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2017 Medicare Physician Fee Schedule Final Rule
Top-Line Summary

On November 2, 2016, the Centers for Medicare and Medicaid Services (CMS) released the **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 Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model *(CMS-1654-F).*** It is posted online, and will be published in the *Federal Register* on November 15, 2016. The CMS fact sheet is available here. A top-line summary of the major provisions follows.

2017 Proposed Medicare Physician Fee Schedule Conversion Factor

√ 2017 Medicare physician fee schedule conversion factor is $ 35.8887; the anesthesia conversion factor is $22.0454

The 2017 Medicare physician fee schedule conversion factor[1] is $35.8887. This is a slight increase from the 2016 conversion factor of $35.8043. The anesthesia conversion factor is $22.0454, which also reflects a slight increase from the 2016 anesthesia conversion factor of $21.9935. The 2017 conversion factors reflect the 0.5 percent update specified by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); a budget neutrality adjustment; an adjustment required by the Protecting Access to Medicare Act (PAMA) of 2014, referred to as target recapture; and an adjustment due to the non-budget neutral 5 percent multiple procedure payment reduction for the professional component of imaging services. Tables 50 and 51 in the final rule (*page 1327, 2017 Final PFS (CMS-1654-F), display copy*) summarize the calculations for the two conversion factors.

Aggregate Impact of 2017 Final Physician Fee Schedule

√ Impact of 2017 proposed Medicare Physician Fee Schedule (PFS) varies by specialty

The overall impact of the changes in the 2017 final PFS varies by specialty. CMS estimates that the impact changes range from a negative 5 percent for interventional radiology to a positive one percent for several specialties (allergy/immunology, family practice, general practice, geriatrics, internal medicine, multispecialty clinics, and physical/occupational therapy).

Differences by specialty in the impacts of the changes implemented through the 2017 PFS are generally related to changes to relative value units (RVUs) for specific services resulting from the Misvalued Code Initiative, including finalized RVUs for new and revised codes. CMS proposed the establishment of a code related to mobility impairment services. This was not finalized for 2017. Specialties that were likely to have reported this code experienced a lower positive impact in the final rule than was estimated in the proposed rule. Table 52 which shows the aggregated impact by specialty of the 2017 final PFS is attached.

Phase-in of Significant RVU Reductions

√ 74 codes subject to significant RVU reduction phase-in in 2017

In 2016, CMS first implemented a provision required by PAMA that requires a phase-in of the implementation of significant RVU reductions (that are not new or revised codes). CMS established a policy of phasing-in negative adjustments of 20 percent or more over a 2-year period. The significant majority of codes with reductions in RVUs that are greater than 20 percent in year one would not be

[1] The Medicare Physician Fee Schedule relies on national relative values that are established for work, practice expense, and malpractice, which are adjusted for geographic cost variations. These values are multiplied by a conversion factor (CF) to convert the RVUs into payment rates.

likely to meet the 20 percent threshold in a consecutive year. However, in a few cases, significant changes could produce reductions of 20 percent or greater in consecutive years. Since the policy was established in 2016, 2017 is the first time codes would be experiencing the second year of the phase-in. CMS proposed that any applicable phase-in be limited to a decrease of 19 percent per year. In other words, every service is evaluated anew each year, and any applicable phase-in is limited to a decrease of 19 percent.

CMS finalized the policy as proposed. As a result, 74 codes are subject to the phase-in in 2017. The list of codes is posted on the CMS website.

Potentially Misvalued Services Under the PFS

The Misvalued Code Initiative was established under the Affordable Care Act (ACA) and requires CMS to periodically identify and review potentially misvalued codes and make appropriate adjustments to assigned RVUs.

Valuing Services that Include Moderate Sedation as an Inherent Part of Furnishing the Procedure

√ CMS removes the value of moderate sedation from over 400 diagnostic and therapeutic procedures

The CPT manual identifies more than 400 diagnostic and therapeutic procedures (listed in Appendix G) for which the CPT Editorial Committee has determined that moderate sedation is an inherent part of furnishing the procedure. CMS is removing moderate sedation from all Appendix G codes. The implication of this is that the value of moderate sedation will be backed out of the current value of the code and the moderate sedation service will have to be separately reported when furnished.

√ CMS established two moderate sedation codes: one for endoscopic services, and one for all other procedures

If the clinician performing a procedure also furnishes moderate sedation, there should be no impact on payment since the physician would report a separate code for the moderate sedation. CMS established a code for moderate sedation for endoscopic services and moderate sedation for all other services.

- G0500, Mod sedat endo service >5yrs (0.10 work RVUs)
- 99152, Mod sed same phys/qhp 5/>yrs (0.25 work RVUs)

If moderate sedation is not performed, and this typically occurs because anesthesiology is separately reported by another clinician, these services will experience a reduction in value (0.10 work RVUs for endoscopy services and 0.25 work RVUs for all other procedures).

Collecting Data on Resources Used in Furnishing Global Services

√ Modified data collection effort of high volume codes, by practices of 10 or more in select states using existing CPT code finalized

MACRA required that beginning no later than January 1, 2017, CMS will collect data on the number and level of visits furnished during the global period and, beginning in 2019, use this data to assess and potentially revise the valuation of surgical services. There are approximately 4,200 10- and 90- day global codes that would be impacted by this policy which has the potential of reducing the value of these services in future years. CMS proposed a rigorous data collection effort that included comprehensive claims-based reporting, a survey of a representative sample of practitioners and a more in-depth direct observation study.

In response to comments, CMS finalized a significantly more modest claims-based data collection effort. CMS estimates that through this modified plan they would collect data on about 260 codes that describe approximately 87 percent of all furnished 10- and 90-day global services and about 77 percent of all Medicare expenditures for 10- and 90-day global services under the PFS. The claims-based data collection effort will be implemented as follows:

- Reporting will be required only for services related to codes reported annually by more than 100 practitioners, and that are reported more than 10,000 times or have allowed charges in excess of $10 million annually.
- Only practitioners 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. Practitioners who only practice in smaller practices or in other geographic areas are encouraged to report data, if feasible, but will not be required to do so.
- CPT code 99024 will be used for reporting post-operative services rather than the proposed set of G-codes.
    - Reporting will not be required for pre-operative visits included in the global package or for services not related to patient visit.
- Practitioners are encouraged to begin reporting post-operative visits for procedures furnished on or after January 1, 2017, but the mandatory requirement to report will be effective for services related to global procedures furnished on or after July 1, 2017.

Since CPT code 99024 will only provide data on the number of visits and no data on the level or resources used in furnishing the visit, CMS indicates that this may be only the first step in gathering the data required by MACRA.

To supplement the claims-based data collection effort, CMS is finalizing the proposal to conduct a survey of practitioners to gain information on post-operative activities. The survey is scheduled to be circulated by mid-2017. CMS is also finalizing a proposal to collect data on the activities and resources involved in delivering services in and around surgical events in the Accountable Care Organization (ACO) context by surveying a small number of ACOs (Pioneer and Next Generation ACOs).

CMS did not propose to implement the option provided in MACRA to withhold up to 5 percent of payment on services on which the practitioner is required to report until the practitioner has completed the required reporting. CMS indicates in the final rule that if they find that compliance with required claims-based reporting is not acceptable, they would consider implementing this option.

Finally, CMS proposed number of other codes for review under the Misvalued Code Initiative. CMS identified 19 codes through the screen for 0-day global services that are typically billed with an Evaluation and Management (E/M) service with modifier 25 listed in Table 8 (*page 139, 2017 Final PFS (CMS-1654-F), display copy*) as well as End Stage Renal Disease (ESRD) home dialysis services (CPT codes 90963 - 90970).

Medicare Telehealth Services:

CMS maintains a list of services eligible for Medicare payment when furnished via telehealth technology. When services on the list meet conditions specified by CMS (related to location, technology, authorized provider, eligible telehealth individual, *etc.*), Medicare pays a facility fee to the originating site and makes a separate payment to the distant site practitioner furnishing the service.

√ Services added to list of Medicare telehealth services

CMS is finalizing its proposal to add several services to the telehealth services list for 2017:

- ESRD–related services (90967-90969).
- Advance care planning codes (99497-99498).
- Telehealth consultations for a patient requiring critical care services (G0508 and G0509).

√ New telehealth Place of Service (POS) code and facility PE RVU payment finalized

CMS is finalizing the adoption of a new POS code for telehealth services (POS 02 Telehealth) for use by the distant provider. CMS believes a POS code for telehealth services would provide consistency in reporting and identifying services furnished via telehealth. The POS code would be used in addition to the existing telehealth modifiers (GT and GQ). The originating site would continue to use the POS code that applies to the type of facility where the patient is located. CMS also finalized a policy to use facility PE RVUs to pay for telehealth services reported by physicians or practitioners reporting the telehealth POS code for CY 2017.

Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services

√ CMS finalized payment to recognize the work of primary care and other cognitive specialties

CMS is establishing new codes and providing payment for services currently bundled in PFS billing code set to more accurately recognize the work of primary care and other cognitive specialties to accommodate the changing needs of the Medicare patient population.

Non-face-to-face prolonged E/M service codes: CMS is establishing separate payment for these codes that are currently bundled. CMS is also establishing payment for assessment and care planning for patients with cognitive impairment (G0505). CMS is designating G0505 as a companion or "base" E/M code to non-face-to-face prolonged services (99358 and 99359).

Code	Descriptor	2017 Non-Facility Payment	2017 Facility Payment
99358	Prolong service w/o contact	$113.41	$113.41
99359	Prolong serv w/o contact add	$54.55	$54.55
G0505	Cog/func assessment outpt	$238.30	$178.01

Behavioral health integration (BHI) services: CMS is establishing three codes to describe services furnished as part of the psychiatric collaborative care model and one code to address other BHI care models.

Code	Descriptor	2017 Non-Facility Payment	2017 Facility Payment
G0502	Init psych care manag, 70min	$142.84	$90.08
G0503	Subseq psych care man,60mi	$126.33	$81.11
G0504	Init/sub psych care add 30 m	$66.04	$43.43
G0507	Care manage serv minimum 20	$47.73	$32.30

For all of the BHI service codes (G0502, G0503, G0504 and G0507), CMS is requiring an initiating visit that is billable separate from the BHI services. CMS is also requiring prior beneficiary consent, recognizing that applicable rules continue to apply regarding privacy.

Complex Chronic Care Management (CCM) Services: CMS is establishing payment for two complex CCM services that are currently bundled.

Code	Descriptor	2017 Non-Facility Payment	2017 Facility Payment
99487	Cmplx chron care w/o pt vsit	$93.67	$52.76
99489	Cmplx chron care addl 30 min	$47.01	$26.56

CCM Initiating Visit: CMS is establishing a code G0506 that is billable only one time at the outset of CCM services. A billing practitioner may choose to report either prolonged services or G0506 (if requirements to bill both prolonged services and G0506 are met), but cannot report both a prolonged service code and G0506.

Code	Descriptor	2017 Non-Facility Payment	2017 Facility Payment
G0506	Comp asses care plan ccm svc	$63.88	$46.30

CMS also is finalizing a number of revisions to the scope of service for CCM with the intent of reducing the administrative burden of reporting these services. These changes are summarized in Table 11 (*page 311, 2017 Final PFS (CMS-1654-F), display copy*).

Improving Payment Accuracy for Care of People with Disabilities

√ CMS did NOT finalize the proposal to increase payment for E/M services for beneficiaries with disability that impairs mobility

CMS estimates that approximately 7 percent of all Medicare beneficiaries have a potentially disabling mobility-related diagnosis, and that this diagnosis may cause an increase in resources needed to provide E/M services to this population.

CMS proposed to create a new add-on G-code (*G0501, Intensive serv during E/M*) to describe the additional services furnished in conjunction with E/M services to beneficiaries with disabilities that impair their mobility. Commenters generally agreed that persons with disabilities face barriers in accessing health services which results in disparities in health outcomes and the underlying reasons for these disparities are multifaceted. Yet, there was not agreement that the establishment of the proposed code would address the reasons for these disparities. While CMS is adding code G0501 to the 2017 code set, CMS is not establishing payment for the code. CMS plans to further analyze the concerns raised by commenters and discuss the issue in future rulemaking.

Expansion of the Medicare Diabetes Prevention Program (MDPP) Model

√ MDPP nationwide expansion effective January 1, 2018

CMS is finalizing its proposal to expand the duration and scope of the MDPP model. The MDPP expanded model will become effective nationwide beginning on January 1, 2018.

Most comments overwhelmingly supported the proposed model expansion. The MDPP is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. In March 2016, the Department of Health and Human Services (HHS) announced that the CMS Office of the Actuary (OACT) certified the pilot Diabetes Prevention Program model as a cost savings program that reduced net Medicare spending.

Because the MDPP expanded model will be implemented through at least two rounds of rulemaking, this final rule addresses aspects of this model expansion that will enable organizations to prepare for enrollment. Issues addressed include: framework for expansion, details of the MDPP benefit, beneficiary eligibility criteria, and MDPP supplier eligibility criteria and enrollment policies.

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

√ FX modifier created to implement plain film x-ray payment reduction

The Consolidated Appropriations Act of 2016 (H.R. 2029) established a series of reimbursement reductions to the PFS payment for both analog/film radiography and computed radiography.

- 20 percent reduction to the technical component of X-rays taken with plain film in 2017 and subsequent years.
- Computed radiography will be reduced by 7 percent from 2018-2022 and 10 percent in 2023 and subsequent years.

To implement the plain film X-ray reduction, CMS is finalizing a proposal to establish a new modifier FX to be used on applicable claims. Beginning January 1, 2017, this modifier would be required on claims for X-rays that are taken using film. The use of this modifier will result in a 20 percent reduction for the X-ray service.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

√ Clinicians begin reporting AUC information on January 1, 2018

PAMA directed CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. In the 2016 Final MPFS Rule, CMS established the requirements and process to establish and specify applicable AUC, along with relevant aspects of the definitions of various terms.

CMS expects that furnishing professionals will be required to begin reporting January 1, 2018, and that they will address this requirement through PFS rulemaking for CY 2018.

CMS finalized proposals related to the implementation AUC.

- Definition of qualified clinical decision support mechanisms (CDSMs) established: 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.
    - CMS also finalized policies related to CDSM qualifications and requirements.
    - The application deadline for this first round of applications is March 1, 2017.
- Eight priority clinical areas identified: coronary artery disease (suspected or diagnosed); suspected pulmonary embolism; headache (traumatic and non-traumatic); hip pain; low back pain; shoulder pain (to include suspected rotator cuff injury); cancer of the lung (primary or metastatic, suspected or diagnosed); and cervical or neck pain.
    - CMS will use priority clinical areas as a way of identifying outlier ordering professionals.

CMS also addressed policies related to an exception to the AUC consultation and reporting requirements for an applicable imaging service ordered for an individual with an emergency medical condition.

Reports of Payments or Other Transfers of Value to Covered Recipients

√ CMS acknowledges comments received on Open Payments

A provision in the ACA required manufacturers of covered drugs, devices, biologicals, and medical supplies to submit on an annual basis information about certain payments or other transfers of value made to physicians and teaching hospitals. To implement this provision, CMS established the Open Payments Program.

No Open Payments program changes were proposed or finalized within this final rule. CMS will consider comments received for any possible future rulemaking.

Recoupment or Offset of Payments to Providers Sharing the Same Taxpayer Identification Number

√ CMS implements ACA provision related to informing providers of recoupment of overpayments

CMS is proposing to implement changes required by the ACA regarding informing providers regarding recoupment or offset of overpayments if the obligated provider fails to repay the overpayment in a timely manner.

A health care system may own a number of hospital providers and these providers may share the same Tax Identification Number (TIN) while having different National Provider Identification (NPI) or Medicare billing numbers. CMS believes that the provision in the ACA could be interpreted to mean that the contractor would be required to notify both the obligated provider and the applicable provider. CMS is adding new language in the regulations that this is not required if both share the same NPI.

Medicare Advantage

√ Medicare Advantage providers/suppliers must be enrolled in Medicare under approved status

CMS is finalizing a proposal that health care providers and suppliers must be screened and enrolled in Medicare in order to contract with a Medicare Advantage organization to provide items and services to beneficiaries enrolled in Medicare Advantage health plans.

√ CMS releases Medicare Advantage data

CMS is finalizing a proposal to release two sets of data related to plan participation in Medicare Advantage and the Part D prescription drug program.

CMS is also finalizing policies related to the release of Medicare Advantage bid pricing data and the release of certain Medicare health and drug plan medical loss ratio data on an annual basis.

Value-Based Payment Modifier and Physician Feedback Program

√ CMS finalizes policies CY 2017 and 2018 payment adjustment periods

The Value-Based Payment Modifier (VM) adjusts payment to a physician or group of physicians under the PFS based upon the quality of care furnished compared to the cost of care. With the implementation of the Merit-Based Incentive Payment System (MIPS), the VM will discontinue at the end of CY 2018.

CMS will update the VM informal review policies and establish how the quality and cost composites under the VM would be implemented for the CY 2017 and CY 2018 payment adjustment periods.

CMS is also finalizing policies for the circumstances where a Medicare Shared Savings Program or an ACO does not does not successfully report quality data on behalf of a group or solo practitioner for purposes of PQRS and how CMS can acquire this quality data. Lack of PQRS data negatively impacts a provider's VM calculation.

Physician Self-referral Updates

√ Limits established on per-unit of service compensation formulas for office space or equipment rental

CMS is finalizing without modification a requirement that the rental charges for the lease of 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.

The final rule also addresses a new coding framework for mammography services based on new CPT, updated Geographic Practice Cost Indices for CY 2017 and policies related to the Medicare Shared Savings Program which are not included in this summary.

TABLE 52: CY 2017 PFS Estimated Impact on Total Allowed Charges by Specialty*

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
TOTAL	$89,866	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$231	0%	1%	0%	1%
ANESTHESIOLOGY	$1,982	0%	0%	0%	0%
AUDIOLOGIST	$61	0%	0%	0%	0%
CARDIAC SURGERY	$324	0%	0%	0%	0%
CARDIOLOGY	$6,485	0%	0%	0%	0%
CHIROPRACTOR	$784	0%	0%	0%	0%
CLINICAL PSYCHOLOGIST	$734	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	$606	0%	0%	0%	0%
COLON AND RECTAL SURGERY	$161	0%	0%	0%	0%
CRITICAL CARE	$311	0%	0%	0%	0%
DERMATOLOGY	$3,308	0%	0%	0%	0%
DIAGNOSTIC TESTING FACILITY	$754	0%	-1%	0%	-1%
EMERGENCY MEDICINE	$3,145	0%	0%	0%	0%
ENDOCRINOLOGY	$460	0%	0%	0%	0%
FAMILY PRACTICE	$6,110	0%	1%	0%	1%
GASTROENTEROLOGY	$1,747	-1%	0%	0%	-1%
GENERAL PRACTICE	$456	0%	0%	0%	1%
GENERAL SURGERY	$2,172	0%	0%	0%	0%
GERIATRICS	$213	0%	1%	0%	1%
HAND SURGERY	$182	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	$1,751	0%	0%	0%	0%
INDEPENDENT LABORATORY	$706	0%	-5%	0%	-5%
INFECTIOUS DISEASE	$656	0%	0%	0%	0%
INTERNAL MEDICINE	$10,915	0%	1%	0%	1%
INTERVENTIONAL PAIN MGMT	$769	0%	-1%	0%	0%
INTERVENTIONAL RADIOLOGY	$317	-1%	0%	0%	-1%
MULTISPECIALTY CLINIC/OTHER PHYS	$129	0%	0%	0%	1%
NEPHROLOGY	$2,210	0%	0%	0%	0%
NEUROLOGY	$1,521	0%	0%	0%	0%
NEUROSURGERY	$789	-1%	0%	0%	-1%
NUCLEAR MEDICINE	$47	0%	0%	0%	0%
NURSE ANES / ANES ASST	$1,214	0%	0%	0%	0%
NURSE PRACTITIONER	$2,988	0%	0%	0%	0%
OBSTETRICS/GYNECOLOGY	$651	0%	0%	0%	0%
OPHTHALMOLOGY	$5,492	-1%	-2%	0%	-2%
OPTOMETRY	$1,219	0%	-1%	0%	-1%
ORAL/MAXILLOFACIAL SURGERY	$49	0%	-1%	0%	-1%
ORTHOPEDIC SURGERY	$3,695	0%	0%	0%	0%
OTHER	$27	0%	0%	0%	0%
OTOLARNGOLOGY	$1,210	0%	0%	0%	-1%
PATHOLOGY	$1,135	0%	-2%	0%	-1%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
PEDIATRICS	$61	0%	0%	0%	0%
PHYSICAL MEDICINE	$1,068	0%	0%	0%	0%
PHYSICAL/OCCUPATIONAL THERAPY	$3,407	0%	1%	0%	1%
PHYSICIAN ASSISTANT	$1,964	0%	0%	0%	0%
PLASTIC SURGERY	$378	0%	0%	0%	0%
PODIATRY	$1,972	0%	0%	0%	0%
PORTABLE X-RAY SUPPLIER	$106	0%	0%	0%	0%
PSYCHIATRY	$1,265	0%	0%	0%	0%
PULMONARY DISEASE	$1,765	0%	0%	0%	0%
RADIATION ONCOLOGY	$1,726	0%	0%	0%	0%
RADIATION THERAPY CENTERS	$44	0%	0%	0%	0%
RADIOLOGY	$4,683	0%	0%	0%	-1%
RHEUMATOLOGY	$537	0%	0%	0%	0%
THORACIC SURGERY	$357	0%	0%	0%	0%
UROLOGY	$1,772	-1%	0%	0%	-2%
VASCULAR SURGERY	$1,046	0%	0%	0%	-1%

** Column F may not equal the sum of columns C, D, and E due to rounding.

2. CY 2017 PFS Impact Discussion

a. Changes in RVUs

The most widespread specialty impacts of the final RVU changes are generally related to the changes to RVUs for specific services resulting from the Misvalued Code Initiative, including finalized RVUs for new and revised codes. Several specialties, including interventional radiology and independent labs, would experience significant decreases to overall payments for services that they frequently furnish as a result of revisions to the coding structure or the final inputs used to develop RVUs for the codes that describe particular services. Other specialties, including endocrinology and family practice, would experience significant increases to payments for similar reasons.

We note that the positive impact for CY 2017 several specialties is lower than it was in the proposed rule, especially for certain specialties disproportionately likely to have reported the