CMS RELEASES
CY 2017 PHYSICIAN FEE SCHEDULE
PROPOSED RULE

July 7, 2016—Today, the Centers for Medicare and Medicaid Services released the CY 2017 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 Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model proposed rule.

The proposed rule includes an estimated CY 2017 conversion factor of $35.7751, which reflects a budget neutrality adjustment of -0.51, the 0.5 percent update factor specified in MACRA, and an imaging MPPR adjustment of -0.07. Pgs. 233 and 786

The proposed rule is open for comment until September 6, 2016.

The display version of the rule can be downloaded from the Federal Register website at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-16097.pdf

Highlights of the Physician Fee Schedule include:

- **Appropriate Use Criteria:** CMS is requiring that practitioners consult appropriate use criteria (AUC) at the time advanced diagnostic imaging is ordered and that imaging suppliers will be required to report this information on claims for all services paid under the MPFS, OPPS, and ASC systems. CMS also is proposing changes to some of the definitions associated with AUC including that for clinical decision support mechanisms (CDSMs). CMS identifies an initial list of eight priority clinical areas (see TABLE 34). The agency is soliciting comments on other potential clinical areas for use at a future time. The proposal includes several requirements that CDSMs would have to fulfill in order to be qualified, including ones related to data privacy and security as well as the method through which ordering professionals could report. Pgs. 525-555

- **Telehealth:** For CY 2017 CMS is proposing several changes to their telehealth services policy. The Agency is proposing to allow telehealth monitoring for ESRD services for dialysis, advance care planning, and critical care consultations. Pgs. 67-88
• **Misvalued Codes**: CMS identifies 83 codes that satisfy their criteria and are being proposed as potentially misvalued for CY 2017. These codes are contained in TABLE 7. Pgs. 92-102

• **Code Values**: Proposed CY 2017 values for several new, revised, and potentially misvalued codes are included in TABLE 23. TABLE 24 of the proposed rule lists proposed codes with direct practice expense (PE) input recommendations that have been accepted without refinements. TABLE 25 lists proposed codes with direct PE input recommendations that have been accepted with refinements. Pgs. 374-495

• **X-Rays**: CMS is proposing that beginning on January 1, 2017 a new modifier XX would be required to be reported on the technical component of claims for X-rays taken using film. This would allow the agency to implement a new law that requires a 20% reduction for the technical component of X-ray services that use film. Pgs. 231-232

• **Mammography**: CMS proposes to adopt the RUC values for three new CPT codes for mammography using digital images (through computer aided detection (CAD)). CMS is proposing to not adopt new resource inputs for the codes for CY 2017 but to crosswalk to the PE RVU technical component for existing CAD G-codes. CMS provides a list of proposed direct and indirect resource inputs for these services and is soliciting comments on the appropriateness of their lists. Pgs. 330-335.

• **Special Radiation Treatment**: CMS is seeking feedback to clarify the description of physician work services versus practice expense services for CPT code 77470. The agency is considering creating two G-codes for the procedure—one describing the work and the other describing the PE portion. P. 326; CMS is also proposing changes to the RVUs for Interstitial Radiation Source Codes (Pgs. 277-278) and Radiation Treatment Devices (Pgs. 325-326).

• **Flow Cytometry**: CMS is proposing to accept some RUC proposed changes related to CPT codes for flow cytometry procedures and to reject others. The agency is soliciting comments on the need to consolidate two codes that currently describe the technical component of flow cytometry and is proposing to remove some of the time associated with input of information related to these procedures while also proposing to not add additional equipment use time. Pgs. 326-330.

**Diabetes Prevention Program Model**

CMS is proposing to expand its diabetes prevention model and is soliciting comments on several areas including enrollment of new suppliers, reimbursement, determining beneficiary eligibility, sites of service, timing of the expansion, and quality monitoring and reporting. Pgs. 621-638
Medicare Shared Savings Program (MSSP)

- CMS is proposing several changes and other revisions to policies related to the quality measures and quality performance standard for MSSP ACO participants, including the following (Pg. 639):
  - Changes to the measure set used in establishing the quality performance standard;
  - Changes to the methodology used to validate quality data submitted by the ACO along with penalties that may apply if the audit match rate is less than 90 percent;
  - Revisions to the use of the terms “quality performance standard” and “minimum attainment level” in the regulation text;
  - Revisions related to use of flat percentages to establish quality benchmarks; and
  - Alignment with policies proposed in the Quality Payment Program (QPP) proposed rule.

- CMS proposes modifications to the Medicare Shared Savings Program to update the quality measures set to align it with the proposals for the Quality Payment Program measures and to reduce provider reporting burden and increase alignment with core measure set recommendations from the Core Quality Measures Collaborative. These include:
  (See Table 36 for details; page 651)

Additions:
- **ACO-12 Medication Reconciliation Post-Discharge (NQF #0097).** The ACO-12 Medication Reconciliation measure was previously in the Shared Savings Program measure set, however, it was replaced with ACO-39, Documentation of Current Medications in the Medical Record. The Core Quality Measures Collaborative, in coordination with providers and stakeholders, determined the original Medication Reconciliation measure would be more appropriate for alignment across quality reporting initiatives. CMS proposes to add this measure to the Care Coordination/Patient Safety domain.
- **ACO-44 Use of Imaging Studies for Low Back Pain (NQF #0052).** CMS proposes adding this measure in the Care Coordination/Patient Safety domain to address a gap in measures related to resource utilization and align with the ACO measures recommended by the Core Quality Measures Collaborative core measure set. CMS proposes to add this measure to the Care Coordination/Patient Safety domain.
- **ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91).** This is a composite measure, currently used in the Physician Value-Based Payment Modifier, which includes PQIs reporting on admissions related to dehydration, bacterial pneumonia, and urinary tract infections. CMS proposes to add this measure to the Care Coordination/Patient Safety domain.

Removal/Replacement:
- **ACO-9 AHRQ Ambulatory Sensitive Conditions (ASC) Admission measure on COPD or Asthma in Older Adults/ACO-10 AHRQ Ambulatory Sensitive Conditions (ASC) Admission measure on Heart Failure**
- **ACO-39** Documentation of Current Medications in the Medical Record (replaced with ACO-12, above)
- **ACO-21** Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented
- **ACO-31** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **ACO-33** Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%).

- As a result of the proposed measure changes, each of the four domains will include the following number of quality measures (See Table 37 for details; page 654):
  - Patient/Caregiver Experience of Care – 8 measures
  - Care Coordination/Patient Safety – 10 measures
  - Preventive Health – 8 measures
  - At Risk Population – 5 measures (3 individual measures and a 2-component diabetes composite measure)

You may access the CMS fact sheets and press releases on the proposed physician rule at:

Fact sheet: [Proposed Rule Policies](#)

Fact sheet: [Diabetes Prevention Program](#)

[Press release](#)

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