2017 Proposed Medicare Physician Fee Schedule Analysis
Exclusively for MGMA Members

The Centers for Medicare & Medicaid Services (CMS) published the proposed 2017 Medicare fee schedule for physician services on July 7, 2016. The regulation discusses policies that affect Part B payments for physician services furnished on or after Jan. 1, 2017. CMS will accept public comments on the rule until Sept. 6, 2016 and intends to issue a final rule by early November. MGMA will submit formal comments and share them with members through the MGMA Washington Connection newsletter.

Payment and RVU updates

CMS estimates that the 2017 Medicare physician fee schedule (PFS) conversion factor will be $35.7751, 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.

**TABLE 41: Calculation of the Proposed CY 2017 PFS Conversion Factor**

| Conversion Factor in effect in CY 2016 | 35.8043 |
| Update Factor                     | 0.50 percent (1.0050) |
| CY 2017 RVU Budget Neutrality Adjustment | -0.51 percent (0.9949) |
| CY 2017 Target Recapture Amount   | 0 percent (1.0000) |
| CY 2017 Imaging MPPR Adjustment   | -0.07 percent (0.9993) |
| CY 2017 Conversion Factor         | **35.7751** |

Additionally, CMS proposes 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.

CMS also proposes changes that could have a significant impact on the payment for certain specialties. For example, if finalized, proposals would result in overall payment reductions of 5% for independent laboratories and 7% for interventional radiologists. In contrast, other proposals would result in overall payment increases of 3% for family practice and 2% for allergy/immunology, endocrinology, general practice, geriatrics, hematology/oncology, internal medicine, pediatrics and rheumatology. **Table 43** displays the estimated impact on total allowed charges by specialty resulting from the proposed payment changes.
Misvalued and revalued codes

CMS continues its ongoing efforts to evaluate and modify potentially misvalued codes and adjust RVUs. CMS proposes 83 0-day global surgical codes as potentially misvalued based on the fact that they are billed with an E/M service using Modifier 25 at least 50% of the time. These codes have not been reviewed in the last 5 years and have greater than 20,000 allowed services. CMS seeks public input on appropriate valuation of these codes, listed in Table 7.

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. This year, CMS proposes to unbundle moderate sedation from these services and require sedation be separately reported when furnished.

Due to laws passed in recent years, physician payment may also be affected by whether CMS meets annual targets for reductions in PFS expenditures by adjusting the RVUs of codes identified as misvalued by CMS. For 2017, the annual target is 0.5%. CMS estimates the net readjustment to misvalued codes in 2017 would be 0.51%, exceeding the 2017 annual target. Because CMS would exceed the target, the reduced expenditure of 0.01% would be redistributed in the PFS in a budget neutral manner. If the misvalued code adjustments fall below the 0.5% target in the final rule, the difference between the net adjustment and the target will be removed from the overall PFS pool and all payments will be reduced through a lower conversion factor.

Medicare telehealth services

CMS proposes to make the following additions 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 Medicare G-codes GTTT1 and GTTT2, valued at work RVUs of 4.0 and 3.86 respectively.

CMS proposes new critical care G-codes to account for the resource cost of providing intensive telehealth consultation services, initial and subsequent, when a qualified health professional has an in-person responsibility to a critically ill patient but the patient would also benefit from additional remote critical care consultation.

Additionally, CMS is proposing to introduce a place of service (POS) code specifically designated for telehealth services to clarify confusion concerning whether to report the POS where the distant site provider is located or the POS where the patient is located. Establishment of POS codes is managed by a POS Workgroup and is not contingent on PFS rulemaking.
however, if created, the telehealth POS code would be required on telehealth claims as early as January 2017 and paid by Medicare using the facility PE RVU.

**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, practice expense and malpractice. In accordance with the law, CMS is proposing new GPCIs 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.

Any California area that is not designated as an MSA would 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 would 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 would begin with one-sixth MSA structure, which would 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 would result 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) may see a slight decrease in GPCI values.

CMS also proposes to revise the methodology used to calculate GPCIs in the U.S. territories for consistency. This revision would increase overall PFS payments in Puerto Rico.

**Transition from traditional x-ray imaging to digital radiography**

The Consolidated Appropriations Act of 2016 required a 20% reduction for technical component (TC) payment of an x-ray taken using film beginning in 2017. CMS proposes to require a new modifier on claims for film x-rays. The modifier would be required on claims for the TC of the x-ray service, including when the service is billed globally. CMS indicates further discussions on required reductions for x-rays taken using computed radiography technology will be included in future rulemaking, since these reductions are not scheduled to begin until 2018.

**Procedures subject to the MPPR and the OPPS cap**

The Consolidated Appropriations Act revised the MPPR 25% reduction on the professional component of advanced imaging services down to 5%. CMS proposes to implement 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 to value these services in 2017 and to use that data to improve payment accuracy of these services by 2019.

CMS proposes a three-pronged approach to collect data on the frequency and input of global surgical codes. First, CMS would require claims-based reporting of the number and level of pre- and post-operative services furnished for 10- and 90-day global services. Specifically, CMS proposes to require practitioners to report new G-codes that distinguish between the setting of care (e.g., inpatient, physician office, or electronically via email or telephone) and whether the services are furnished by a physician or by their clinical staff. Physicians would be required to report the G-codes for every 10 minutes dedicated to a patient before and after a procedure or surgery.

Second, CMS proposes to survey 5,000 physicians about the activities involved in and the resources used in providing pre- and post-operative visits. Third, CMS proposes to conduct an in-depth study that would include direct observation of the pre- and post-operative care delivered at a number of sites, such as accountable care organizations (ACOs). CMS states they are not proposing to withhold payment for non-compliance at this time, but may do so in the future.

New payments for primary care and care management services

CMS proposes a number of payment changes designed to increase coverage for primary care, care management, and other cognitive services. The agency proposes to adopt 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.

The agency would also establish several new G-codes to pay for additional primary care and care coordination services beginning in 2017. For instance, CMS proposes to create code GPPP6 for separate payment for assessing and creating a care plan for beneficiaries with a cognitive impairment (e.g., dementia).

To improve access and quality of care for patients with mobility-related disabilities, CMS also proposes a new add-on G-code (GDDD1) to pay practitioners for the additional resources involved in providing appropriate care during E/M visits for patients with mobility impairments. For example, these visits can require more physician and clinical staff time to assist the patient in carefully moving and may involve specialized equipment, including wheelchair accessible scales and movable exam tables.

Additionally, CMS proposes to establish three new G-codes (GPPP1, GPPP2, GPPP3) to separately pay for behavioral health integration services included in the Psychiatric Collaborative Care Model (CoCM). In CoCM, care is provided by a primary care team, consisting of a primary care physician, a behavioral health specialist, and other healthcare professionals.
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 attainment or failure to attain treatment goals or lack of engagement over a consecutive six-month period. CMS also proposes to create a new G-code (GPPPX) to pay for behavioral health integration services furnished outside the CoCM.

**Improvements to chronic care management payment and billing requirements**

In response to MGMA advocacy, CMS proposes to mitigate the extensive and onerous requirements to bill chronic care management (CCM) services. Specifically, CMS would make the following improvements:

- Limit 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. Additionally, CMS proposes to create an add-on payment for initiating visits that involve care planning beyond the scope of the initiating visit.
- Remove the requirement that practitioners furnishing CCM after hours must have access to the electronic care plan.
- Permit 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 would also allow transmission of the care plan by fax.
- Modify the requirement to share clinical summaries during transitions of care to require the billing practitioner share “continuity of care” documents.
- Provide more flexibility to practices to determine the best format for sharing a care plan with a patient or a patient’s caregiver.
- Allow documentation of the beneficiary’s consent in the medical record rather than requiring a written agreement.
- Eliminate 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 proposes to cover more complex and time-intensive CCM services by adopting CPT codes 99487 and 99489. These codes would have the same billing requirements as the existing CCM code, and therefore can only be reported once per calendar month by one practitioner who provides care management for the beneficiary in that month.

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

CMS proposes to revise the CCM and TCM billing rules to allow auxiliary staff to furnish these services under general – rather than direct – supervision of an RHC or FQHC practitioner. The
agency believes this change would enable RHCs and FQHCs to contract with third parties to furnish aspects of CCM and TCM services.

**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 identify mechanisms for consultation with AUC by April 1, 2016 and begin mandating the use of AUC by both ordering and furnishing professionals on Jan. 1, 2017. This year, CMS proposes to set up AUC for eight priority clinical areas, to define the requirements of clinical decision support mechanisms (CDSMs), and establish 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 and anticipates that professionals will begin reporting on AUC as early as Jan. 1, 2018.

**Prohibition on billing Qualified Medicare Beneficiary (QMB) individuals for Medicare 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.

**Recoupment or offset of payments to providers sharing the same tax identification number (TIN)**

CMS proposes to clarify its notification process for overpayments that may be recouped or offset by CMS. Specifically, in cases where there are multiple entities sharing the same TIN, each would be liable for the overpayment, although CMS would only notify the entity responsible for the overpayment.

**Medicare Advantage provider enrollment**

CMS makes a number of proposals related to Medicare Advantage (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 could face sanctions including contract termination. Additionally, CMS proposes to prohibit MA organizations from paying providers that are excluded by the OIG or revoked from the Medicare program. The MA organization would be required to notify the beneficiary in writing that no future payment will be made to the provider. The agency proposes to make these provisions effective the first day of the next plan year that begins two years from the date of publication of the final rule.
Release of Part C Medicare Advantage bid pricing data and Part C and Part D medical loss ratio data

CMS proposes to make public the bid data for Medicare Advantage (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 plans to release data associated with these bids 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 proposes to expand the Diabetes Prevention Program into Medicare beginning Jan. 1, 2018 and to refer to the new model as the Medicare Diabetes Prevention Program (MDPP). CMS outlines the framework for the MDPP, which would allow DPP organizations recognized by the Centers for Disease Control to submit claims for payment tied to beneficiary educational sessions and achievement of weight loss goals. The proposed MDPP services and payments are included in Table 35. CMS proposes to allow DPP organizations to provide MDPP services in-person or virtually using remote technology.

MDPP would be available to beneficiaries who are enrolled in Medicare Part B, have a body mass index of at least 25 or at least 23 if self-identified as Asian, and have within 12 months prior to attending the first educational session a hemoglobin A1C test with a value of 5.7-6.4%, or a fasting plasma glucose of 110-125 mg/dL within the last 12 months, or 2-hour plasma glucose of 140-199 mg/dl. CMS seeks comment on whether the program should be rolled out nationally or phased in, which would allow the agency time to refine technical issues prior to broader model scaling.

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

CMS seeks 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 proposes to include a requirement that rental charges for the office space or equipment are not 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 in cases where “unanticipated issues arise”**

CMS proposes to update how the quality and cost scores under the VM would be affected for the 2017 and 2018 payment years in cases where an informal review request overturns the status of group practice’s VM determination or if more widespread data accuracy issues arise.

**Widespread data accuracy issues**

In the event of a widespread claims issue (i.e., one impacting multiple group practices), the agency proposes to recalculate the quality and cost composites for affected groups. In such a scenario, practices with low quality or high cost composites would be automatically reclassified as “average.” In cases where the quality data is considered unusable, affected groups would be automatically designated as having “average quality” and would retain their original cost determinations except in cases where the group would have been designated as “high cost.” In this case, they would be reclassified as “average cost” for purposes of avoiding a negative adjustment without sufficient, scoreable quality data.

**Reversal of automatic penalty following informal review**

In the event that a practice’s automatic VM penalty designation is reversed following an informal review, quality and cost composite scores under quality-tiering would be evaluated differently based on whether the practice’s billing providers reported PQRS measures as individuals or collectively through the group practice reporting option (GPRO). Groups reporting under the GPRO would automatically receive an “average” quality score, regardless of actual performance, while cost would continue to be calculated from claims, with the exception that any groups receiving a “high” cost designation would be reclassified as having “average” cost. For practices whose providers elect to report as individuals, both quality and cost composite scores would be retained as originally calculated, with an important exception that “low” quality remarks would be rescored as “average.”

**Medicare Shared Savings Program**

**Quality measures and alignment with MIPS/APMs proposals**

CMS proposes to align the MSSP quality measure set with the measures proposed for web interface reporting under MIPS. To maintain consistency moving forward, any changes to the general web interface measures would automatically be applied to the MSSP web interface measures. New measures would be pay-for-reporting for the 2017 and 2018 performance years then gradually shift to pay-for-performance. Pay-for-reporting measures would be evaluated on an all-or-nothing basis contingent on complete and accurate reporting.
In anticipation of the transition from PQRS and VM to the new Merit-Based Incentive Payment System (MIPS), which will impact Medicare physician payment for the first time in 2019, CMS proposes to broaden the scope of the EHR web interface measure for MSSP ACOs (currently ACO #11). This measure would apply to all eligible clinicians participating in the ACO, as opposed to strictly primary care providers as it does now.

**Allowing MSSP ACO participants to report quality data outside of the ACO**

In a proposed reversal of its current policy, CMS would allow MSSP ACO participants to report quality data outside of the ACO for purposes of satisfying PQRS and VM requirements for the 2017 and 2018 payment years. CMS will continue to evaluate payment adjustments from the data submitted by the ACO, and will only defer to data submitted outside of the ACO in the event that the ACO fails to successfully report quality data on behalf of its participants.

Among the many MSSP proposed changes, CMS also proposes to:

- Clarify that in the event a Track 2 or 3 ACO should fall below 5,000 assigned beneficiaries at the time of financial reconciliation, it would be eligible to share in savings and losses at the level consistent with the MSR/MLR chosen at the start of the agreement period.
- Allow certain ACOs to opt into voluntary assignment by ACO beneficiaries in which a beneficiary would designate which provider he or she considers responsible for their overall care.
- Clarify merged or acquired TINs will not be required to remain Medicare enrolled if they are no longer used to bill Medicare.
- Increase the number of records audited per measure to achieve a higher level of statistical confidence and while it does not propose a specific number, anticipates it would not exceed 50. In addition, CMS proposes to streamline the audit process into a single step, as opposed to the current three-phase process.
- Establish a new, 90-day grace period for the SNF 3-day rule waiver for Track 3 MSSP participants which would 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 admitted within 90 days of when CMS delivered the quarterly beneficiary exclusions list to an ACO.