The Centers for Medicare & Medicaid Services (CMS) published the final 2017 Medicare physician fee schedule (PFS) in the Federal Register on Nov. 15, 2016. The regulation finalized policies that affect Medicare Part B payments for physician services furnished on or after Jan. 1, 2017 and set the calendar year (CY) 2017 PFS conversion factor at $35.8887. The CY 2017 national average anesthesia conversion factor is $22.0454. MGMA created this analysis exclusively for members to help them understand the new and updated policies in place for the Medicare program next year.

Medicare Part B beneficiary cost-sharing

Medicare Part B’s monthly premiums for one-third of Medicare beneficiaries will increase about 10% in 2017 to $134 from $121.80 in 2016. About 70% of beneficiaries will be “held harmless” from the increase due to a lower than usual Social Security cost-of-living adjustment. For beneficiaries held harmless, the average 2017 premium will be about $109, up from $104.90. The annual deductible for all Medicare Part B beneficiaries will be $183 in 2017, compared to $166 in 2016.

Payment and RVU updates

CMS estimates the CY 2017 PFS conversion factor will be $35.8887, which includes a 0.5% update as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The conversion factor calculation, included below, also factors in adjustments due to the multiple procedure payment reduction (MPPR) for advanced imaging services and budget neutrality, which is triggered when CMS adjusts relative value units (RVUs) to the extent that PFS expenditures would differ by more than $20 million.

Due to laws passed in recent years, the conversion factor was also affected by whether CMS met an annual target for reductions in PFS expenditures by adjusting the RVUs of codes identified as misvalued by CMS. For 2017, the annual target was 0.5%. CMS estimated the net adjustment to misvalued codes in 2017 was 0.32%, which falls short of the 0.5% target. Therefore, the difference between the net adjustment and the target was removed from the overall PFS pool, and all payments will be reduced 0.18% through a lower conversion factor, displayed below.
TABLE 50: Calculation of the Final CY 2017 PFS Conversion Factor

<table>
<thead>
<tr>
<th>Conversion Factor in effect in CY 2016</th>
<th>35.8043</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Factor</td>
<td>0.50 percent (1.0050)</td>
</tr>
<tr>
<td>CY 2017 RVU Budget Neutrality Adjustment</td>
<td>-0.013 percent (0.99987)</td>
</tr>
<tr>
<td>CY 2017 Target Recapture Amount</td>
<td>-0.18 percent (0.9982)</td>
</tr>
<tr>
<td>CY 2017 Imaging MPPR Adjustment</td>
<td>-0.07 percent (0.9993)</td>
</tr>
<tr>
<td>CY 2017 Conversion Factor</td>
<td>35.8887</td>
</tr>
</tbody>
</table>

Additionally, CMS finalized annual updates to malpractice (MP) RVUs. Overall MP RVUs comprise a much smaller portion (approximately 4%) of Medicare payments in comparison to work or practice expense (PE) RVUs.

The changes finalized in the PFS will have a varied impact on payments depending on specialty. For example, independent laboratories will have their overall payments reduced by 5% in 2017. In contrast, there will be modest payment increases of 1% for many specialties, including allergy/immunology, family practice, general practice, geriatrics, internal medicine, and nephrology. Table 52 displays the estimated impact on total allowed charges by specialty resulting from the finalized payment changes.

**Misvalued and revalued codes**

CMS continues its ongoing efforts to evaluate and modify potentially misvalued codes and adjust RVUs. CMS pared back its proposal to review 83 codes for 0-day global surgical codes as potentially misvalued. Instead, the agency will review 19 codes, listed in Table 8. Using 2015 claims data, CMS determined these codes were billed more than 50% of the time with an evaluation and management (E/M) code with Modifier 25. CMS believes this may indicate a valuation problem, as the global period is intended to include all routine care associated with the service. CMS seeks recommended values of these codes from the American Medical Association’s Relative Value Update Committee and other stakeholder groups.

Previously, the agency identified more than 400 primarily endoscopic services that include moderate sedation as an inherent part of furnishing the procedure as potentially misvalued. The agency noted that anesthesia is increasingly being separately reported for these procedures. For CY 2017, CMS unbundled moderate sedation from these services and will require sedation to be separately reported using designated CPT codes when furnished. This CMS table lists the impacted codes and displays the new RVUs for these services.

**Medicare telehealth services**

CMS added the following services to the 2017 approved list of Medicare telehealth services:

- Advance care planning (ACP) CPT codes 99497 and 99498
• End-stage renal disease (ESRD) home dialysis CPT codes 90967, 90968, 90969 and 90970
• Critical care evaluation and management using new Medicare G-codes G0508 and G0509, with finalized work RVUs of 4.0 and 3.86 respectively

For a complete list of 2017 Medicare telehealth services, download this chart.

Additionally, CMS adopted a new place of service (POS) code for telehealth services (POS 02) for use by a distant site provider for services furnished on or after Jan. 1, 2017. CMS will use the facility PE RVU to pay for telehealth services reported by practitioners with the telehealth POS code.

The new telehealth POS code will not apply to the originating site where the patient is located. The originating site facility fee will be statutorily increased from $25.10 to $25.40 in 2017.

**Geographic practice cost indices (GPCIs)**

CMS is required by law to adjust payments under the PFS to reflect differences in practice costs using GPCIs for each component of PFS payment - work, PE and MP. In accordance with the law, CMS finalized GPCI changes to be phased-in during 2017 and 2018.

The Protecting Access to Medicare Act of 2014 (PAMA) requires CMS to use new locality definitions for California beginning in 2017. The fee schedule areas in California must be based on either Metropolitan Statistical Areas (MSAs) designated by the Office of Management and Budget and paid under a new methodology, or a single rest-of-state area.

CMS finalized the proposed California locality implementation plan. Starting in 2017, any California area that is not designated as an MSA will begin a transition period that blends the new MSA-based locality structure with the current locality structure using a phased-in approach. Payment in transition areas will be phased in over six years, from 2017-2021, using a weighted sum of the GPCIs calculated by the new MSA methodology and the GPCIs calculated using the current structure. The phased-in calculation will begin with one-sixth MSA structure, which will increase by one-sixth increments over six years until the old structure is phased-out completely by 2022. For the first year, transition areas, which account for 50 of California’s 58 counties, will be held harmless if the new phased-in calculation results in a decrease in GPCI value. The remaining eight counties that are not designated as transition areas (Orange, Los Angeles, Alameda, Contra Costa, San Francisco, San Mateo, Santa Clara and Ventura) could see a slight decrease in GPCI values.

CMS will also revise the methodology used to calculate GPCIs in the U.S. territories for consistency. This revision will increase overall PFS payments in Puerto Rico.
Transition from traditional x-ray imaging to digital radiography

The Consolidated Appropriations Act of 2016 (CAA) required a 20% reduction for technical component (TC) payment of an x-ray taken using film beginning in 2017. CMS finalized the establishment of a new modifier "FX" to be reported on claims for film x-rays. The modifier is required on claims for the TC of the x-ray service, including when the service is billed globally. Beginning Jan. 1, 2017, all claims for imaging services that are film x-rays must include modifier "FX" and the use of this modifier will result in a 20% reduction for the TC of the x-ray service.

Procedures subject to the MPPR and the Hospital Outpatient Prospective Payment System (OPPS) cap

The CAA revised the MPPR 25% reduction on the professional component of advanced imaging services down to 5%. CMS finalized the implementation of this provision for services furnished on or after Jan. 1, 2017.

Reporting requirements for global surgical codes

In MACRA, Congress prohibited CMS from moving forward with its previously finalized plan to eliminate the use of 10- and 90-day global surgical codes. However, MACRA requires the agency to begin collecting data on resources used in furnishing these services in 2017 and to use that data to improve the payment accuracy of these services by 2019.

In response to the concerted advocacy efforts of MGMA and other stakeholders, CMS significantly mitigated its burdensome and overly complex proposal to collect data on services furnished during global surgical periods. Rather than require claims-based reporting of the number and level of pre- and post-operative services furnished during 10- and 90-day global surgical codes using new G-codes assigned in 10-minute increments, CMS will require surgeons and practitioners in medium and large practices in selected states to report CPT code 99024 for each post-operative visit during global surgical periods.

Providers who practice in groups with 10 or more practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island will be required to report this data. Reporting will be limited to high-volume global surgical codes, a list of which will be released on the CMS website. Additionally, CMS delayed the reporting start date from Jan. 1, 2017 until July 1, 2017 to give practices time to adjust EHR and billing software and train staff. CMS will not withhold payment for non-compliance with these reporting requirements at this time, but may do so in the future.

CMS will also conduct a survey of 5,000 physicians about the activities involved in and the resources used in providing pre- and post-operative visits. The agency will separately collect data on services furnished during global surgical periods by accountable care organizations (ACOs) using a survey instrument.
New payments for collaborative care and care management services

CMS finalized a number of payment changes designed to increase coverage for primary care, care management and other cognitive services. The agency adopted CPT codes 99358 and 99359 to pay separately for non-face-to-face prolonged E/M services before or after direct patient care, which are currently considered to be bundled under the PFS, beginning Jan. 1, 2017. CMS also finalized creation of code G0505 for separate payment for assessing and creating a care plan for beneficiaries with a cognitive impairment (e.g., dementia).

Additionally, CMS established three new G-codes (G0502, G0503, G0504) to separately pay for behavioral health integration (BHI) services included in the Psychiatric Collaborative Care Model (CoCM). In CoCM, care is provided by a primary care team, consisting of a primary care provider and care manager who work in collaboration with a psychiatric consultant, and includes structured care management with regular assessments of clinical status using validated tools and modifications of treatment. Patients are treated for an episode of care, beginning when the behavioral health care manager engages in care of the patient under appropriate supervision of the treating physician and ending with attaining or failure to attain treatment goals or lack of engagement over a consecutive six-month period. CMS also adopted a new G-code (G0507) to pay for BHI services furnished outside of the CoCM.

The agency did not, however, finalize its proposal to establish a new add-on G-code to pay practitioners for the additional resources involved in furnishing appropriate care during E/M visits for patients with mobility impairments. Many stakeholders, including MGMA, raised concerns about the unintended consequences of this proposal, including a potential appearance of discrimination against people with disabilities by charging them an additional co-payment for an office visit or fraud and abuse implications through routine waiver of this out-of-pocket expense. Instead, CMS will engage with interested providers and beneficiaries to explore improvements in payment accuracy for care of people with disabilities in the future.

Improvements to chronic care management (CCM) payment and billing requirements

In response to MGMA advocacy efforts, CMS mitigated the extensive and onerous requirements to billing CCM services. Specifically, CMS finalized the following improvements:

- Limiting the face-to-face initiating visit requirement to CCM patients who are new or who have not been seen within the past year, rather than all beneficiaries receiving CCM services.
- Creating a G-code (G0506) as an add-on payment for initiating visits that involve care planning beyond the scope of the initiating visit.
- Removing the requirement that practitioners furnishing CCM after hours must have access to the electronic care plan.
- Permitting billing practitioners to share electronic care plan information with practitioners furnishing after-hours urgent care on a timely basis rather than mandating
24/7 access to the electronic care plan. CMS will also allow transmission of the care plan by fax.

- Modifying the requirement to share clinical summaries during transitions of care to require the billing practitioner to share “continuity of care” documents.
- Providing more flexibility to practices to determine the best format for sharing a care plan with a patient or a patient’s caregiver.
- Allowing documentation of the beneficiary’s consent in the medical record rather than requiring a separate written agreement.
- Eliminating the requirement to use certified EHR technology to document communication with home- and community-based providers regarding the beneficiary’s psychosocial needs and functional deficits.

CMS also adopted CPT codes 99487 and 99489 to cover more complex and time-intensive CCM services. These services have the same billing requirements as the existing CCM code, and therefore can only be billed once per calendar month by one practitioner who provides care management for the beneficiary in that month.

**Therapy caps**

As required by statute, CMS applies annual, per beneficiary limitations, or “therapy caps,” on expenses for outpatient therapy services under Medicare Part B. There is one therapy cap for physical therapy (PT) and speech-language pathology (SLP) services combined and a separate therapy cap for outpatient occupational therapy (OT) services. CMS finalized a slight increase in the therapy cap amount to $1,980 in 2017 from $1,960 in 2016. Congress has repeatedly extended an exceptions process to the therapy caps and did so most recently in MACRA. Without further congressional intervention, the exceptions process will expire on Dec. 31, 2017.

Under existing statutory requirements, CMS applies a manual medical review process to claims when a beneficiary’s incurred expenses exceed $3,700 for PT and SLP services or $3,700 for OT services. As a result of MACRA, therapy claims exceeding the $3,700 thresholds no longer trigger automatic manual review. Rather, CMS conducts targeted medical reviews of these claims based on factors, such as high claims denial rates for therapy services or outlier billing practices. Without further congressional intervention, this review process will also expire on Dec. 31, 2017.

**CCM and transitional care management (TCM) in rural health clinics (RHCs) and federally qualified health centers (FQHCs)**

CMS revised the CCM and TCM billing rules to allow auxiliary clinical staff to furnish these services under general – rather than direct – supervision of an RHC or FQHC practitioner. The agency believes this change will enable RHCs and FQHCs to contract with third parties to furnish aspects of CCM and TCM services. CMS also finalized a number of changes to the scope of service requirements for furnishing CCM services in an RHC or FQHC to align with the changes made for furnishing these services in a physician office setting.
Appropriate use criteria (AUC) for advanced diagnostic imaging services

In the 2016 PFS, CMS took the first step in establishing a program that requires the use of AUC for advanced diagnostic imaging. Under PAMA, CMS is required to begin identifying mechanisms for consultation with AUC by April 1, 2016 and begin mandating the use of AUC both ordering and furnishing professionals by Jan. 1, 2017. This year, CMS finalized proposals to establish eight priority clinical areas for AUC consultation, to define the requirements of qualified clinical decision support mechanisms (CDSMs), and create exceptions for ordering professionals for whom consultation with AUC would pose a significant hardship. The agency notes that it will not meet the statutory timeline that ordering and furnishing professionals must consult qualified CDSMs by Jan. 1, 2017. At the earliest, the first qualified CDSM will be specified on June 30, 2017. CMS anticipates that some ordering professionals could begin consulting AUC shortly thereafter and expects furnishing professionals will be required to begin reporting Jan. 1, 2018. CMS intends to propose and finalize additional procedures in the 2018 PFS.

Prohibition on billing Qualified Medicare Beneficiary (QMB) individuals for cost-sharing

CMS reminds providers that federal law prohibits them from collecting Medicare Part A and Part B deductibles, coinsurance or copayments from beneficiaries enrolled in the QMB Program.

Payment recoupment or offset to providers sharing same tax identification number (TIN)

CMS finalized a change to its notification process for overpayments that may be recouped or offset. Specifically, in cases where there are multiple entities sharing the same TIN and each may be liable for the overpayment, CMS will only notify the entity responsible for the overpayment. The agency plans to engage in provider outreach and education prior to implementation of this change.

Medicare Advantage (MA) provider enrollment

CMS finalized a number of proposals related to MA, including requiring physicians to be enrolled in Medicare in order to provide services and contract with MA organizations. If a physician is not enrolled in Medicare as an approved status, the MA organization may be subject to sanctions including contract termination. Additionally, CMS will prohibit MA organizations from paying providers that are excluded by the Department of Health and Human Services Office of Inspector General or revoked from the Medicare program. These provisions are effective the first day of the next plan year that begins two years from Nov. 15, 2016, the date of publication of the final rule.

Release of Part C MA bid pricing data and Part C and Part D medical loss ratio data

CMS finalized a proposal to make public the bid data for MA plans and medical loss ratios submitted by MA plan sponsors and Part D drug plan sponsors in order to remain consistent with
the Administration’s goal of transparency. The agency will release data associated with these bids and medical loss ratios on an annual basis. The data would be at least five years old and would exclude any proprietary information.

**Expansion of the Diabetes Prevention Program (DPP) model**

CMS finalized expansion of the DPP into Medicare beginning Jan. 1, 2018 and will refer to the new model as the Medicare Diabetes Prevention Program (MDPP). Although CMS settled a number of key components of the model to allow practices and others times to prepare for the 2018 implementation, the agency deferred a number of key model specifics, such as payment information, to future rulemaking. MGMA will continue to advocate for policies that support group practices in furnishing these services.

As finalized, MDPP will allow organizations meeting the enrollment criteria to submit claims for payment tied to beneficiary educational sessions and achievement of weight loss goals. All interested organizations, including those already enrolled in Medicare, must obtain Diabetes Prevention Recognition Program recognition from the Centers for Disease Control and Prevention and separately enroll in Medicare as an MDPP supplier. Upon enrollment, MDPP organizations must provide a list of coaches that will furnish MDPP services. CMS anticipates enrollment will begin in late 2017 and will engage in provider outreach and education in advance of enrollment.

MDPP would be available to beneficiaries who are enrolled in Medicare Part B and meet pre-diabetic indicators, such as certain body mass index, fasting plasma glucose and hemoglobin A1C metrics. Eligible beneficiaries would only be able to receive MDPP services once in their lifetime, and ongoing maintenance sessions are only available to those patients who maintain their weight loss. MDPP services would be designated as preventive services, and Medicare cost-sharing would not apply.

**Improving payment accuracy of diabetes self-management training (DSMT)**

CMS continues to seek input on ways to eliminate barriers to access of DSMT services, which are intended to educate beneficiaries in successful self-management of diabetes. Recent research found that only 5% of Medicare beneficiaries with newly diagnosed diabetes used DSMT services. CMS also plans to address a number of concerns in subregulatory guidance, including confusion about the credentials of individuals who can furnish these services and where these services may be delivered.

**Stark Law Updates**

CMS finalized a requirement that rental charges for office space or equipment must not be determined using a formula based on per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee. CMS notes there is not an absolute prohibition on rental charges based on units of service furnished. Per-unit of
service rental charges for the rental of office space or equipment are permissible in instances where the referral for the service to be provided in the rented office space or using the rented equipment did not come from the lessor. This update is a clarification made due to a recent court case, Council for Urological Interests v. Burwell, 790 F.3d 212 (D.C. Cir. 2015).

Value-Based Payment Modifier (VM) determinations when “unanticipated issues arise”

CMS finalized standardized procedures for how VM quality and cost scores would be affected for the 2017 and 2018 payment years in cases where an informal review request overturns the status of group practice’s automatic VM determination or if widespread data accuracy issues arise. These policies are summarized in Table 44. In any scenario, CMS would apply the additional +1.0x adjustment to practices deemed to care for high-risk beneficiaries, if appropriate.

Medicare Shared Savings Program (MSSP)

Modifications to quality measures

In an effort to align MSSP quality measures with those recommended by the Core Quality Measures Collaborative and the Quality Payment Program final rule, CMS finalized a number of changes to ACO quality measures, including adding, replacing and removing certain measures. Table 42 reflects these most recent changes and lists the final MSSP quality measure set that will be used to assess quality performance starting with the 2017 performance year, as well as the timeline for phasing in the evaluation of new measures based on performance. Notably among these changes, CMS modified ACO-11 to assess CEHRT use by all eligible clinicians participating in the ACO, rather than exclusively primary care providers. Any future changes to web interface measures will be automatically applied to MSSP ACO quality measures.

Reporting data outside of the ACO for purposes of PQRS and the VM

For the final two performance years of PQRS and the VM, CMS will allow eligible professionals (EPs) participating in ACOs an opportunity to report quality data outside of the ACO for purposes of satisfying PQRS and VM requirements and avoiding a penalty in the event that the ACO fails to report adequate data on their behalf. Because the reporting period for 2015 has already passed, CMS will allow providers to get credit towards both the 2015 and 2016 reporting years by submitting 2016 PQRS data directly to CMS. In such a scenario, impacted providers and groups would automatically receive “average” quality and cost scores under the VM. Any quality data reported for these purposes will not alter or impact an ACO’s quality assessment under the MSSP.

Voluntary beneficiary assignment

In a modified final policy, CMS will take beneficiary attestations into account and voluntarily align beneficiaries annually and prospectively to ACOs participating in all MSSP tracks at the
beginning of each performance year, provided the beneficiary is eligible for assignment. Voluntary assignment would supersede assignment based on claims. CMS will provide further operational details regarding implementation process and timelines through subregulatory guidance and outreach. The agency intends to begin incorporating voluntary designations in the 2018 performance year, but may delay if an automated system is not available in time.

Other technical changes and clarifications

- In the event a Track 2 or 3 MSSP ACO falls below 5,000 assigned beneficiaries at the time of financial reconciliation, the ACO will be eligible to share in savings (or losses) at a level consistent with the minimum savings or loss rate chosen by the ACO at the start of the agreement period.
- Merged/acquired TINs will not be required to remain Medicare enrolled after they have been merged or acquired and are no longer used to bill Medicare.
- A new, 90-day grace period for the SNF 3-day rule waiver for Track 3 MSSP participants will allow a beneficiary who was prospectively assigned to a waiver-approved ACO, but subsequently unassigned during the performance year, to receive covered SNF services if he/she was admitted within 90 days of CMS delivering the beneficiary exclusions list to the ACO, provided such services would otherwise be covered under the waiver. In light of these recently finalized changes, SNF 3-day waiver confirmations for Track 3 ACOs for the 2017 performance year may be delayed, but are anticipated by April 2017.
- CMS finalized four modifications to the audit process (outlined below) to increase statistical rigor, streamline audit operations, and more closely align MSSP audits with other CMS quality program audits. The following changes take effect beginning with audits for the 2016 performance year:
  - Increase the number of records audited per measure to achieve a higher level of statistical confidence.
  - Conduct the quality validation audit in a single step, rather than the current multi-phased process.
  - Assess an ACO’s audit mismatch rate collectively across all measures, rather than at the measure level and aggregating the results.
  - Should an ACO fail its audit, CMS may require a corrective action plan and adjust its overall quality score proportional to its audit performance, though the agency will retain its discretion not to apply this adjustment “in certain unusual circumstances.”