2017 MPFS Proposed Rule

On July 7, 2016, the Centers for Medicare & Medicaid Services (CMS) released the Proposed Rule for the Medicare Physician Fee Schedule (MPFS). The Rule will be published in the Federal Register on July 15, and public comments are due by September 6. The Final Rule will be released by early November and will be effective January 1, 2017.

CMS estimates a 2017 conversion factor of $35.7551, which reflects the 0.5% update specified by the Medicare Access and CHIP Reauthorization Act (MACRA), a budget neutrality adjustment, and an adjustment due to the non-budget neutral 5% multiple procedure payment reduction for the professional component of imaging services. While this represents a slight decrease, it will increase funding to primary care providers by $900 million in 2017. Proposed policy changes of interest to radiology providers include:

Mammography: The Proposed Rule states that the current CPT® codes for mammograms and computer-aided detection (CAD) are being deleted for 2017 and replaced with 3 new codes that include both mammography and CAD. CMS states that this CPT® revision eliminates the need for the HCPCS G codes for mammograms (G0202, G0204, G0206), which will be deleted. CMS plans to accept the work RVUs that were recommended by the RUC (Relative Value Update Committee) for the new mammogram CPT® codes. However, CMS proposes to crosswalk the practice expense RVUs for the technical component of the new codes to the corresponding G codes for 2017, while requesting public input regarding equipment prices.

CMS proposes to maintain its current coding structure for digital breast tomosynthesis for 2017, except that G0279 (the add-on code for diagnostic tomosynthesis) would now be reported together with the new CPT® codes for diagnostic mammography, which will replace G0204 and G0206.

Multiple Procedure Payment Reduction (MPPR): As required by the Consolidated Appropriations Act of 2015, CMS is reducing the professional component payment reduction for multiple advanced imaging exams from 25% to 5%, effective January 1, 2017.

Appropriate Use Criteria (AUC): In the 2016 rulemaking cycle CMS established an approval process for AUC. In the 2017 rulemaking cycle the agency is establishing an approval process for Clinical Decision Support Mechanisms (CDSMs), which are the interactive electronic tools through which ordering physicians will consult the AUC when ordering advanced diagnostic imaging services. CMS is proposing the following list of “priority clinical areas” that each CDSM must include:

- Chest pain (includes angina, suspected myocardial infarction, and suspected pulmonary embolism)
- Abdominal pain (any locations and flank pain)
- Headache, traumatic and non-traumatic
- Low back pain
- Suspected stroke
- Altered mental status
- Cancer of the lung (primary or metastatic, suspected or diagnosed)
- Cervical or neck pain

CMS will also use these priority clinical areas when determining which ordering professionals fall into the outlier category. (Outlier professionals will be required to obtain prior authorization for advanced imaging services beginning in calendar year 2020.)

CMS anticipates publishing the first list of qualified CDSMs by June 30, 2017. CMS notes that PAMA (the Protecting Access to Medicare Act of 2014) requires ordering professionals to begin using AUC by January 1, 2017, but since CMS will not have published a list of qualified CDSMs by that date, ordering professionals will not be required to consult CDSMs by that date, nor will imaging professionals be able to report AUC results on their claims by that date. CMS anticipates that imaging professionals could begin claims reporting of AUC results as early as January 1, 2018, but the agency will not provide detailed information until the 2018 rulemaking cycle.

Exceptions to the AUC consultation and reporting requirements include imaging exams on patients with emergency medical conditions, and imaging exams on inpatients. Additionally, CMS proposes to grant a hardship exception to ordering professionals who qualify for a hardship exception for purposes of the Medicare EHR Incentive Program. However, this does not include ordering professionals with a primary specialty of anesthesiology, radiology, or pathology, unless they meet other hardship requirements such as lack of Internet access. In other words, radiologists who order advanced diagnostic imaging exams for outpatients will be required to comply with AUC requirements.

**Payment for Film X-Rays:** The Consolidated Appropriations Act of 2016 requires a 20% payment reduction for the technical component (regardless of whether billed separately or as part of the global service) of x-rays taken using film rather than digital radiography. This reduction will begin in 2017, and CMS proposes to require providers to use a modifier to identify film x-rays so that they may be discounted. A payment reduction for computed radiography will begin in 2018, and CMS will address that provision in future rulemaking.

**Moderate Sedation:** CMS proposes to no longer include payment for moderate sedation in procedures that are listed in Appendix G of the CPT® manual, and the CPT® Editorial Panel is eliminating Appendix G for 2017. Instead, providers will use 6 new CPT® codes and 1 new HCPCS code to report moderate sedation whenever it is provided. This will allow CMS to avoid including payment for moderate sedation in the procedure payment even in those cases when the procedure was performed under anesthesia rather than moderate sedation. CMS also proposes to reduce the RVUs for the Appendix G procedures to reflect the fact that moderate sedation is now separately reportable.

**Global Surgery Services:** MACRA requires CMS to begin collecting data in 2017 from a representative sample of physicians regarding items and services furnished during the global period of services with 10-day or 90-day global periods. There are over 4,000 such services, including several performed by radiologists, such as insertion of tunneled central venous catheter, percutaneous gastrostomy,
vertebroplasty/kyphoplasty, and carotid stent placement. CMS is required to use the collected data in rate-setting beginning in 2019.

CMS’s proposed data collection process would include:

- Claims reporting of all pre- and postoperative visits for 10-day and 90-day global procedures by any physician or practitioner who provides these services.
- A survey of approximately 5,000 physicians and practitioners who have billed Medicare for more than a minimum number of 10-day and 90-day global procedures. The survey would collect information on a sample of 20 postoperative visits provided during a brief window of time, such as 2 weeks.
- Direct observation of pre- and postop care in a small number of sites.

Claims reporting would be required for global services provided on or after January 1, 2017. Each office/outpatient visit during the global period would be reported with one of 8 new HPCS codes, depending on:

- Who provided the service (physician/practitioner vs clinical staff)
- Whether it was provided in person or electronically (via phone or Internet)
- Whether the visit was inpatient or outpatient
- How long the visit lasted
- Whether the visit was “typical,” complex, or involved a critical illness

The Proposed Rule includes a list of activities that would be included in a “typical” visit, and the visit would not be considered complex unless it included services beyond the typical list. All of the new codes would be nonpayable.

CMS has the authority to hold 5% of the physician’s payment if he or she fails to report the required information, but CMS does not intend to use this authority at this time.

0-Day Global Services Billed with E/M: CMS has identified 83 codes that have 0-day global periods and were billed together with an evaluation and management code (with modifier 25) more than 50% of the time. Since routine E/M services are included in the valuation of 0-day global services, CMS believes this indicates a problem with the procedure RVUs, and these services are being flagged as potentially misvalued. The list includes services sometimes performed by radiologists, such as thoracentesis, arthrocentesis, and injection of tendon, tendon sheath, and trigger points.

The MPFS Proposed Rule also includes information on the Medicare Diabetes Prevention Program Expansion, Updated California 2017 GPCI information, Transfers of Value to Covered Recipients, Release of Part C Medicare Advantage Bid Pricing Data and Part C & Part D Medical Loss Ratio Data, Medicare Advantage Provider Enrollment, Value Based Modifier, Physician Self-Referral Updates and the Medicare Shared Savings Program.

The full text of this Proposed Rule is located at: