AMERICAN ACADEMY OF OTOLARYNGOLOGY– HEAD AND NECK SURGERY

AAO-HNS SUMMARY OF CY 2015 FINAL MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)

On October 31, 2014, the Centers for Medicare & Medicaid Services (CMS) posted the proposed rule for payments in the Medicare physician fee schedule (MPFS) for calendar year (CY) 2015. In addition to payment policy, payment rate updates, CMS quality initiative program incentives and penalties (PQRS, Value Based Payment Modifier, and EHR incentive programs) 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) and the America Taxpayer Relief Act of 2012. ***CMS will accept comments on the 2015 final rule during a 60 day comment period which concludes at 5pm ET on December 30, 2014. The Academy plans to submit comments on members' behalf which can be found on our website.***

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

1) Medicare Sustainable Growth Rate (SGR):

CMS projects that the CF for the first three months of CY 2015 would be $35.8013 (compared to the 2014 conversion factor of $35.8228). This estimate is based on a zero percent update (through March 31, 2015, as provided under the Protecting Access to Medicare Act of 2014 (PAMA) and the adjustments necessary to maintain budget neutrality for the policies in this proposed rule. CMS applies this CF to all of CY 2015 for purposes of completing its regulatory impact analysis, however, absent further Congressional action, a Medicare Sustainable Growth Rate (SGR)-induced reduction of over 20% would occur on April 1, 2015 (CF of $28.2239).

2) Estimated Overall Impact on Total Allowed Charges for ENT Services (Table 93)

Based on the **Impact table** below, the following impacts for ENT, Allergy, Plastic Surgery, Audiology, and Oral/Maxiollofacial surgery are estimated under the MFPS in 2015. **It is important to note that these estimates DO NOT INCLUDE the proposed reduction attributable to the SGR absent a Congressional fix prior to January 1, 2015 and are not necessarily reflective of changes that may occur among families of codes within any given specialty designation.**

Specialty	Allowed Charges (Mil)	Impact of work RVU changes	Impact of PE RVU changes	Impact of Malpractice RVU changes	Total Impact (%)
Oral/Maxillofacial	$45	0%	0%	0%	0%
Otolaryngology	$1,174	0%	0%	0%	0%
Allergy	$216	0%	0%	0%	0%
Audiology	$60	0%	0%	0%	0%
General Surgery	$2,245	0%	0%	0%	0%
General Practice	$506	0%	0%	0%	0%
Family Practice	$6,107	1%	1%	0%	1%

3) Practice Expense (p. 76)

Using OPPS and ASC Rates in Developing PE RVUs

Within the final rule, CMS revisits their CY 2014 proposed policy to limit the nonfacility PE RVUs for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting. CMS adds that it is not proposing a similar policy for the CY 2015 PFS and that if it did do so in the future rulemaking, it would consider all of the comments received previously. ***CMS notes, however, that it continues to believe that there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology to ensure that the relative costs for PFS services are developed using data that is auditable and comprehensively and regularly updated.*** CMS adds that section 220(a) of PAMA, Publ. L. 113-93, provides them with the authority to exploring ways of collecting better and updated resource data from physician practices, including those that are provider-based, and other non-facility entities paid under the PFS, and that using this information does not detract from the statutorily required "relativity" of the MPFS. CMS says that such efforts will be challenging given the wide variety of practices and likely impose some burden on EPs. CMS notes that through a validation contract, it has been gathering time data directly from physician practices, from which it has learned much about the challenges of gathering data directly from physician practices.

CMS further notes that section 220 of PAMA provides authority to use alternative approaches to establish PE RVUs, including the use of data from other suppliers and providers, and that the agency is exploring how best to exercise this authority. They note that they continue to believe that there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology to ensure that the relative costs for PFS services are developed using data that is auditable and comprehensively and regularly updated. They feel that OPPS cost data is routinely updated and is an auditable resource cost information submitted contemporaneously by a wide array of providers across the country, and therefore, is a valid reflection of ''relative'' resources and could be useful to supplement the resource cost information developed under our current methodology based upon a typical case that are developed with information from a small number of representative practitioners for a small percentage of codes in any particular year. They note that their own experience has shown that is difficult to obtain invoices for supply and equipment items that we can use in pricing direct PE inputs. Many specialty societies also have noted the challenges in obtaining recent invoices for medical supplies and equipment. Further, PE calculations rely heavily on information from the Physician Practice Expense Information Survey (PPIS) survey, which, as discussed earlier, was conducted in 2007 and 2008. When we implemented the results of the survey, many in the community expressed serious concerns over the accuracy of this or other PE surveys as a way of gathering data on PE inputs from the diversity of providers paid under the PFS. They note that the OPPS pricing information could be as a means to validate or, perhaps, in setting the relative resource cost assumptions within the PFS PE methodology.

Transition from Film to Digital Direct PE Inputs

CMS finalized their proposal to convert existing PE inputs for CPT codes that utilize a PACS system from the existing input that is now outmoded, to that of a digital PE input replacement. Since the RUC did not provide CMS with paid invoices for PACS systems, CMS has finalized their proposal to use a desktop computer (ED021) as a proxy for the PACS workstation as a direct expense. Specifically, for the 31 services that already contain ED021 (computer, desktop, w-monitor), we proposed to retain the time that is currently included in the direct PE input database. For the remaining services that are valued in the nonfacility setting, we proposed to allocate the full clinical labor intraservice time to ED021, except for codes without clinical labor, in which case we proposed to allocate the intraservice work time to ED021. For services valued only in the facility setting, we proposed to allocate the post-service clinical labor time to ED021, since the film supply and/or equipment inputs were previously associated with the post-service period. This impacted the following ENT services: CPT 61580, 61581, 92521, 92523, 92524, 92601, 92603, 92611, 92612, 92614, 92616, 95800, 95801.

Collecting Data on Off-Campus Provider-Based Outpatient Departments

CMS also continues to seek a better understanding regarding the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments. CMS adds that as more physician practices become hospital-based, it is difficult to know which PE costs typically are actually incurred by the physician, which are incurred by the hospital, and whether Medicare's bifurcated site-of-service differential adequately accounts for the typical resource costs given these relationships. ***CMS finalized two policy changes within the final rule to address these concerns.***

1) They finalized two new place of service (POS) codes (one for outpatient services furnished on-campus, remote, or satellite locations of a hospital, and a second to identify services furnished in off-campus hospital provider-based outpatient department) to replace POS 22 (Hospital outpatient). There will be no voluntary reporting period for these codes, but CMS intends to do education prior to their release an expect them to be available after July 1, 2015.

2) for hospital claims they are creating a HCPCS modifier that must be reported with every code for outpatient hospital services furnished in an off-campus PBD of a hospital. This is not required for remote locations or satellite facilities of a hospital, or for services furnished in an ED. The modifier will be available as of January 1, 2015 with the label "PO". Reporting of the modifier will be voluntary for one year and required beginning on January 1, 2016.

4) Potentially Misvalued Services Under the Fee Schedule (p. 202)

In recent years CMS and the AMA Relative Update Committee (RUC) have taken increasingly significant steps to address potentially misvalued codes. Most recently, section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of 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 Protecting Access to Medicare Act (PAMA)), authorized the Secretary to collect or obtain i nformation from any eligible professional (EP) or any other source on the resources directly or indirectly related to furnishing services for which payment is made under the PFS. This information can be collected or obtained through surveys of physicians or other supplies, providers of services, manufacturers, and vendors; surgical logs, billing systems or other practice or facility records, EHRs; and any other mechanism determined appropriate by the Secretary. If CMS uses this information they are required to disclose the sources of the information via rulemaking. **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 that have experienced 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

In CY 2013, CMS finalized their policy to allow public nomination of potentially misvalued codes which should be considered for review. Within the 2015 proposed rule two codes were nominated by the public as potentially misvalued / requiring review. Notably, one was CPT 41530 Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session, which was nominated by the Academy during 2014 notice and comment periods. The Academy felt that based on input from members and review by experts of the Sleep Committee and other stakeholders that two of the practice expense inputs in the existing code had become outdated and required refinement based on current pricing and technology utilized for this procedure. In our comments on the NPRM, we noted that these concerns had been addressed by a

review of the PE for 41530 during the April RUC meeting and therefore, additional review was not necessary. CMS responded in the final rule and stated, "***The RUC only provided us with recommendations for PE inputs for CPT code 41530. Under our usual process, we value work and PE at the same time and would expect to receive RUC recommendations on both before we revalue this service. We disagree with the commenter's statement that codes that may save money for the Medicare program should not be considered as potentially misvalued. Our aim, consistent with our statutory directive, is to value all services appropriately under the PFS to reflect the relative resources involved in furnishing them. After consideration of public comments, we are finalizing CPT code 41530 as potentially misvalued." This essentially means that CMS is requiring 41530 to be fully surveyed.***

Further, CMS proposed a new screen which captures approximately 65 codes listed below as potentially misvalued codes as a prioritized subset of codes that account for the majority of spending under the physician fee schedule. Specifically, they note that within their usual identification process for capturing potentially misvalued codes it is possible to miss certain services that are important to a segment of Medicare practitioners and beneficiaries because the specialty that typically furnishes the service does not have high volume relative to the overall PFS utilization. To capture such services in developing this list, they began by identifying the top 20 codes by specialty in terms of allowed charges. They excluded codes from our proposed potentially misvalued list reviewed since CY 2009, with fewer than $10 million in allowed charges, and that describe anesthesia or E/M services. **Within the final rule, however, CMS rescinded this screen as a result of their decision to finalize the transition of all codes to 000 globals by 2018. Rather, they directed that the RUC should focus their efforts on how to operationalize that policy change, and delayed this screen and review of associated codes to a time uncertain. The codes relevant to Otolaryngology that were captured in this screen are listed below. Review of codes in red has been cancelled, or postponed, based on the delay of the screen.**

TABLE 10: Proposed Potentially Misvalued Codes Identified Through High Expenditure Specialty Screen

11100 Biopsy skin lesion
11101 Biopsy skin add-on
14060 Tis trnfr e/n/e/l 10 sq cm/<
31575 Diagnostic laryngoscopy
31579 Diagnostic laryngoscopy
92557 Comprehensive hearing test
95004 Percut allergy skin tests
95165 Antigen therapy services

5) Valuing New, Revised and Potentially Misvalued Codes (p. 202)

In the CY 2012 rulemaking process, CMS proposed and finalized consolidation of the five-year review and the potentially misvalued code activities into an annual review of potentially misvalued codes. Under this process, CMS issues interim final RVUs for all revaluations and new codes in the PFS final rule with comment period and payments are based on those values during the CY covered by the final rule. CMS considers it appropriate to establish interim values for new, revised and potentially misvalued codes because of the timing incongruities between the PFS rulemaking cycle and the release of codes by the AMA CPT Editorial Panel and the RUC review process.

CMS notes that their recent revaluation of several code families have raised concerns from stakeholders with the existing process based on the reductions in payment for those services. Specifically, that they did not receive notice of the possible reductions before they occurred, CMS notes that stakeholders should be aware of changes because either CPT has made changes or CMS has identified the codes as potentially misvalued, and representatives of the affected specialties are participating in the RUC meetings. Commenters have asserted, however, they are not aware of RUC recommendations, they have no opportunity to respond to RUC recommendations and not all suppliers are permitted to participate in the RUC process. Additionally, some stakeholders objected to interim final decisions because they do not have an opportunity to meaningfully comment before the values are implemented in the next year's final rule.

In response to these concerns, CMS issued several proposals to modify the process of finalizing values for new and revised services via rulemaking each year. Based on comments received, they have elected to finalize the following:

2016 will be a transition year during which they will propose values for new, revised, and potentially misvalued codes that they receive RUC recommendations in time for inclusion in the 2016 NPRM. For all others, they will establish interim final values in the 2016 final rule as they have historically done.

In 2017, CMS will include proposed values for all codes for which CMS has complete RUC recommendations by **February 10th** of the preceding year. This will allow for stakeholder comment on the proposed values within the proposed rule notice and comment period, annually. For codes where CMS does not receive a RUC recommendation by the deadline, CMS will use G-codes in order to facilitate continued payment for certain services (those with predecessor codes) for which we do not receive RUC recommendations in time to propose values; and adopt interim final values in the case of wholly new services, for which there are no predecessor codes or values, and for which we do not receive RUC recommendations in time to propose values.

Refinement Panels

Within the NPRM, CMS proposed to eliminate the refinement panel process given that under the new structure outlined above, stakeholders would have the opportunity to comment on proposed values prior to them becoming finalized for the following year. CMS noted that they received a number of comments criticizing the refinement panel process, but overall were encouraged to retain it as a method of "appeal" for

stakeholders. CMS clarifies in the final rule that the purpose of the refinement panel is to give them additional information to consider in exercising our responsibility to establish appropriate RVUs for Medicare services. Like many of the commenters, CMS agreed the refinement panel is not achieving its purpose and often reiterates the issues raised and information discussed at the RUC. Since CMS had access to this information at the time interim final values were established, it seems unlikely that a repeat discussion of the same issues would lead them to change valuations based upon information that already had been carefully considered. **However, in light of the significant concerns raised by commenters, CMS did not finalize their proposal to eliminate the refinement panel. They stated they will explore ways to address the many concerns that they, and stakeholders, have about the refinement panel process and whether the change in process eliminates the need for a refinement panel.**

6) Improving Valuation of the Global Surgical Package – Concerns with 010 and 090 Globals (p. 127)

Within the 2015 NPRM, CMS proposed a major change to reporting global surgical procedures by suggesting a two year transition of all 010 and 090 global services to a 000 global. CMS finalized this proposal in within the final 2015 MPFS rule. They justify this decision based on their belief that in the context of the misvalued code initiative, it is critical for the RVUs used to develop PFS payment rates reflect the most accurate resource costs associated with PFS services. CMS does not believe that maintaining the post-operative 10-and 90-day global periods is compatible with their continued interest in using more objective data in the valuation of PFS services and accurately valuing services relative to each other. Because the typical number and level of post-operative visits during global periods may vary greatly across Medicare practitioners and beneficiaries, they believe that continued valuation and payment of these face-to-face services as a multi-day package may skew relativity and create unwarranted payment disparities within PFS payment. They also believe that the resource based valuation of individual physicians' services will continue to serve as a critical foundation for Medicare payment to physicians, whether through the current PFS or in any number of new payment models. Therefore, they feel it is critical that the RVUs under the PFS be based as closely and accurately as possible on the actual resources involved in furnishing the typical occurrence of specific services.

CMS plans to make this transition for current 10-day global codes in CY 2017 and for the current 90-day global codes in CY 2018, pending the availability of data on which to base updated values for the global codes. CMS believes that transitioning all 10- and 90-day global codes to 0-day global codes would:

- Increase the accuracy of PFS payment by setting payment rates for individual services based more closely upon the typical resources used in furnishing the procedures;
- Avoid potentially duplicative or unwarranted payments when a beneficiary receives post-operative care from a different practitioner during the global period;
- Eliminate disparities between the payment for E/M services in global periods and those furnished individually (CMS is clear in the rule they do not believe there should not be increased PE for surgical specialties when post-operative visits are provided, as compared to the PE included in a standard E/M visit);
- Facilitate availability of more accurate data for new payment models and quality research.

As they transition these codes, CMS acknowledges they will need to establish RVUs that reflect the change in the global period for all the codes currently valued as 10- and 90-day global surgery services. **CMS also states they intend to monitor any changes in the utilization of E/M visits following its implementation and seeking comment on potential payment policies that will mitigate such a change in behavior.**

CMS urges stakeholders to engage with them to determine the best method of operationalizing this change and puts forward several suggested approaches for consideration, including:

- Surveying high volume surgical codes as standalone procedures via the normal RUC process;
- Using a reverse building block approach to back visits out of the global codes to obtain a base procedure RVU and then using the current potentially misvalued code process to identify and value the small number of codes that represent the majority of the volume of services that are currently reported with codes with post-operative periods. Then adjusting the aggregate RVUs to account for the number of visits and using magnitude estimation to value the remaining services in the family;
- Valuing one code within a family through the current valuation process and then using magnitude estimation to value the remaining services in the family;
- Surveying a sample of codes across all procedures to create an index that could be used to value the remaining codes.

CMS states that prior to implementing these changes they intend to gather objective data on the number of E/M and other services furnished during the current post-operative periods and use that data to inform both the valuation of particular services and the budget neutrality adjustments required to implement this proposal. They note that collecting information through claims submission may be the best approach and they will propose such a collection through future rulemaking. They also ask for alternative suggestions to gather this information.

7) Establishing RVUs for 2015

The Academy is pleased to announce that as a result of our advocacy and comments on the 2014 final MPFS rule, we were able to obtain increases for 8 ENT services for CY 2015. Additionally, for all services RUC surveyed in the CY 2014 cycle, CMS affirmed the RUC valuation. For additional payment policy and RVU details, visit our RUC summary online.

8) Malpractice RVUs (p. 162)

Section 1848(c)(2)(B)(i) of the SSA requires CMS to review, and if necessary adjust, RVUs no less often than every 5 years. In CY 2015, CMS is implementing their third comprehensive review of malpractice (MP) RVUs. The MP RVUs were calculated by a CMS contractor based on updated MP premium data obtained from state insurance rate filings. The calculation requires using information on specialty-specific MP premiums linked to a specific service based on the relative risk factors of the specialties that furnish a particular service. MP premium information is weighted geographically and by specialty to account for variations by state and specialty. CMS describes the steps for calculating the proposed MP RVUs to include the following: (1) compute a preliminary national average premium for each specialty; (2) determine which premium class(es) to use within each specialty; (3) calculate a risk factor for each specialty; (4) calculate malpractice RVUs for each HCPCS code; and (5) rescale for budget neutrality so that the total proposed resource-based MP RVUs equal the total current resource-based MP RVUs. **CMS finalized this proposal with minor changes based on a wealth of comments received. The only change impact ENT is that they corrected an error which assigned cardiology as the dominant specialty for 31320 Diagnostic incision larynx, and replaced ENT as the dominant specialty for their service to assign the risk factor.**

9) Validating RVUs of Services (p. 102)

Under the ACA, the Secretary is directed to validate a sampling of RVUs for services identified by the seven categories listed above. ***In the CY 2013 proposed rule CMS informed the public of their intent to, "enter into a contract to assist them in validating RVUs of potentially misvalued codes that will explore a model for the validation of physician work under the PFS, both for new and existing services."*** Both contracts will extend over a 2 year period. More details were released regarding these contracts in the 2015 NPRM, including the first interim report from the Urban Institute. The RAND Corporation will use available data to build a validation model to predict work RVUs and the individual components of work RVUs, time and intensity. The model design will be informed by the statistical methodologies and approach used to develop the initial work RVUs and to identify potentially misvalued procedures under current CMS and AMA RUC processes. RAND will use a representative set of CMS-provided codes to test the model. RAND will consult with a technical expert panel on model design issues and the test results. Urban Institute will focus on the central role of time in establishing work RVUs and the concerns that have been raised about the current time values. A key focus of the project is collecting data from several practices for services selected by the contractor. The data will be used to develop time estimates. Urban Institute will use a variety of approaches to develop objective time estimates, depending on the type of service, which will be a very resource-intensive part of the project. Objective time estimates will be compared to the current time values used in the fee schedule. The project team will then convene groups of physicians from a range of specialties to review the new time data and their potential implications for work and the ratio of work to time. Additional detail on both projects can be found here. CMS notes that they are not making any policy surrounding this issue in the 2015 final rule, but they anticipate that a interim report on the RAND project will be available by the end of the year.

10) Payment for Secondary Interpretation of Images (P.502)

CMS says that questions have arisen as to whether and under what circumstances it would be appropriate for Medicare to permit payments under the PFS when physicians furnish subsequent interpretations of existing radiology images. Under current policy, Medicare can pay for a second interpretation (which is billed using modifier -77) under "unusual circumstances (for which documentation is provided)." ***CMS sought comment on the proposed rule to assess whether there is an expanded set of circumstances under which it would be appropriate to allow more routine Medicare payment for a second professional component for radiology services, and whether such a policy would be likely to reduce the incidence of duplicative advanced imaging studies. CMS also stated in the NPRM based on comment received,*** it will consider whether any further action is appropriate, such as proposing under future rulemaking to allow for payment of subsequent interpretations of advanced diagnostic images in lieu of duplicative studies.

Within the final rule CMS thanked commenters for their helpful feedback, but neglected to make any policy changes within this rule. They note that Any changes to the current policy on allowing physicians to more routinely bill for secondary interpretations of images will be addressed in future rulemaking.

11) Removal of Employment Requirements for Billing "Incident To" for Rural Health Clinic and Federally Qualified Health Center Visits (p. 563)

To provide RHCs and FQHCs with as much flexibility as possible to meet their staffing needs, CMS proposed to revise existing regulations (in several places) to remove the requirement that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC to allow nurses, medical assistants, and other auxiliary personnel to furnish "incident to" services under contract in RHCs and FQHCs. CMS stated this would involve no cost to the federal government, and adds that it cannot estimate a cost savings for RHCs and FQHCs. Within the final rule CMS finalized this policy as proposed for CY 2015.

12) Physician Compare Website (p. 601)

Under the ACA, CMS was required to develop, no later than January 1, 2011, a Physician Compare Internet website with information physicians enrolled in the Medicare program. The Act also requires that no later than January 1, 2013, CMS make a plan publicly available that will allow information on physician performance related to quality and patient experience measures. This includes requirements to make the information posted reliable and statistically valid, as well as ensuring that physicians whose information is posted have a reasonable opportunity to review their results before posting the information online. This consists of a 30-day previous period for all measurement performance data before it is publicly available. In addition, by 2015 CMS must submit a report to Congress updating them on the status of the website development and include information on efforts and plans to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice.

CMS released a redesigned Physician Compare website which can be found here: www.medicare.gov/physiciancompare. Information that is currently reflected on the site includes address, education and ABMS board certification information, hospital affiliations, and language skills. CMS is required to post the names of EPs who satisfactorily report under PQRS as well as those who are successful e-prescribers under the Medicare eRx Incentive Program. There is also a section on each provider's page indicating the quality programs under which the eligible professional satisfactorily reported. This information is reflected by links on the website. CMS states that all information posted on the website is derived from the PECOS system, and is verified by claims. (Please note: CMS states it is working to find ways to minimize the delay between when an edit is made in PECOS and when that edit is processed by Medicare Administrative Contractors (MACs) so as to minimize the delays in updating information on Physician Compare. To update information not found in PECOS, such as hospital affiliation and foreign language, professionals should contact the Physician Compare support team directly at PhysicianCompare@westat.com.) Further, to the extent practicable, CMS is required to include certain types of measures for public reporting, including: measures collected under PQRS; an assessment of patient health outcomes and functional status of patients; an assessment of the continuity and coordination of care; an assessment of efficiency; an assessment of patient experience and patient/caregiver engagement; and other information as determined by the Secretary.

CMS is continuing the expansion of public reporting on Physician Compare by making an even broader set of quality measures available for publication. CMS is continuing with its phased in approach and is not persuaded that the timeline for expansion is too aggressive. Within the CY 2015 MPFS final rule, CMS finalized the following:

(1) Inclusion of a notation for satisfactory PQRS GPRO reporters annually in the year following the year it was reported;
(2) Publicly reporting ALL 2015 PQRS measures for individual EPs collected through a Registry, EHR, or claims (but will not publicly report a measure that is in its first year);
(3) Publicly reporting ALL 2015 PQRS Group Practice Reporting Option (GPRO) measures reported via the Web Interface, EHR, and Registry for group practices of 2 or more EPs and all measures reported by ACOs with a minimum sample size of twenty patients (but will not publicly report a measure that is in its first year);
(4) Inclusion of an indicator for satisfactory reporters under PQRS, participants in the EHR MU Incentive Program, and EPs that satisfactorily reports all four of the Cardiovascular Prevention measure (the measure group has been removed from PQRS under this rule) for Million Hearts;
(5) Inclusion of an indicator for individuals who have earned the 2014 PQRS Maintenance of Certification Incentive;
(6) Publicly reporting 2015 CAHPS for PQRS for groups of 2 or more EPs and CAHPS for ACOs for those who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor;
(7) Publicly reporting ALL 2015 Qualified Clinical Data Registry (QCDR) measure data collected at the individual level, but will not publicly report any QCDR measures newly available for reporting for at least one year.

Note: CMS will publicly report all measures submitted and reviewed and deemed to be statistically valid and reliable in a downloadable file. Specific measures to be included on Physician Compare would be decided once CMS has analyzed the collected data, consumer testing, and stakeholder feedback. CMS notes its willingness to reach out to stakeholders, such as specialty societies, to ensure the measures for consideration remain clinically relevant and accurate. Group practices and eligible professionals with available data for public reporting will be informed via email when a 30-day preview period will occur. This 30-day period has been deemed sufficient to allow providers enough time to preview the data to be published. In the email correspondence from CMS, providers will be given instructions for previewing as well as information on how to request help. No preview period is afforded for demographic data, so it is important members ensure their information is up-to-date. For any question regarding demographic data, members should contact the Physician Compare support team at PhysicianCompare@westat.com.

CMS is also sought input regarding the items listed below. No formal proposal was set forth and CMS will be reviewing commenters feedback to determine inclusion for future rulemakings.
(1) Creating composites using 2015 data and publishing composites scores in 2016 by grouping measures based on the PQRS GPRO measure groups, if technically feasible (e.g., care coordination/patient safety measures, preventive care measures, coronary artery disease module);
(2) Creating composites and publishing composite scores for individual providers (e.g., coronary artery disease, preventive care, diabetes mellitus); and
(3) Posting specialty society measures on Physician Compare and linking from Physician Compare to specialty society websites that publish non-PQRS measures.

13) Physician Quality Reporting System (PQRS) (p. 653

For background and information on who is eligible to participate in PQRS, visit the Academy's website and fact sheets at http://bit.ly/entPQRS. The final rule focuses on CMS proposals related to the 2017 Physician Quality Reporting System (PQRS) payment adjustment, which will be based on an eligible professional's (EP's) or a group practice's reporting of quality measures data during the ***12-month calendar year reporting period occurring in 2015*** (that is, January 1 through December 31, 2015). ***The PQRS payment adjustment for 2016 and subsequent years for failure to meet the PQRS reporting requirements for the applicable reporting period is -2 percent.***

Criteria for Satisfactory Individual Reporting in 2017 (2015 performance year)

CMS made several changes to the criteria for satisfactory individual reporting for performance year (PY) 2015. A key change for 2015 is that CMS is now requiring individuals reporting via qualified registry (PQRS Wizard) and groups reporting via the GPRO reporting options to report on 1 of the new cross-cutting measures in addition to other reporting requirements if they see at least 1 Medicare patient in a face-to-face encounter (defined as a surgical procedure or general office visit/outpatient visit etc.).

Proposed Changes to Measures in CY 2015

New Individual Measures	Individual Cross-Cutting Measures	Measures with NQS Domain Changes	Measures Removed in 2015	Changes to how Measures can be Reported	Changes to Measure Groups	Changes to GPRO Measures
CMS has ADDED 20 measures in CY 2015. Listed in Table 53.	CMS has finalized the inclusion of 19 measures in the cross-cutting measures set. Listed in Table 52.	CMS has changed the NQS domain for 23 measures. Listed in Table 54.	CMS has REMOVED 50 measures. Listed in Table 55.	CMS has changed the way 33 measures are reported. Listed in Table 56.	CMS has increased the required minimum number of measures in measures groups from 4 to 6. As a result of Academy Advocacy, CMS has **added 2 new measures groups: Sinusitis and AOE**. CMS has removed 6 measures groups, including perioperative care.	CMS has added 4 measures to GPRO (listed in table 80) and removed 4 measures (listed in Table 79).

Changes to Individual Reporting Requirements

Reporting via Claims: CMS has finalized the proposal to require 9 measures covering at least 3 NQS domains be reported to satisfactorily report for the 2017 PQRS payment adjustment. In the event that EPs lack 9 measures applicable to their practice, the EP may still satisfactorily participate by reporting on 1-8 measures (as many measures are eligible to the EP's practice). EPs who report on fewer than 9 measures across 3 domains will be subject to the Measure Applicability Validation (MAV) process. EPs will not be required to report on cross-cutting measures if none of the measures in the measures set apply to the EP's practice.

If an EP sees at least 1 Medicare patient in a face-to-face encounter during the 12-month reporting period, 1 of the 9 required measures must be measures contained in the cross-cutting measures set. An EP will therefore report at least 1 cross-cutting measure and 8 additional PQRS measures covering 3 NQS domains.

Changes for Reporting via Qualified Registry:

CMS did NOT finalize the proposal to require registries to be able to report all cross-cutting measures found in Table 52; however, registries must be able to report at least 1 cross-cutting measure on behalf of its EP and group practices, provided that the EP sees at least one Medicare patient in a face-to-face encounter.

Instead of the proposed 3 outcome measure requirement, a qualified clinical data registry (QCDR) must possess at least 2 outcome measures. If the QCDR does not possess 2 outcome measures, then the registry may report at least 1 outcome measure and 1 of the following other types of measures – resource use, patient experience of care, efficiency/appropriate use, or safety (further defined on pages 834-835).

CMS has increased the number of optional additional measures that a QCDR may elect to submit. Beginning in 2015, a QCDR may now submit data for a maximum of 30 non-PQRS measures, instead of only 20.

CMS has extended the deadline for qualified registries to submit quality measures data to March 31 following the applicable reporting period (for example, March 31, 2016 for reporting period ending in 2015).

CMS has finalized a proposal to require that registries make publicly available the quality measures data for which its EPs report. An exception to this requirement will be made for new PQRS and non-PQRS measures that are in their first year of reporting by a QCDR. The QCDR will determine whether to report performance results at the individual or aggregate level.

Changes for Reporting via EHR:

If reporting via direct electronic health record (EHR) and EHR data submission vendor products that are certified electronic health record technology (CEHRT), CMS notes that updated implementation guides for data file formats for 2015, when available, will be posted at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms. These implementation guides will describe the

technical requirements for data submission, which CMS proposes to continue to apply to direct EHR products and EHR data submission vendor products for 2015 and beyond.

In 2015, CMS will NOT require eligible professional or group practices to provide the CMS EHR Certification Number of the product used, as it is not feasible for CMS to collect and store the information at this time.

CMS has finalized the proposal that individual EPs reporting individual measures via a direct EHR product that is CEHRT (or an EHR data submission vendor product that is CEHRT) must report 9 measures covering at least 3 of the NQS domains. If the CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, the EP will be required to report all of the measures for which there is Medicare patient data.

Individual reporting criteria for the satisfactory reporting of quality measures data via claims, qualified registry, EHRs, and satisfactory participation in QCDRs is summarized in Table 50.

Changes to Group Practice Reporting Option

In hopes of providing timelier feedback, CMS has changed the deadline by which a group practice must register to participate in the Group Practice Reporting Option (GPRO) to June 30 of the applicable 12-month reporting period (that is, June 30, 2015, for reporting periods occurring in 2015), rather than the previous deadline of September 30.

Group practice reporting criteria for satisfactory reporting via the GPRO is summarized in Table 51.

Changes to PQRS Quality Measures for 2015 and Beyond

The Academy is pleased that, as a direct result of its advocacy efforts, two new measures groups for Acute Otitis Externa (AOE) and Sinusitis have been added for PQRS reporting in 2015 and beyond. Additionally, CMS had proposed dropping some PQRS measures that lacked assigned measure owners/stewards. Fortunately, the Sleep Apnea Measures Group will remain in PQRS in 2015, as CMS has identified a measure steward for the group.

The Perioperative Measures Group has been removed as a reporting option; however, CMS has retained several of the individual perioperative measures which will continue to be available for PQRS in 2015 via claims and registry reporting options.

CMS also notes that it is beginning to group the final measures available for reporting according to specialty and refers readers to the current listing of measures by specialty at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html. CMS emphasizes that EPs are not required to report measures according to these suggested groups of measures. CMS adds that it plans to have a measure subset that specifically addresses multiple chronic conditions.

14) Value Based Payment Modifier (VBM) and Physician Feedback Reporting Program (p. 924)

Beginning **January 1, 2015,** CMS is required to apply a value-based payment modifier (VM) to specific physicians and groups of physicians under the PFS. In 2013, CMS finalized the decision to initially apply the VBM to all groups of physicians, identified by a single TIN, with 100 or more EPs (EPs) (physician, practitioner, therapist, speech-language pathologist, or audiologist). CMS had previously finalized CY 2013 as the initial performance period for the VBM that will be applied in CY 2015, and they propose that performance in CY 2015 will be used to calculate the payment modifier applied in CY 2017. **In CY 2017, CMS will apply the VM to all physicians and groups of physicians, regardless of group size. (Note: In the final rule, CMS delayed applying the VM to nonphysicians until CY 2018.)**

Finalized Policies for the VM

As discussed below in greater detail, CMS finalizes the following policies for the VM:

Apply the VM to all physicians and nonphysician EPs in groups with 2 or more EPs and to solo practitioners starting in CY 2017.

Make quality-tiering mandatory for groups and solo practitioners with Category 1 for the CY 2017 VM. Groups with **10 or more EPs would be subject to upward, neutral, or downward adjustments. Groups with between 2 and 9 EPs and solo practitioners who participate in PQRS, even if they do not meet requirements, would be held harmless from a penalty and subject to only an upward or neutral adjustment.**

Increase the amount of payment at risk under the VM from -2.0 percent in CY 2016 to -4.0 percent in CY 2017 for groups of 10 or more and -2.0 percent penalty to groups with two to nine EPs and solo practitioners that fall in Category 2. When combined with the PQRS penalty, this would total a -4% penalty for groups with two to nine EPs and solo practitioners and a -6 percent penalty for groups of 10 or more.

Apply the VM to physicians EPs participating in an ACO under the Shared Savings Program, or other similar CMS initiatives starting in CY 2017. (CMS decided not to finalize the policy to apply the VM to nonphysicians in an ACO.)

Finalizes the exclusion of non-assigned claims for non-participating providers from the VM.

Align the quality measures and quality reporting mechanisms for the VM with those available to groups and individuals under the PQRS during the CY 2015 performance period.

Expand the current informal inquiry process to allow additional corrections for the CY 2015 payment adjustment period.

Address the concerns raised by NQF regarding the per capital cost measures in the cost composite.

Group Size & Definitions

CMS finalized the policies that beginning with CY 2017, the VM would be applied to physician and nonphysician EPs in groups with 2 or more EPs and to solo practitioners based on the CY 2015 PQRS performance period.

Physicians are defined as: doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

EP are defined as any of the following: (1) a physician; (2) a practitioner described in section 1842(b)(18)(C) of the Act: physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse mid-wife, clinical social worker, clinical psychologist, registered dietician, or nutritional professional; (3) a physical or occupational therapist or qualified speech-language pathologist; or (4) a qualified audiologist.

CMS will define a group of physicians as a single TIN with 2 or more EPs, as identified by their individual NPI and have reassigned their Medicare billing rights to the TIN. During the payment adjustment period, all nonphysician EPs who bill under a group's TIN would be subject to the same VM that would apply to the physicians who bill under the TIN.

CMS will define a solo practitioner as a single TIN with 1 EP as identified by an individual NPI billing under the TIN.

Approach to Setting the VM Adjustment Based on PQRS Participation

CMS will classify groups and solo practitioners subject to the CY 2017 VM using a two-category approach that is based on whether and how groups and solo practitioners participate in the PQRS in 2015. Similar to the categorization of groups of physicians eligible for the CY 2016 VM, **CMS finalized the two-category approach for the CY 2017 VM based on participation in the PQRS by groups and solo practitioners** (PQRS reporting requirements are discussed above).

Category 1	**Category 2**
INCLUDES: Groups of any size and solo practitioners who **DO** participate in PQRS (even if they do not meet the PQRS requirement) fall into this category. **This specifically includes:** **Groups** that meet the criteria for satisfactory reporting data on PQRS quality measures via the GPRO (through use of the web-interface, EHR, or registry reporting mechanism) **Groups** that do not register to participate in the PQRS GPRO in CY 2015 and that have at least 50 percent of the group's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals (through the use of claims, EHR, or registry reporting mechanism) for the CY 2017 payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS-qualified clinical data registry for the CY 2017 PQRS payment adjustment. **Solo practitioners** that meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals (through the use of claims, EHR or registry reporting mechanisms) for the CY 2017 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS-qualified clinical data registry for the CY 2017 PQRS payment adjustment **(-2.0% penalty from PQRS but no penalty for VM)**.	**INCLUDES:** Groups of any size and solo practitioners who **DO NOT** participate in PQRS fall into this category and could receive penalties. **This specifically includes:** Those groups and solo practitioners that are subject to the CY 2017 VM and do not meet the criteria for Category 1. As discussed above, CMS finalized a -2.0 percent VM to groups with **two or more EPs and solo practitioners** that are in Category 2 **(-2.0% penalty from PQRS AND -2.0% VM)**. For **10 or more EPs**, CMS will apply -4.0 % penalty for those with low quality/high cost.

Payment Adjustment Amount

The ACA requires the VM to be implemented in a budget neutral manner. In the CY 2014 PFS FR, CMS adopted a policy to apply a maximum downward adjustment of 2.0 percent for the CY 2016 VM for groups of physicians with 10 or more EPs that are in Category 2 and for groups of physicians with 100 or more EPs that are in Category 1 and are classified as low quality/high cost groups. In CY 2017, CMS finalized the policy to increase the downward adjustment under the VM by doubling the amount of payment at risk from 2.0 percent in CY 2016 to 4.0 percent in CY 2017, for groups of ten or more. **In response to commenters who suggested that a gradual phase-in of adjustments should be allowed for smaller groups, CMS made a change to their proposed policy.** The agency finalized the policy to hold groups with two to nine EPs and solo practitioners in Category I (those who participate in PQRS even if do not meet the requirements) harmless from any VM penalty.

Table 88 and 89, show the proposed quality-tiering payment adjustment amounts for CY 2017 based on CY 2015 performance.

TABLE 88: CY 2017 Value-Based Payment Modifier Amounts for Groups with 2-9 EPs and Solo Practitioners

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	-0.0%	+0.0%	+1.0x*
High Cost	-0.0%	-2.0%	+0.0%

TABLE 89: CY 2017 Value-Based Payment Modifier Amounts for Groups with 10 or More EPs

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

*For both tables, groups and solo practitioners eligible for an additional +1.0x if reporting Physician Quality Reporting System ("x" is determined after the performance period has ended based on the aggregate amount of downward payment adjustments.)

Physician Feedback Program / Quality Resource Use Reports (QRURs)

In September 2014, CMS disseminated QRURs based on CY 2013 data to all physicians even though groups with fewer than 100 EPs will not be subject to the VM in CY2015. CMs notes these reports will contain performance on the quality and cost measures used to score the cost and quality composites for the VM.

Beginning in CY2016 payment adjustment period, CMS finalized allowing 60 days from the release of the QRUR for a group or solo practitioner to request a correction of a perceived error related to the VM calculation. CMS will also take steps to establish a process for accepting requests from providers to correct certain errors made by CMS or a third-party vendor (i.e., registry).

While CMS noted it is not feasible to provide the annual QRURs earlier in the year while still allowing sufficient time for claims run out and reporting period, the agency is exploring how to provide semi-annual reports.

Episode Costs and the Supplemental QRURs: The ACA requires the Secretary to develop an episode grouper and include episode-based costs in the QRURs. While the current episodes are informational only and not specific to otolaryngology, the Academy continues to monitor the status of CMS efforts to develop and implement episode groupers and participate in any grouper related to the specialty. For more information, visit: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html. CMS is considering whether to propose their inclusion in the VM through future rulemaking.

15) Electronic Health Record Incentive Program (EHR) (p. 841)

The Electronic Health Records (EHR) Meaningful Use (MU) Incentive Program is an initiative designed to facilitate the use of certified EHR technology (CEHRT) in clinical settings. Eligible professionals, hospitals, and critical access hospitals that demonstrate meaningful use of EHRs are eligible for incentive payments. Starting in 2015, EPs, hospitals and critical access hospitals that do not successfully demonstrate MU of EHRs will be subject to penalties. Providers must report the required number of objectives and CQMs (and meet other reporting requirements) to be successful participants. In order for EPs to successfully report the CQMs selected by CMS, EPs must report in the form and manner specified by CMS.

Under the CY 2014 MPFS final rule, EPs seeking to report CQMs electronically under the EHR Incentive Program are required to use the most recent version of the electronic specifications for the CQMs and have CEHRT that is tested and certified to the most recent version of the electronic specifications for the CQMs. According to CMS, the latter requirement created additional difficulties and expenses, and therefore it changed the requirement in the CY 2015 MPFS final rule. Specifically, EPs are not required to ensure that their CEHRT products are recertified to meet the most recent version of the electronic specification for CQMs. ***However, EPs must still report the most recent version of the electronic specifications for the CQMs.*** In 2015, if CMS discover errors in the most recently updated electronic measure specifications for a certain measure, CMS would use the version that immediately preceded the most recent update. This is to account for instances where errors are discovered in the update electronic measure specifications.

Additional Information

The CY 2015 final MPFS rule with comment period on interim policies is published at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-P.html. CMS will respond to comments in the CY 2015 MPFS final rule. The electronic submissions of comment can be made at URL: www.Regulations.gov search for CMS and final rules.