AAO-HNS SUMMARY OF CY 2018 FINAL MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)

On November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) posted the final rule for payments in the Medicare physician fee schedule (MPFS) for calendar year (CY) 2018. In addition to payment policy, payment rate updates, CMS quality initiative program incentives and penalties, the MPFS addresses a number of provisions of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (referred to as the "Affordable Care Act" or ACA), the America Taxpayer Relief Act of 2012, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93, enacted on April 1, 2014, and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, enacted on April 16, 2015. ***There is no formal comment period for this year's final rule, however, the Academy plans to submit comments on members' behalf prior to the new year which can be found on the CMS website.***

Important Otolaryngology-Head and Neck Surgery policies addressed by CMS:

1) 2017 Conversion Factor (CF) (p. 114)

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 established the update factor for calendar years 2015 through 2025. To calculate the conversion factor for the update year, CMS multiplies the product of the current year conversion factor and the update factor by the budget neutrality adjustment. CMS estimated the CY 2018 PFS conversion factor to be lower than the finalized CF of 35.9996. CMS states that the CY 2018 net reduction in expenditures resulting from adjustments to RVUs of misvalued codes to be 0.41 percent. Since this amount does not meet the 0.5 percent target required, payments under the fee schedule must be reduced by the difference between the target for the year and the estimated net reduction in expenditures, known as the target recapture amount. As a result, CMS estimates that the CY 2018 target recapture amount will produce a reduction to the conversion factor of -0.09 percent. To calculate the final conversion factor for this year, they multiplied the product of the current year conversion factor and the update adjustment factor by the target recapture amount and the budget neutrality adjustment, totaling the adjustments listed below.

TABLE 48: Calculation of the Final CY 2018 PFS Conversion Factor

Conversion Factor in effect in CY 2017 = 35.8887
Update Factor 0.50 percent (1.0050)
CY 2018 RVU Budget Neutrality Adjustment -0.10 percent (0.9990)
CY 2018 Target Recapture Amount -0.09 percent (0.9991)
CY 2018 Conversion Factor 35.9996

2) Estimated Overall Impact on Total Allowed Charges for ENT Services (p 1152)

Based on the **Impact table** below, the following impacts for ENT, Allergy, Plastic Surgery, Audiology, and Oral/Maxiollofacial, under the MPFS in 2018.

TABLE 50: CY 2018 PFS 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	**$93,149**	**0%**	**0%**	**0%**	**0%**
ALLERGY/IMMUNOLOGY	**$247**	**0%**	**-3%**	**0%**	**-3%**
AUDIOLOGIST	**$66**	**0%**	**0%**	**0%**	**0%**
ORAL/MAXILLOFACIAL SURGERY	**$57**	**0%**	**-1%**	**0%**	**-1%**
OTOLARNGOLOGY	**$1,237**	**0%**	**-1%**	**0%**	**-2%**
PLASTIC SURGERY	**$384**	**0%**	**0%**	**0%**	**1%**

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

3) Potentially Misvalued Services Under the Fee Schedule (p. 154)

In recent years CMS and the AMA Relative Update Committee (RUC) have taken increasingly significant steps to address potentially misvalued codes. Most recently, the Act (as added by the ACA) **directed the Secretary to specifically examine potentially misvalued services in seven categories:**

(1) Codes and families of codes for which there has been the fastest growth,
(2) Codes or families of codes that have experienced substantial changes in practice expenses,
(3) Codes that are recently established for new technologies or services,
(4) Multiple codes that are frequently billed in conjunction with furnishing a single service,
(5) Codes with low relative values, particularly those that are often billed multiple times for a single treatment,
(6) Codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'), and
(7) Other codes determined to be appropriate by the Secretary.

In addition, 2014 legislation, **the PAMA also added nine new categories that the Secretary must consider in identifying potentially is valued codes:**

(1) Codes that account for the majority of spending under the PFS
(2) Codes for services with a substantial change in the hospital length of stay or procedure time
(3) Codes for which there may be a change in the typical site of service since the code was last valued
(4) Codes for which there is a significant difference in payment for the same service between different sites of service
(5) Codes for which there may be anomalies in RVUS within a family of codes
(6) Codes for services where there may be efficiencies when a services is furnished at the same time as other services
(7) Codes with high intra-service work per unit of time (IWPUT)
(8) Codes with high PE RVUs
(9) Codes with high cost supplies

For CY 2018 CMS did not propose any new screens and sought comment on proposals from the public. In the final rule they confirmed their proposal to not initiative any new screens for CY 2018.

4) E/M Guidelines (p.492)

In the proposed rule, CMS stated their agreement with stakeholders that the E/M documentation guidelines should be substantially revised. They note that a comprehensive reform of E/M documentation guidelines would require a multi-year, collaborative effort among stakeholders, but revised guidelines could both reduce clinical burden and improve documentation in a way that would be more effective in clinical workflows and care coordination. In addition, they feel updated E/M guidelines coupled with technological advancements in voice recognition, natural language processing and user-centered design of EHRs could improve documentation for patient care while also meeting requirements for billing and population health management. CMS recognizes that achieving the goal of reduced clinician burden and improved, meaningful documentation for patient care will require both updated E/M guidelines, as well as changes in technology, clinician documentation practices and workflow and thus, they solicited input from a broad array of stakeholders, including patient advocates, on the specific changes we should undertake to reform the guidelines, reduce the associated burden, and better align E/M coding and documentation with the current practice of medicine.

The summary of comments received indicated that commenters were appreciative and generally supportive of CMS undertaking this reform effort. Many of the comments reflected agreement with CMS (and other payers) that documentation standards are necessary to demonstrate and provide a clear record of what was performed in support of payment, as well as for legal and clinical reasons. However, commenters did not agree on how the current standards should be changed, and different specialties expressed different challenges and recommendations regarding the guidelines. Many professional specialty associations urged CMS to employ a more considered, long-term process such as a task force rather than immediate changes.

There appeared to be some agreement among commenters that the documentation requirements for history and physical exam are particularly outdated. Commenters stated, for example, that they are often required to include or cut-and-paste into the record extraneous documentation detail regarding irrelevant history, review of unaffected systems, and unnecessary (and in some cases burdensome to the patient) physical exam elements, in order to justify an E/M code that most adequately reflects their work. They stated that this information bloats the medical record unnecessarily, increasing the time it takes to find or convey to the reader the most important and relevant clinical information at a given point in time. They said this detracts significantly from spending time on more important patient care activities.

A few commenters believe that the two elements of history and exam could be eliminated entirely, while many commenters believe they needed to be retained, but changed or rolled up somehow into MDM. Some commenters believe that MDM is under-emphasized or could be assigned greater weight, while still recognizing the critical role that history and exam continue to play for patients, especially new patients. Some commenters believe that new guidelines to support MDM-driven E/M documentation need to be in place before requirements for history and exam are eliminated. Some specialties (for example,

hematology-oncology and emergency medicine) explained that ensuring adequate performance and documentation of both history and physical exam at every visit is critical to their work for clinical, legal, operational, and other reasons.

Some commenters raised the possibility of allowing flexibility at the practitioner or organization level. For example, one commenter suggested that CMS could encourage the use of unspecified standards, while allowing individual physicians to decide what components of a history and physical exam are required or should be documented for individual patients. Some commenters believe there are clinical reasons to include a history and exam in a patient's record, but they are not needed to determine the E/M code level. Others advised CMS to eliminate all numeric (counted) elements for history and exam in the documentation guidelines and allow physicians to document only what is relevant to the patient's specific diagnosis. There was no consensus among commenters on changes that would need to be made to MDM and time rules in order for CMS to rely more on these elements (in lieu of history and exam) to justify service level billed. Some commenters recommended clarification of ambiguities or more uniform interpretation of the current MDM guidelines. Others believe the existing criteria for assessing MDM are themselves inadequate, and that while MDM should carry the most weight, it is the hardest to measure meaningfully and is frequently subjective.

Some commenters recommended alternatives such as different MDM levels reflecting comorbidity or the intensity of a single, highly active medical condition. Some believe that MDM was a key determinant but not sufficient to stand alone. Many commenters urged CMS to proceed cautiously by making changes over a period of multiple years, using a representative task force and additional public forums such as open door forums and listening sessions prior to implementing broad changes. Some commenters suggested that reforming the guidelines is a monumental task that would have a far-reaching impact and needs to be done judiciously since, for example, commercial payers often follow Medicare rules in this area. These commenters stated that, if done correctly, revising the guidelines will be a significant undertaking that is likely to last several years and require an inclusive, transparent, iterative and perhaps transitional process to ensure that all stakeholders across all specialties are involved, that a thoughtful examination of options can take place, and that the benefits and consequences of any potential changes can be identified. Some commenters specified that the CPT Editorial Panel, private insurers and EHR vendors should be involved.

CMS concludes by stating their intent to continue to work on all of these issues with stakeholders in future years though we are immediately focused on revision of the current E/M guidelines in order to reduce unnecessary administrative burden.

5) Valuation of Specific Codes (p. 213)

Federal law specifies that for services that are not new or revised codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year, the applicable adjustments in work, PE, and MP RVUs shall be phased-in over a 2-year period. **Otolaryngology only had three services on this list for CY 2018:**

HCPCS	Descriptor	PE RVU in facility without phase in	PE RVU in facility with phase in (value for 2018)
31081	Removal of frontal sinus	14.95	18.23
31085	Removal of frontal sinus	15.56	18.89
31600	Incision of windpipe	2.32	2.68

A. Physician Work

After considering numerous comments, including extensive clinical feedback from the Academy, regarding their proposals to reduce AMA RUC recommended values for all otolaryngology services reviewed within this year's RUC cycle, **CMS elected to accept RUC recommended values for otolaryngology services** and finalized the following values for CY 2018 for Otolaryngology procedures reviewed in CY 2016/17.

TABLE 12: FINAL CY 2018 Work RVUs for New, Revised and Potentially Misvalued Codes

HCPCS	Descriptor	Current RVU	RUC Proposed RVU	CMS FINAL RVU	CMS Time Refinement

15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	19.86	23.00	23.00	No
15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity	17.04	17.04	17.04	No
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity	19.04	19.04	19.04	No
157X1	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	NEW	13.50	13.50	No
157X2	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)	NEW	15.68	15.68	No
30140	Submucous resection inferior turbinate, partial or complete, any method	3.57	3.00	3.00	No
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	1.10	1.10	1.10	No
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	1.54	1.54	1.54	No
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial	1.97	1.97	1.97	No
30906	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent	2.45	2.45	2.45	No
31XX1	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	NEW	8.00	8.00	No
31XX2	Nasal/sinus endoscopy, surgicalwith ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed	NEW	9.00	9.00	No
31XX3	Nasal/sinus endoscopy, surgicalwith ethmoidectomy; total (anterior and posterior), including sphenoidotomy	NEW	8.00	8.00	No
31XX4	Nasal/sinus endoscopy, surgicalwith ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus	NEW	8.48	8.48	No
31XX5	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)	NEW	4.50	4.50	No
31254	Nasal/sinus endoscopy, surgicalwith ethmoidectomy; partial (anterior)	4.64	4.27	4.27	No
31255	Nasal/sinus endoscopy, surgicalwith ethmoidectomy; total (anterior and posterior)	6.95	5.75	5.75	No
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy	3.29	3.11	3.11	No
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	5.45	4.68	4.68	No
31276	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed	8.84	6.75	6.75	No
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy	3.91	3.50	3.50	No
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	4.57	4.10	4.10	No

31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasalor canine fossa	2.70	2.70	2.70	No
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)	3.29	3.10	3.10	No
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	2.64	2.44	2.44	No
31600	Tracheostomy, planned (separate procedure)	7.17	5.56	5.56	No
31601	Tracheostomy, planned (separate procedure); younger than 2 years	4.44	8.00	8.00	No
31603	Tracheostomy, emergency procedure; transtracheal	4.14	6.00	6.00	No
31605	Tracheostomy, emergency procedure; cricothyroid membrane	3.57	6.45	6.45	No
31610	Tracheostomy, fenestration procedure with skin flaps	9.38	12.00	12.00	No
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction,	.01	.01	.01	No

Discussion of these valuation assignments is below by code family:

a. Muscle Flaps (CPT codes 15734, 15736, 15738, 157X1, and 157X2)

CPT codes 15732 and 15736 were identified via a screen of high level E/M visits included in their global periods. This screen identified that a CPT code 99214 office visit was included for CPT codes 15732 and 15736 but not included in the other codes in this family. During the CPT Editorial Panel's review process for this family of codes, CPT code 15732 was deleted and replaced with two new codes, CPT codes 15730 and 15733, to better differentiate and describe the work of large muscle flaps performed on patients with head and neck cancer depending on the site where the service was performed. ***For CY 2018, CMS finalized the RUC-recommended work RVUs of 23.00 for CPT code 15734, 17.04 for CPT code 15736, 19.04 for CPT code 15738, 13.50 for CPT code 15730, and 15.68 for CPT code 15733.***

b. Resection Inferior Turbinate (CPT code 30140)

CMS finalized the RUC recommended value of 3.00 RVUs for this code. One notable comment received related to this code included a request that CMS add a new supply named the "turbinate reduction wand" to the supply inputs associated with this procedure when performed in the physician office setting. The commenter stated that this device is designed to ablate, coagulate, and remove a core of tissue that provides the desired volumetric reduction of the anatomy, and supplied several invoices for use in pricing the new supply.

CMS responded stating the suggested turbinate reduction wand has a price of nearly $200, which would add substantially to the costs of CPT code 30140. Before including such significant resource costs in the code, they requested input from the physician community such as the RUC. At present, they do not have any information to suggest that the use of this new supply is typical for CPT code 30140, and the RUC did not recommend the inclusion of this supply on either of the two occasions when this code was reviewed in CY 2017. For these reasons, CMS did not believe that it would be appropriate to add the turbinate reduction wand to CPT code 30140 at this time, but welcomed the submission of additional information regarding this use of this supply from stakeholders.

c. Control Nasal Hemorrhage (CPT codes 30901, 30903, 30905, and 30906)

For CY 2018, CMS finalized the RUC-recommended work RVUs for CPT codes 30901 (a work RVU of 1.10), 30903 (a work RVU of 1.54), 30905 (a work RVU of 1.97), and 30906 (a work RVU of 2.45). CMS also accepted the RUC recommendations for direct PE inputs for this family of codes. They expressed appreciation for comments from specialties and the RUC which explicitly addressed their alternative values for these services.

d. Nasal Sinus Endoscopy (CPT codes 31254, 31255, 31256, 31267, 31276, 31287, 31288, 31295, 31296, 31297, 31XX1, 31XX2, 31XX3, 31XX4, and 31XX5)

In October 2016, the CPT Editorial Panel created five new codes (CPT codes 31XX1, 31XX2, 31XX3, 31XX4 and 31XX5) and revised CPT codes 31238, 31254, 31255, 31276, 31287, 31288, 31296, and 31297. CPT codes 31XX2 – 31XX5 are newly bundled services representing services that are frequently reported together. CPT code 31XX1 represents a new service. The RUC reviewed this family of codes at their January 2017 meeting. ***For CY 2018, CMS finalized the RUC-recommended work RVUs for all 15 CPT codes in this family: 4.27 for CPT code 31254, 5.75 for CPT code 31255, 3.11 for CPT code 31256, 4.68 for CPT code 31267, 6.75 for CPT code 31276, 3.50 for CPT code 31287, 4.10 for CPT code 31288, 2.70 for CPT code 31295, 3.10 for CPT code 31296, 2.44 for CPT code 31297, 8.00 for CPT code 31241, 9.00 for CPT code 31253, 8.00 for CPT code 31257, 8.48 for CPT code 31259, and 4.50 for CPT code 31298***.

Some key comments received on this family of codes included: one commenter suggested that codes in the family with reductions of greater than 20 percent be phased in over 2 years' time. CMS responded noting that new and revised codes are not subject to the statutory phase in requirements.

CMS also requested commend on whether the endobase reduction policy should apply to this family of codes. CMS stated they did not receive consistent comments on this issue and would continue to consider comments on the topic going forward, but for CY 2018 they would finalize continued use of the MPPR policy for nasal endoscopy services.

Last, CMS noted their receipt of a request to mirror the in-office direct PE inputs for 31254 for 31255. CMS requested comment on the clinical appropriateness of providing this service in the office and noted that PE inputs were not requested for this code via the RUC valuation process.

Balloon pricing: Regarding the recommended direct PE inputs, CMS expressed concern about one of the supply items used in furnishing services for several CPT codes in this family: "sinus surgery balloon (maxillary, frontal, or sphenoid) kit" (SA106). In the current recommendations, half of one kit (each kit has sufficient supply for two sinuses) is included in the PE inputs for CPT codes 31295, 31296, and 31297. The new CPT code 31298 has one full kit, reflecting a service consisting of two sinuses, according to the RUC's explanation. The price of the full kit (two sinuses) of this disposable supply is $2,599.06. Our analysis of 2016 Medicare claims data indicated that 48 percent of the time one of the three CPT codes (31295, 31296, and 31297) is billed, it is reported on a claim with either one or both of the other codes. Ten percent of the time one of the three CPT codes is billed, it is reported on a claim with both of the other two codes.

Effectively, 10 percent of claims reporting these CPT codes are being paid for three sinuses. CMS sought comments on the number of units of this supply item that are used for each service and welcomed suggestions about improved methodologies for identifying the quantity of this disposable supply used during these procedures and will continue to monitor utilization and reporting of these services.

Commenters, including the RUC, noted that each kit includes one balloon, and each sinus requires 0.5 of a balloon, and that the current PE input of 0.5 of SA106 is appropriate for CPT 31295, 31296, and 31297. Commenters also noted that, since CPT code 31298 bundles CPT codes 31296 and 31297, an entire balloon kit is appropriate. The RUC also reiterated support for CMS to develop a standalone HCPCS supply code for the balloon kit. In response, CMS is finalizing the PE input for supply item SA106 as proposed, which includes 0.5 kit for CPT codes 31295, 31296, and 31297, and one kit for CPT code 31298.

e. Tracheostomy (CPT codes 31600, 31601, 31603, 31605, and 31610)

CPT code 31600 was identified as part of a screen of high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. CPT codes 31601, 31603, 31605, and 31610 were added and reviewed as part of the code family. CMS is proposing the RUC-recommended work RVUs for all five codes in this family. ***For CY 2018, CMS finalized work RVUs of 5.56 for CPT code 31600, 8.00 for CPT code 31601, 6.00 for CPT code 31603, 6.45 for CPT code 31605, and 12.00 for CPT code 31610.*** They again stated their appreciation for thoughtful comments from specialties on the alternative values proposed for this family and based on those comments, were able to confirm acceptance of the RUC proposed values.

f. Percutaneous Allergy Skin Tests (CPT code 95004)

In the CY 2016 PFS proposed rule (80 FR 41706), CPT code 95004 was identified through the high expenditures screen as potentially misvalued. The RUC suggested in its comments on the CY 2016 PFS proposed rule (80 FR 41706), that CPT code 95004 should be removed from the list of potentially misvalued codes because it has a work RVU of 0.01 and that it would serve little purpose to survey physician work for this code. The RUC and CMS previously determined that there is physician work involved in providing this service since the physician must interpret the test and prepare a report. In the CY 2016 PFS final rule with comment period (80 FR 70913), CMS reiterated an interest in the review of work and PE for this service. ***After review, CMS finalizes the RUC recommended value of .01 RVUs, as well as the direct PE inputs, for this code.***

B. PE Direct Input Refinements

Codes with CMS modifications to direct PE inputs:

- **30140**: CMS increased minutes allocated to many pieces of equipment used during the procedure and increased staff time for taking of vitals, overall impact was an increase of $0.90.
- **30901-30906**: CMS increased minutes allocated to many pieces of equipment used during these procedures.
- **31254 and 31295-31298:** CMS increased minutes allocated to many pieces of equipment used during these procedures, however, they removed staff time for activities such as education and consent, post procedure phone calls and prescriptions, and completion of diagnostic/referral forms.

- **95004**: CMS increased minutes allocated to equipment used during this procedure.

Codes **without modification** to direct PE inputs:

- 15733 Musc myoq/fscq flp h&n pedcl
- 15734 Muscle-skin graft trunk
- 15736 Muscle-skin graft arm
- 15738 Muscle-skin graft leg
- 31241 Nsl/sins ndsc w/artery lig
- 31253 Nsl/sins ndsc total
- 31255 Nsl/sins ndsc w/tot ethmdct
- 31256 Exploration maxillary sinus
- 31257 Nsl/sins ndsc tot w/sphendt
- 31259 Nsl/sins ndsc sphn tiss rmvl
- 31267 Endoscopy maxillary sinus
- 31276 Nsl/sins ndsc frnt tiss rmvl
- 31287 Nasal/sinus endoscopy surg
- 31288 Nasal/sinus endoscopy surg
- 31600 Incision of windpipe
- 31601 Incision of windpipe
- 31603 Incision of windpipe
- 31610 Incision of windpipe

6) Therapy Caps (pg. 512)

The therapy cap amounts under section 1833(g) of the Act are updated each year based on the MEI. Specifically, the annual caps are calculated by updating the previous year's cap by the MEI for the upcoming calendar year and rounding to the nearest $10.00. ***Increasing the CY 2017 therapy cap of $1,980 by the CY 2018 adjusted MEI of 1.4 percent and rounding to the nearest $10.00 results in a CY 2018 therapy cap amount of $2,010.*** Under the therapy caps exception process, authorized by statute, beneficiaries can exceed the annual therapy caps so long as the need for therapy is medically necessary and documented by the use of a "KX" modifier. This exception is set to expire on December 31, 2017 and if not extended via legislation, beneficiaries would become 100 percent liable for any therapy exceeding the annual cap amount.

7) Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging (pg. 418)

A. Background

AUC present information in a manner that links: a specific clinical condition or presentation, one or more services and, an assessment of the appropriateness of the service(s). For purposes of this program, AUC is a set or library of individual appropriate use criteria. Each individual criterion is an evidence-based guideline for a particular clinical scenario. Each scenario in turn starts with a patient's presenting symptoms or condition. Evidence-based AUC for imaging can assist clinicians in selecting the imaging study that is most likely to improve health outcomes for patients based on their individual clinical presentation.

Clinical Decision Support Mechanism (CDSMs) are the electronic portals through which clinicians access the AUC during the patient workup. While CDSMs can be standalone applications that require direct entry of patient information, they may be more effective when they automatically incorporate information such as specific patient characteristics, laboratory results, and lists of co-morbid diseases from Electronic Health Records (EHRs) and other sources. Ideally, practitioners would interact directly with the CDSM through their primary user interface, thus minimizing interruption to the clinical workflow.

There are four major components of the AUC program, and each component has its own implementation date: (1) establishment of AUC by November 15, 2015; (2) identification of mechanisms for consultation with AUC by April 1, 2016; (3) AUC consultation by ordering professionals, and reporting on AUC consultation by furnishing professionals by January 1, 2017; and (4) annual identification of outlier ordering professionals for services furnished after January 1, 2017. CMS did not identify mechanisms for consultation by April 1, 2016 therefore did not require ordering professionals to consult CDSMs or furnishing professionals to report information on the consultation by the January 1, 2017 date.

In the CY 2017 PFS final rule, CMS identified the circumstances specific to ordering professionals under which consulting and reporting requirements are not required. These include orders for applicable imaging services: (1) for emergency services when provided to individuals with emergency medical conditions; (2) for an inpatient and for which payment is made under

Medicare Part A; and (3) by ordering professionals who are granted a significant hardship exception to the Medicare EHR Incentive Program payment adjustment for that year.

B. AUC Program Proposal

CMS proposes ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2019. Additionally, CMS is required to implement a prior authorization program for outlier ordering professionals in the future. CMS is proposing a program start date of January 1, 2019 for AUC for Advanced Diagnostic Imaging and anticipates implementation of the prior authorization component would be delayed. We expect to discuss details around outlier calculations and prior authorization in the CY 2019 PFS proposed rule. In the CY 2017 PFS final rule, CMS published the first list of priority clinical areas to guide identification of outlier ordering professionals, which included cervical or neck pain. CMS does not propose adding to this list for CY 2018.

CMS is also proposing that furnishing professionals report the following information on Medicare claims for applicable imaging services, furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2019: (1) which qualified CDSM was consulted by the ordering professional; (2) whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered; and (3) the NPI of the ordering professional (if different from the furnishing professional). Statute requires that payment may only be made if the includes the required information. This information, to the extent feasible, is required across claim types (including both the furnishing professional and facility claims) and across all three applicable payment systems (PFS, hospital outpatient prospective payment system and ambulatory surgical center payment system).

To implement this requirement, CMS proposes establishing a series of G-codes to describe the specific CDSM that was used by the ordering professional. CMS intends for there to be one G-code for every qualified CDSM with the code description including the name of the CDSM. However, because the claims processing system can only recognize new codes quarterly, CMS may not be able to update the G-code descriptors simultaneously with the announcement of any new qualified CDSMs which is expected to occur in June of each year. To ensure that there is a code available to immediately describe newly qualified CDSMs, CMS proposes to establish a generic G-code that would be used to report that a qualified CDSM was consulted, but would not identify a specific qualified CDSM; clinicians would only be permitted to use this code if a more specific named code did not yet exist for that clinician's CDSM.

CMS proposes to give Merit-based Incentive Program (MIPS) credit to ordering professionals for consulting AUC using a qualified CDSM as a high-weight improvement activity for the performance period beginning January 1, 2018 (82 FR 30484).

C. Exemptions

For 2018, CMS proposes keeping the following AUC program significant hardship exceptions identified in the 2017 final rule: Insufficient Internet Connectivity; Extreme and Uncontrollable Circumstances; Lack of Control over the Availability of CEHRT; Lack of Face-to-Face Patient Interaction. CMS also proposes an exemption for ordering professionals who are granted re-weighting of the advancing care information performance category to zero percent of the final MIPS score for the year.

8) Physician Quality Reporting System Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment

For 2018, CMS proposes keeping the following AUC program significant hardship exceptions identified in the 2017 final rule: Insufficient Internet Connectivity; Extreme and Uncontrollable Circumstances; Lack of Control over the Availability of CEHRT; Lack of Face-to-Face Patient Interaction. CMS also proposes an exemption for ordering professionals who are granted re-weighting of the advancing care information performance category to zero percent of the final MIPS score for the year.

9) Clinical Quality Measurement for Eligible Professionals Participating in the Electronic Health Record (EHR) Incentive Program for 2016 (pg. 457)

CMS proposes to align the EHR Incentive Program CQM reporting through the PQRS portal with the PQRS program as well as 2017 MIPS requirements by changing the reporting criteria for the CY 2016 reporting period from 9 CQMs covering at least 3 NQS domains to 6 CQMs with no domain requirement. CMS does not propose collecting any additional data for 2016. CMS also proposes We are proposing that an EP or group who satisfies the proposed reporting criteria may qualify for the 2016 incentive payment and may avoid the downward payment adjustment in 2017 and/or 2018, depending on the EP or group's applicable EHR reporting period for the payment adjustment year. CMS is not

proposing to change the previously finalized requirements for CQM reporting in 2016 for eligible hospitals and CAHs; or the previously finalized requirements for EPs who chose to report CQMs through attestation in 2016 for the Medicare EHR Incentive Program

10) Medicare Shared Savings Program (pg. 463)

CMS proposes changes to Medicare Shared Savings Program methodology under the 21st Century Cures Act, passed on 2016. These include beginning January 1, 2019, the Secretary determine an appropriate method to assign Medicare FFS beneficiaries to an ACO based on their utilization of services furnished by rural health clinics (RHCs) or federally qualified health centers (FQHCs), and (2) addition of new chronic care management and behavioral health integration (BHI) service codes to our definition of primary care services. CMS also proposes easing the application burden by reducing documentation submission requirements in the initial application.

11) Value-Based Payment Modifier and Physician Feedback Program

As previously mentioned, CMS proposes to revise the previously finalized satisfactory reporting criteria for the CY 2016 reporting period to lower the requirement from 9 measures across 3 NQS domains, where applicable, to only 6 measures with no domain or cross-cutting measure requirement. Due to the changes in reporting, for the 2018 CY adjustment period, CMS proposes reducing the automatic downward adjustment for or groups with 10 or more EPs and at least one physician to negative 2 percent and negative 1 percent for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs. CMS proposes to hold all groups and solo practitioners that avoid a PQRs payment adjustment harmless and reduces the maximum upward adjustment under the quality-tiering methodology to two times an adjustment factor (+2.0x) for groups with 10 or more EPs.

12) MACRA Patient Relationship Categories and Codes

CMS proposes Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include the following applicable HCPCS modifiers, as well as the NPI of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner). **CMS proposes voluntary reporting of patient relationship modifiers initially to allow clinicians to gain familiarity.**

Proposed HCPCS Modifier	Patient Relationship Category
X1	Continuous/broad services
X2	Continuous/focused services
X3	Episodic/broad services
X4	Episodic/focused services
X5	Only as ordered by another clinician