider these codes on a case-by-case basis.

(4) Potentially Misvalued Codes

a. 0-Day Global Services Typically Billed with an E/M Code with Modifier 25

CMS reduced from 83 to 19 the CPT codes identified as potentially misvalued. These codes were identified because they are global services that are routinely billed with an E/M code using modifier 25, which is intended to capture “significant, separately identifiable” E/M services performed on the same day as the primary service. CMS states that these codes may be misvalued because routine E/M is supposed to be included in the value of 0-day global services, but providers are routinely billing for the E/M add-on as well.

Table 7 of the Final Rule identifies the codes that were removed from the proposed list, which includes codes for biopsies of lips, ears, and eyelids. Table 8 lists the 19 codes finalized as potentially misvalued, including a code for biopsy of uterine lining.⁸

b. Revaluation of 10-Day and 90-Day Global Services

CMS explains that MACRA prohibited the agency from implementing a policy proposed in CY 2015 to transform all 10-day and 90-day global codes to 0-day codes, until CMS collects specified data about the value of surgical services paid for under such codes. (10-day and 90-day packages include payment not only for the services performed the day of the surgical procedure but also for those performed within 10 or 90 days, respectively, of the procedure.)

⁸ *Id.* at 80204-206.

For CY 2017, instead of requiring all physicians to report services performed during the global period using a series of new G-codes, CMS will require a sample of physicians to report using CPT code 99024 on select post-operative services that would ordinarily be paid for through the global package. Practitioners in large groups (10 or more practitioners) in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island will be required to report specific post-operative services furnished on or after July 1, 2017. CMS will publish a list of which services must be reported on its website.⁹ CMS finalized plans for a survey of practitioners about the type and level of services provided during the global period, which will be sent out in mid-2017.¹⁰

(5) Care Management and Collaborative Care

In a continuation of policy reforms made in recent years to promote accurate payment for care management and collaborative care services, CMS finalized a number of changes to payment under the PFS for primary care, care management, and patient-centered services.

CMS finalized RVUs for:

- Four new G-codes for care management services related to behavioral health, including three new G-codes (G0502, G0503, and G0504) for services furnished under the psychiatric collaborative care model and one new G-code (G0507) for care management services for behavioral health conditions.¹¹
- One new G-code (G0505) for cognition and functional assessment service for patients with cognitive impairment.¹²
- One new G-code (G0506) for comprehensive assessment and care planning for patients who require chronic care management (CCM).¹³
- CMS did not finalize a proposed new G-code for resource-intensive services for patients who need specialized mobility assistance technology. Although CMS did not add the payment code, it will include G0501 as a reportable code, should practitioners wish to report it.¹⁴

CMS also adopted additional CPT codes in the family of codes for CCM services, and adjusted payment for the initial CCM visit to account for new care plan detail. CMS also finalized changes to the scope of service rules for CCM services, including changes in the requirements for the initiating visit, 24/7 access to care and continuity of care, format and sharing of the care plan and clinical summaries, beneficiary receipt of the care plan, beneficiary consent, and documentation. These changes are outlined in Table 11 of the Final Rule.¹⁵

⁹ *Id.* at 80212-213.

¹⁰ *Id.* at 80223.

¹¹ *Id.* at 80351.

¹² *Id.* at 80351-352.

¹³ *Id.* at 80352.

¹⁴ *Id.* at 80255.

¹⁵ *Id.* at 80251.

CMS also finalized separate payment for non-face-to-face prolonged E/M services under CPT codes 99358 (Prolonged evaluation and management service before and/or after direct patient care, first hour) and 99359 (Prolonged evaluation and management service before and/or after direct patient care, each additional 30 minutes (List separately in addition to code for prolonged service)), which had been “bundled” under the PFS (i.e., not separately billable). CMS also increased payment for CPT code 99354 (Prolonged evaluation and management or psychotherapy 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 hour), which already was separately billable.¹⁶

(6) Misvalued Code Target

In CY 2016, CMS finalized a methodology to reach an annual savings target for adjustments to misvalued codes in the PFS for CY 2016 through CY 2018, as required by PAMA and the Achieving a Better Life Experience Act of 2014. If the annual savings target is met or exceeded, all savings are redistributed within the PFS and savings in excess of the target are counted toward the target for the subsequent year. If the annual savings target is not met, a reduction equal to the target recapture amount (the magnitude of the annual savings shortfall from the annual target) must be made to payment for all PFS services.

For CY 2017, CMS finalized, without modification, its proposal to adjust the methodology for calculating the target for savings to account for codes for which changes in value are best measured over three years, rather than two.¹⁷

(7) Phased-in Reduction of Code Values

In CY 2016, pursuant to a statutory requirement of PAMA, CMS implemented a policy under which any reduction in total RVUs equal to or greater than 20 percent would be phased in over a two-year period.

For CY 2017, CMS finalized, without modification, its proposal to apply this policy consistently to any cases where RVUs for a code would be reduced by 20 percent or more in consecutive years. In such cases, CMS will continue phasing in the reduction in RVUs over multiple years (with a maximum of 19 percent total reduction applied each year) until the reduction is complete.¹⁸

(8) Payment Incentive for Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services

CMS finalized its proposal to implement a provision of the Consolidated Appropriations Act of 2016 (CAA) that reduces payment under the PFS for certain imaging services using older technologies.

¹⁶ *Id.* at 80229, 80349.

¹⁷ *Id.* at 80259-260.

¹⁸ *Id.*

Effective January 1, 2017, CMS will reduce by 20 percent payment under the PFS for the technical component (including the technical component of a global service) of imaging services that are X-rays using film. CMS finalized establishment of a new modifier “FX” to implement this policy. A list of affected CPT codes is available on the CMS website at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-P.html>. The Final Rule clarified that it did not intend this list to indicate that CMS would be developing or displaying an exhaustive list of applicable codes and that the agency believes that physicians and non-physician practitioners are in the best position to determine whether a particular imaging service is an X-ray taken using film.

The statute also requires CMS to reduce payment under the PFS for imaging services that are X-rays taken using computed radiology by seven percent (for CYs 2018 through 2022) and by ten percent for CY 2023 and thereafter. Because this reduction is not required until CY 2018, however, the Proposed Rule deferred any proposals related to this requirement, and the Final Rule took no further action.¹⁹

(9) MPPR

CMS currently applies an MPPR of 25 percent to the professional component (PC) of certain advanced imaging services, which applies when multiple imaging procedures are furnished by the same physician or group practice to the same patient in the same session on the same day. In those cases, Medicare makes full payment for the PC for the highest-priced procedure but reduces payment for all other imaging procedures by 25 percent.

CMS finalized its proposal to implement a provision of the CAA that adjusts the MPPR from 25 percent to five percent, effective for services furnished on or after January 1, 2017.²⁰

(10) Medicare Payment for Certain Radiation Treatment Services

a. CPT Codes 77778 and 77790

With respect to payment for interstitial radiation services (CPT codes 77778, 77790), CMS proposed to adopt a work RVU of 8.00 for CPT code 77778 and a work RVU of 0 for 77790. However, upon consideration of comments, CMS was persuaded that the RUC-recommended work RVUs of 8.78 for 77778 are appropriate because the work includes the supervision, handling, and loading of radiation seeds, and because it reflects the bundling with 77790. The proposed work RVU of 0 for 77790 is finalized in the Final Rule.²¹

¹⁹ *Id.* at 80270-271.

²⁰ *Id.* at 80271.

²¹ *Id.* at 80318-319.

CPT Code	Description	CY 2017 Final Payment		Q4 CY 2016 Payment		% Change	
		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
77778	Apply interstit radiat compl	\$836.57	\$461.53	\$789.13	\$417.12	6.0%	10.6%
77790	Radiation handling	\$15.07	N/A	\$15.04	N/A	0.2%	N/A

b. CPT Codes 77332, 77333, and 77334

With respect to payment for radiation treatment devices (CPT codes 77332, 77333, and 77334, depending on complexity of the device design), although the American Medical Association/Specialty Society Relative (Value) Update Committee (RUC) recommended no change in the current work RVUs, CMS finalized reduced RVUs for each of the three codes because the RUC also recommended a decrease in the time it takes to furnish these services. CMS established the lower work RVUs for code 77332 by crosswalking the work RVUs from CPT code 93287 due to “its identical intraservice time, similar total time, and similar level of intensity.” The work RVUs for codes 77333 and 77334 are based on an incremental increase from the work RVUs for code 77332, so the work RVUs for those codes likewise were reduced under the Final Rule.²²

CPT Code	Description	CY 2017 Final Payment		Q4 CY 2016 Payment		% Change	
		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
77332	Radiation treatment aid(s)	\$68.55	\$24.05	\$83.78	\$28.64	-18.2%	-16.1%
77333	Radiation treatment aid(s)	\$98.34	\$39.48	\$53.71	\$44.04	83.1%	-10.4%
77334	Radiation treatment aid(s)	\$133.15	\$60.65	\$154.32	\$64.81	-13.7%	-6.4%

c. CPT Code 77470

With respect to payment for special radiation treatment (CPT code 77470), CMS finalized the RUC-recommended work RVU of 2.03. However, CMS noted in the Final Rule that it continues to have serious concerns about the validity of this coding, because it believes there is a disparity between work RVUs and PE RVUs for the code based on the description of service and the vignette for the code.²³

²² *Id.* at 80316-317.

²³ *Id.* at 80317-319.

CPT Code	Description	CY 2017 Final Payment		Q4 CY 2016 Payment		% Change	
		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
77470	Special radiation treatment	\$146.78	\$107.31	\$157.90	\$109.20	-7.0%	-1.7%

(11) Changes to Medicare Payment for Mammography – CAD Bundling

Since 2002, CMS has paid for digital mammography services using G-codes G0202, G0204, and G0206, and for film mammography services using CPT codes 77055, 77056, and 77057, with use of CAD reported using CPT codes 77051 and 77052. For CY 2017, the CPT Editorial Panel decided to delete CPT codes 77051, 77052, 77055, 77056, and 77057, and to create three new CPT codes, 77065, 77066, and 77067, to describe mammography services bundled with CAD. The RUC recommended work RVUs for each of the new CPT codes, as well as new PE inputs for use in developing resource-based PE RVUs for each code. Based on concerns that adopting the new input values would result in “drastic” reductions in payment for mammography services, however, CMS proposed to delay implementation of the recommended resource inputs and to crosswalk the PE RVUs for the technical component of the current corresponding G-codes to the new codes.

CMS finalized the proposed RVUs for the new mammography codes, but because CMS would not be able to process claims using the new code numbers (77065, 77066, 77067) in 2017 due to “several reasons related to claims processing systems,” CMS will continue using G0202, G0204, and G0206 but updated the descriptors and RVUs of these G-codes to mirror CPT codes 77065, 77066, and 77067.²⁴ The Final Rule states that CMS will consider the recommended inputs (including pricing of required equipment) “as carefully as possible” prior to proposing revised PE values in subsequent rulemaking.

Service	Proposed Coding	Finalized Coding	CY 2017 Physician Payment Rate – Non Facility	CY 2017 Physician Payment Rate – Facility
Dx mammo incl cad uni	77065	G0206	\$134.94	\$39.84
Dx mammo incl cad bi	77066	G0204	\$171.19	\$49.53
Scr mammo bi incl cad	77067	G0202	\$138.17	\$37.68

(12) Medicare Telehealth Services

Physicians may bill for certain services under the PFS when provided via telehealth under certain circumstances, if the applicable CPT code is included on the annually updated CMS list of approved telehealth services.

²⁴ *Id.* at 80314.

a. New CPT codes for ESRD services added to the list of eligible telehealth services

CMS finalized its proposal to add certain CPT codes for ESRD services to the list of eligible CPT codes:

- CPT 90967 (ESRD related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age);
- CPT 90968 (ESRD related services for dialysis less than a full month of service, per day; for patients 2-11 years of age);
- CPT 90969 (ESRD related services for dialysis less than a full month of service, per day; for patients 12-19 years of age); and
- CPT 90970 (ESRD related services for dialysis less than a full month of service, per day; for patients 20 years of age or older).

a. Advance care planning services

CMS finalized its proposal to add the following two advance care planning services, given that they are similar to the annual wellness visits that already are included on the list of approved telehealth services:

- CPT 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), or surrogate); and
- CPT 99498 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)).²⁵

b. Telehealth consultations for critically ill patients

CMS finalized its proposal to create a distinction between telehealth consultations for critically ill patients, for example stroke patients, relative to telehealth consultations for other hospital patients, through the establishment of two new G-codes, which have been added to the approved list of Medicare telehealth services. HCPCS codes G0508 (initial) and G0509 (subsequent) are to be used for critical care consultation services furnished to via telehealth when a qualified health care professional has in-person responsibility for the patient, but the patient benefits from additional services from a distant-site consultant specially trained in providing clinical care services. The services are limited to one per day per patient.

c. Establishment of a POS code

CMS also finalized its proposal to establish a POS code to identify services furnished via telehealth under the PFS. After January 1, 2017:

²⁵ *Id.* at 80192-202.

- Claims for telehealth services reported by physician or practitioner must be submitted with provided via telehealth must include POS 02.
- The facility PE RVU rate will be used to pay for telehealth services reported by physicians or practitioners with the telehealth POS code.
- There are a few HCPCS codes on the telehealth list that do not have a calculated facility PE RVU. For these services, the non-facility PE RVU will serve as a proxy.
- The POS code for telehealth does not apply to originating sites billing the facility fee. Originating sites are not furnishing a service via telehealth because the patient is physically present in the facility. The facility fee for originating sites for CY 2017 is \$25.40.²⁶

(13) AUC for Advanced Diagnostic Imaging

Section 218(b) of PAMA directs CMS to establish AUC for advanced diagnostic imaging services provided in physician offices, hospital outpatient departments, and ambulatory surgical centers, and to require certain ordering professionals (OPs) to report that they consulted those AUC as a condition of payment for the imaging service. PAMA requires the requirement to take effect on January 1, 2017; however, CMS notes in the Final Rule that implementation will be delayed until January 1, 2018.²⁷

When the program is fully implemented, OPs must consult specified AUC through a qualified clinical decision support mechanism (CDSM) for every applicable imaging service that would be furnished in an applicable setting and paid for under an applicable payment system in order for payment to be made for the service.

In the 2016 rulemaking cycle, CMS implemented the first stage of the AUC program by establishing a timeline and process for provider-led entities (PLEs) to become qualified to develop, modify, or endorse AUC. The list of the 11 qualified PLEs CMS named in June is available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html>.

For CY 2017, CMS finalized requirements for qualified CDSMs, the tool that OPs would use to consult a specific AUC. Among other things, the Final Rule:

- Defines CDSM as an “interactive electronic tool for use by clinicians that communicates AUC information to the user and assists them in making the most appropriate treatment decision for a patient’s specific clinical condition”²⁸ and
- Finalizes a revised list of the following eight initial priority clinical areas:
 - Coronary artery disease (suspected or diagnosed)
 - Suspected pulmonary embolism
 - Headache (traumatic and non-traumatic) (as proposed)
 - Hip pain

²⁶ *Id.* at 80201-202.

²⁷ *Id.* at 80420.

²⁸ *Id.* at 80405, 80554.

- Low back pain
- Shoulder pain (to include suspected rotator cuff injury)
- Cancer of the lung (primary or metastatic, suspected or diagnosed)
- Cervical or neck pain

These priority clinical areas are significantly changed from the initial list, which included chest pain, abdominal pain, and suspected stroke and altered mental status.²⁹

Additionally, CMS finalized its proposal to codify in regulations the seven statutory requirements for qualified CDSMs and to require, among other things, that qualified CDSMs must:

- At a minimum, include specified applicable AUCs that reasonably encompass the entire clinical scope of all priority clinical areas;
- Provide the OP with a description of the extent to which an applicable imaging service is consistent with applicable AUCs;
- Generate and provide a certification or documentation of which qualified CDSM was consulted, the name and National Provider Identifier (NPI) of the OP and the extent to which a service was consistent with an AUC; and
- Provide aggregate feedback to OPs.³⁰

CMS finalized that CDSMs must apply to CMS to become qualified and must reapply every five years. CMS states that at the earliest, the first qualified CDSMs will be specified on June 30, 2017. CMS may remove a CDSM from its list of qualified CDSMs at any time if the CDSM fails to meet CMS' requirements.³¹

CMS finalized its proposal to codify certain statutory exceptions to AUC consultation for individuals with emergency medical conditions; for hospital inpatients; and for OPs for whom CMS determines on a case-by-case basis and subject to annual review that consultation would result in significant hardship (for example, where there is limited internet access). This last exception will be tied to the hardship exceptions under the EHR Incentive Program to the extent technically feasible, except that certain categorical exceptions under the EHR Incentive Program (for example, for anesthesiologists) would not apply to AUC consultation.

CMS will continue to implement the AUC program with OPs expected to begin reporting AUC consultation beginning January 1, 2018, and will address the consultation requirement further in the CY 2018 PFS rulemaking, including detailed information on how to report consultation on Medicare claims.³²

(14) MSSP

²⁹ *Id.* at 80408.

³⁰ *Id.* at 80418.

³¹ *Id.* at 80420.

³² *Id.* at 80424.

CMS finalized several proposals to refine the rules applicable to the MSSP. Generally, CMS finalized its proposals to:

- Change the quality measures used to assess Accountable Care Organization (ACO) quality performance and change the methodology used in quality validation audits, including how the results of these audits may affect an ACO's sharing rate;³³
- Revise definitions of some terminology used in quality assessment such as "quality performance standard" and "minimum attainment level";³⁴
- Increase flexibility of reporting under the PQRS and QPP for physicians who participate in Shared Savings Program ACOs, including allowing such physicians to report separately from the ACO;³⁵
- Implement a process whereby beneficiaries may voluntarily align with an ACO by designating an ACO professional as responsible for their overall care;³⁶
- Introduce beneficiary protections related to use of the Skilled Nursing Facility (SNF) 3-Day Waiver;³⁷ and
- Make technical changes to certain rules related to merged and acquired tax identification numbers and to the minimum savings rate (MSR) and minimum loss rate (MLR) that are used during financial reconciliation for ACOs that fall below 5,000 assigned beneficiaries.³⁸

³³ *Id.* at 80492.

³⁴ *Id.* at 80493.

³⁵ *Id.* at 80496, 80501.

³⁶ *Id.* at 80509.

³⁷ *Id.* at 80512.

³⁸ *Id.* at 80516-517.

**Comparison of Final CY 2017 and Q4 2016 Physician Fee Schedule
Payment Rates for Drug Administration Services**

CPT Code	Description	CY 2017 Final Payment		Q4 CY 2016 Payment		% Change	
		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
96360	Hydration iv infusion init	\$58.50	N/A	\$57.64	N/A	1.46%	N/A
96361	Hydrate iv infusion add-on	\$15.43	N/A	\$15.40	N/A	0.24%	N/A
96365	Ther/proph/diag iv inf init	\$69.98	N/A	\$69.82	N/A	0.24%	N/A
96366	Ther/proph/diag iv inf addon	\$19.02	N/A	\$18.98	N/A	0.24%	N/A
96367	Tx/proph/dg addl seq iv inf	\$31.22	N/A	\$30.79	N/A	1.38%	N/A
96368	Ther/diag concurrent inf	\$20.82	N/A	\$20.77	N/A	0.24%	N/A
96369	Sc ther infusion up to 1 hr	\$180.52	N/A	\$194.06	N/A	-7.50%	N/A
96370	Sc ther infusion addl hr	\$15.43	N/A	\$15.04	N/A	2.56%	N/A
96371	Sc ther infusion reset pump	\$69.27	N/A	\$73.40	N/A	-5.97%	N/A
96372	Ther/proph/diag inj sc/im	\$25.84	N/A	\$25.42	N/A	1.62%	N/A
96373	Ther/proph/diag inj ia	\$19.38	N/A	\$19.69	N/A	-1.61%	N/A
96374	Ther/proph/diag inj iv push	\$58.14	N/A	\$57.29	N/A	1.47%	N/A
96375	Tx/pro/dx inj new drug addon	\$22.61	N/A	\$22.56	N/A	0.24%	N/A
96376	Tx/pro/dx inj same drug adon	\$0.00	\$0.00	\$0.00	\$0.00	N/A	N/A
96379	Ther/prop/diag inj/inf proc	\$0.00	\$0.00	\$0.00	\$0.00	N/A	N/A
96401	Chemo anti-neopl sq/im	\$75.37	N/A	\$75.19	N/A	0.24%	N/A
96402	Chemo hormon antineopl sq/im	\$33.02	N/A	\$32.58	N/A	1.32%	N/A
96405	Chemo intralesional up to 7	\$82.90	\$30.86	\$82.71	\$30.43	0.24%	1.40%
96406	Chemo intralesional over 7	\$121.30	\$47.37	\$117.80	\$47.26	2.89%	0.24%
96409	Chemo iv push sngl drug	\$112.33	N/A	\$111.71	N/A	0.55%	N/A
96411	Chemo iv push addl drug	\$63.16	N/A	\$62.66	N/A	0.80%	N/A
96413	Chemo iv infusion 1 hr	\$139.61	N/A	\$136.41	N/A	2.29%	N/A
96415	Chemo iv infusion addl hr	\$28.71	N/A	\$28.64	N/A	0.24%	N/A
96416	Chemo prolong infuse w/pump	\$141.04	N/A	\$141.79	N/A	-0.53%	N/A
96417	Chemo iv infus each addl seq	\$66.04	N/A	\$63.02	N/A	4.57%	N/A
96420	Chemo ia push technique	\$107.67	N/A	\$106.34	N/A	1.23%	N/A
96422	Chemo ia infusion up to 1 hr	\$187.34	N/A	\$171.14	N/A	8.64%	N/A
96423	Chemo ia infuse each addl hr	\$76.08	N/A	\$79.13	N/A	-4.00%	N/A
96425	Chemotherapy infusion method	\$185.54	N/A	\$182.96	N/A	1.39%	N/A
96440	Chemotherapy intracavitary	\$789.91	128.840433	\$855.01	143.575243	-8.24%	-11.44%
96446	Chemotx admn prtl cavity	\$205.64	29.428734	\$202.65	29.359526	1.45%	0.24%
96450	Chemotherapy into cns	\$184.11	82.54401	\$184.03	82.34989	0.04%	0.24%
96521	Refill/maint portable pump	\$141.76	N/A	\$139.28	N/A	1.75%	N/A

96522	Refill/maint pump/resvr syst	\$115.56	N/A	\$114.22	N/A	1.16%	N/A
96523	Irrig drug delivery device	\$25.12	N/A	\$25.06	N/A	0.24%	N/A
96542	Chemotherapy injection	\$125.97	43.06644	\$122.45	42.96516	2.79%	0.24%