

## Summary of the 2017 Proposed Medicare Physician Fee Schedule

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### Executive Summary

On July 7, the Centers for Medicare & Medicaid Services (CMS) released a [proposed rule](#) titled, “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model.” In addition, the agency issued a related [press release](#) and [fact sheet](#). In particular, this year’s proposed rule places a specific emphasis on primary care. CMS leaders also published a [blog](#) titled, “Focusing on Primary Care for Better Health.” In this blog, CMS discusses how the agency should:

*...reinvest in what we value — primary care — as a practice, as a profession, and as an abundant resource for patients. In recent years, we have begun taking a number of meaningful steps to begin this reinvestment process. Today, we are proposing significant actions to improve how we pay primary care physicians, mental health specialists, geriatricians, and other clinicians. By better valuing primary care and care coordination, we help beneficiaries access the services they need to stay well. In addition to keeping people healthy, health care costs are lower when people have a primary care provider and team of doctors and clinicians overseeing and coordinating their care.*

CMS proposes several new physician fee schedule policies that address Medicare payment for services provided by primary care physicians for patients with multiple chronic conditions, mental and behavioral health issues, and cognitive impairment or mobility-related disabilities.

CMS proposes to expand the Medicare Diabetes Prevention Program model starting in 2018. This development marks the first time a preventive service model from the CMS Innovation Center and only the second time an Innovation Center model would be expanded into the Medicare program.

CMS also proposes to add several codes to the list of services eligible to be furnished via telehealth, including: Advance Care Planning (ACP) services and critical care consultations furnished via telehealth using new Medicare G-codes.

In addition CMS also proposes:

- Modifications to the Medicare ACO Shared Savings Program to update the quality measures set and align with the proposals for the Quality Payment Program (QPP) and the Core Quality Measures Collaborative recommendations, changes to take beneficiary preferences for ACO assignment into consideration, and changes that would improve beneficiary protections when ACOs are approved to use the Skilled Nursing Facility (SNF) 3-day waiver rule;
- Requiring health care providers and suppliers to be screened and enrolled in Medicare in order to contract with Medicare Advantage health plans;
- Increasing transparency of Medicare Advantage price data and medical loss ratio data; and
- Continuing to implement Appropriate Use Criteria for advanced diagnostic imaging services.

This regulation will be published in the July 15 *Federal Register* and comments are due to the agency by September 6. The AAFP is currently analyzing the regulation and will provide detailed comments to CMS.

### **Conversion Factor for 2017**

To calculate the payment for each service, the relative value unit (RVU) components of the fee schedule (work, practice expense, and malpractice) are adjusted by geographic practice cost indices (GPCIs) to reflect the variations in the costs of furnishing the services. RVUs are converted to dollar amounts through the application of a conversion factor, which is calculated based on a statutory formula. The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

$$\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU practice expense} \times \text{GPCI practice expense}) + (\text{RVU Malpractice} \times \text{GPCI Malpractice})] \times \text{conversion factor}.$$

For 2017, CMS estimates the conversion factor to be **\$35.7751**, which is slightly lower than the 2016 conversion factor of \$35.8043. Included at the end of the AAFP summary is CMS Table 41, which illustrates how CMS calculated the estimated 2017 conversion factor. Unlike in 2016, CMS did not need to apply an adjustment for a target recapture amount.

Also, included at the end of the AAFP summary is Table 43 (proposed rule estimated impact on total allowed charges by specialty). Family physicians, in aggregate and compared to other specialties, are projected to receive an estimated 3-percent increase in Medicare-allowed charges based on the provisions of the proposed rule. This increase is the largest estimated update for a given specialty.

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

#### **Background**

The Medicare Payment Advisory Commission (MedPAC) commented to CMS that the fee schedule is an ill-suited payment mechanism for primary care and cognitive care generally. MedPAC recommended that Congress replace the expired Primary Care Incentive Payment (PCIP) with a capitated payment mechanism and expressed preference for codes like Chronic Care Management (CCM), which are

beneficiary-centered codes that do not pay for each distinct care coordination activity. Additionally, a number of modifications to the current CCM payment rules have been recommended to CMS in order to cover the cost of furnishing these services.

### Proposed Changes

Of particular significance to primary care physicians, CMS proposes increased payments for several care management services; specifically, the regulation includes proposals that:

- Make separate payments for certain existing Current Procedural Terminology (CPT) codes describing non-face-to-face prolonged evaluation and management services.
- Revalue existing CPT codes describing face-to-face prolonged services.
- Make separate payments using new codes to describe the comprehensive assessment and care planning for patients with cognitive impairment (e.g., dementia).
- Make separate payments using new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions.
- Make separate payments using new codes to recognize the increased resource costs of furnishing visits to patients with mobility-related impairments.
- Make separate payments for codes describing CCM for patients with greater complexity.
- Make several changes to reduce administrative burden associated with the CCM codes to remove potential barriers to furnishing and billing for these important services.

Included at the end of this summary is an AAFP-created table that shows the national Medicare reimbursement amount unadjusted by geographic payment factors for these proposed services. Actual payment allowances for an individual physician will vary geographically and based on any other payment adjustments (PQRS, VM, etc.) that apply to the individual.

## **Identification and Review of Potentially Misvalued Services**

### Background

The *Affordable Care Act* requires CMS to periodically identify potentially misvalued services and to review and make appropriate adjustments to the relative values for those services. The *Achieving a Better Life Experience Act* set targets for adjustments to misvalued codes in the fee schedule for 2016, 2017, and 2018. The target was one percent for 2016 and 0.5 percent for each of 2017 and 2018. If the net reductions in misvalued codes in 2017 are less than 0.5 percent of the total revenue under the fee schedule, a reduction equal to the percentage difference between 0.5 percent and the percent of expenditures represented by misvalued codes reductions must be made to all fee schedule services.

### Proposed Changes

CMS proposes misvalued code changes that achieve 0.51 percent in net expenditure reductions. If finalized, these changes meet the misvalued code target of 0.5 percent, thereby avoiding an overall reduction in Medicare payments.

## **Medicare Telehealth Services: End-Stage Renal Disease (ESRD) and Advanced Care Planning**

### Background

Several conditions must be met for Medicare to make payments for telehealth services under the fee schedule. The service must be on the list of Medicare telehealth services and meet all of these requirements; namely, that the service must be furnished:

- via an interactive telecommunications system.
- by a physician or other authorized practitioner.
- to an eligible telehealth individual.

In addition, the individual receiving the service must be located in a telehealth originating site. When all of these conditions are met, Medicare pays a facility fee to the originating site and makes a separate payment to the distant-site practitioner furnishing the service.

### Proposed Changes

CMS proposes to add several codes to the list of services eligible to be furnished via telehealth. These include:

- ESRD related services for dialysis;
- ACP services;
- Critical care consultations using new Medicare G-codes.

CMS also proposes payment policies related to the use of a new place-of-service code for reporting services furnished via telehealth.

### **Payment for Mammography Services**

#### Background

In 2002, CMS began reimbursing three G-codes pertaining to digital mammography services (screening mammography, unilateral diagnostic mammography, and bilateral diagnostic mammography) and reimbursed film mammography through the use of CPT codes.

#### Proposed Changes

Recognizing the use of Computer-Aided Detection (CAD) mammography, CMS proposes to implement new CPT coding for mammography services. The coding revision reflects current technology used in furnishing these services, including a transition from film to digital imaging equipment and elimination of separate coding for CAD services. CMS proposes to maintain current valuation for the technical component of mammography services in order to implement coding and payment changes over several years.

### **Updated Geographic Practice Cost Indices (GPCIs)**

#### Background

CMS is required to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three components—physician work, practice expense, and malpractice—of the fee schedule. The agency must review and adjust the GPCIs, as necessary, every 3 years at minimum.

Since 2009, a permanent 1.5 work GPCI floor for services furnished in Alaska has existed. Since 2011, there has also been a permanent 1.0 practice expense GPCI floor for services furnished in “frontier states” (defined as at least 50 percent of the state’s counties have a population density of less than 6 persons per square mile). CMS has identified five frontier states: Montana, Wyoming, North Dakota, Nevada and South Dakota.

#### Proposed Changes

As required by law, CMS proposes new GPCIs using updated data to be phased in over 2017 and 2018. In conjunction with this proposed update, CMS proposes to revise the methodology used to calculate GPCIs in the U.S. territories for consistency among the Pacific and Caribbean islands. This proposed revision would increase overall fee schedule payments in Puerto Rico.

The *Protecting Access to Medicare Act* requires that CMS use new locality definitions for California based on a combination of Metropolitan Statistical Areas as defined by the Office of Management and Budget and the current locality structure. The California locality provision is not budget-neutral, meaning that payments to physicians in California will increase in the aggregate without across-the-

board reductions in physician services elsewhere. The movement to the new locality structure in California may increase payments to many physicians in urban parts of California without any reductions in specified counties that the law “holds harmless” from payment reductions. In a few areas of California, the new locality structure may decrease Medicare fee schedule payments.

## **Collecting Data on Resources Used in Furnishing Global Services**

### Background

Under the misvalued code initiative in the 2015 final rule, CMS finalized a policy to transform all 10- and 90-day global codes to 0-day global codes, beginning in 2018. Under this policy, CMS would have valued the surgery or procedure to include all services furnished on the day of surgery and paid separately for visits and services furnished after the day of the procedure. Subsequently, Congress intervened and prohibited CMS from implementing this AAFP-backed policy. Instead, CMS is now required to gather data on visits in the post-surgical period that could be used to accurately value these services.

### Proposed Changes

CMS proposes a data collection strategy, including claims-based data collection and a survey of 5,000 practitioners, to gather data on the activities and resources involved in furnishing these services. To the extent that this data results in proposals to revalue any surgical services, that revaluation will be done through future rulemaking.

## **0-day Global Services That Are Typically Billed with an Evaluation and Management (E/M) Service with Modifier 25**

### Background

Because CMS assumes that the valuation of codes with 0-, 10-, and 90-day global periods includes a certain amount of evaluation and management of the patient, Medicare only makes separate payment for E/M services that are provided in excess of those considered included in the global procedure. In such cases, the physician would report the additional E/M service with Modifier 25 appended, which is defined as a significant, separately identifiable E/M service performed by the same physician on the day of a procedure above and beyond other services provided or beyond the usual preservice and post-service care associated with the procedure that was performed. Modifier 25 allows physicians to be paid for E/M services that would otherwise be denied as bundled.

### Proposed Changes

CMS notes that several high-volume procedure codes are typically reported with a modifier that unbundles payment for visits from the procedure, even though the modifier should only be used for reporting services beyond those usually provided. Therefore, CMS believes the services may be misvalued. As a result, CMS proposes to prioritize 83 services for review as potentially misvalued. Included at the end of the AAFP summary is CMS Table 7 that lists these 83 services.

## **Medicare Diabetes Prevention Program**

### Background

The [Medicare Diabetes Prevention Program](#) is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. The clinical intervention consists of 16 intensive “core” sessions of a curriculum in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control. After the 16 core sessions, less-intensive monthly follow-up meetings help ensure that the participants maintain healthy behaviors. The primary goal of the intervention is at least 5 percent average weight loss among participants.

In March 2016, the Department of Health and Human Services announced that the CMS Office of the Actuary certified that expansion of the Medicare Diabetes Prevention Program model would reduce net Medicare spending. The expansion was also determined to improve the quality of patient care without limiting coverage or benefits. These are the requirements a CMS Innovation Center model must meet to be eligible for expansion. The Diabetes Prevention Program is the second CMS Innovation Center – and the first preventive – model to meet these requirements.

### Proposed Changes

CMS proposes to expand the Diabetes Prevention Program within Medicare beginning January 1, 2018. The agency proposes to designate services in the Medicare Diabetes Prevention Program as “additional preventive services” under Medicare Part B, since CMS considers the services of this program to be consistent with other types of additional preventive services. Through expansion, more Medicare beneficiaries will be able to access the benefits of the program. CMS seeks public comment on how the program should:

- Allow CDC-recognized Diabetes Prevention Program organizations to enroll in Medicare beginning on January 1, 2017.
- Reimburse programs for diabetes prevention sessions attended and the achievement and maintenance of a minimum weight loss.
- Require CDC-recognized Diabetes Prevention Program entities to submit claims to Medicare using standard claims forms and procedures, submitted electronically in batches.
- Define eligible pre-diabetic beneficiaries based on body mass index (BMI) in addition to hemoglobin A1C tests, or plasma glucose levels.
- Develop program integrity policies to monitor and audit Medicare Diabetes Prevention Program entities.
- Establish site-of-service requirements.
- Provide education, training, and technical assistance on Medicare enrollment, data security, claims submission, and medical record keeping for Medicare Diabetes Prevention Program entities.
- Collect quality metrics for payment and public reporting to guide beneficiary choice of entities.
- Be expanded over time such as nationally in the first year or phased in gradually.

### **Reports of Payments or Other Transfers of Value to Covered Recipients**

#### Background

In 2013, CMS published the final rule, titled “Transparency Reports and Reporting of Physician Ownership or Investment Interests.” It requires manufacturers of covered drugs, devices, biologicals, and medical supplies (applicable manufacturers) to submit annually information about certain payments or transfers of value made to physicians and teaching hospitals (covered recipients). The law also requires applicable manufacturers and group purchasing organizations (GPOs) to disclose any ownership or investment interests in such entities held by physicians or their immediate family members, as well as information on payments or other transfers of value provided to such physician owners or investors. Commonly referred to as either the CMS Open Payments program or Sunshine Act, this policy creates transparency around the nature and extent of relationships that exist between drug, device, biologicals, medical supply manufacturers, physicians, and teaching hospitals.

In 2015 CMS issued final regulations that specifically:

- Deleted the definition of “covered device”;
- Removed the continuous medical education (CME) exclusion;
- Expanded the marketed name reporting requirements to biologicals and medical supplies; and
- Required stock, stock options, and any other ownership interests to be reported as distinct forms of payment.

### Proposed Changes

CMS discusses that various stakeholders have provided feedback regarding aspects of the Open Payment program and that the agency has identified areas in the rule that might benefit from revision. Therefore, CMS asks several questions and seeks comments to inform future rulemaking.

## **Medicare Advantage (Part C) Provider Enrollment**

### Background

To receive payment for a furnished Medicare Part A or Part B service or item, or to order, certify, or prescribe certain Medicare services, items, and drugs, a provider or supplier must enroll in Medicare. The enrollment process requires the provider or supplier to complete, sign, and submit to its assigned Medicare contractor the appropriate Form CMS-855 enrollment application. The CMS-855 application form captures information about the provider or supplier that is needed for CMS or its contractors to screen the provider or supplier and determine whether the provider or supplier meets all Medicare requirements. This screening prior to enrollment helps to ensure that unqualified individuals and entities do not bill Medicare and that the Medicare Trust Funds are accordingly protected. Data collected and verified during the enrollment process generally includes, but is not limited to:

- Basic identifying information (for example, legal business name, tax identification number);
- State licensure information;
- Practice locations; and
- Information regarding ownership and management control.

### Proposed Changes

CMS proposes to require physicians, providers, and suppliers to be screened and enrolled in Medicare in order to contract with a Medicare Advantage organization to provide Medicare-covered items and services to beneficiaries enrolled in Medicare Advantage health plans. This proposal creates consistency with enrollment requirements for all other Medicare (Part A, Part B, and Part D) programs, as well as a requirement that health care providers in a Medicaid managed care plan's network be screened and enrolled with the state Medicaid program. This proposal also prevents Medicare Advantage participation by health care providers or suppliers that have had their Medicare enrollment revoked or have been excluded by the Office of the Inspector General.

## **Release of Part C Medicare Advantage Bid Pricing Data and Part C and Part D Medical Loss Ratio Data**

### Background

As part of the annual bidding process, Medicare Advantage (MA) organizations submit bids for each plan they wish to offer in the upcoming contract year. As required by law, data supporting medical loss ratios (MLR) are submitted annually to CMS by MA plans and Part D sponsors.

### Proposed Changes

CMS proposes to release two new sets of data annually, MA bid pricing data and Part C and Part D MLR data. CMS hopes that making this data publicly available will assist public research, future policymaking efforts, and beneficiaries in making enrollment decisions. The MA bid pricing data would be at least five years old and would exclude information treated as proprietary.

## **Appropriate Use Criteria for Advanced Diagnostic Imaging Services**

### Background

The *Protecting Access to Medicare Act* establishes a program under the Medicare fee-for-service program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services.

This policy requires physicians ordering certain imaging services—magnetic resonance, computed tomography, nuclear medicine, and positron emission tomography imaging—for Medicare beneficiaries to consult with AUC applicable to the imaging modality.

In the 2016 proposed Medicare physician fee schedule, CMS stated that AUC “crosses almost every medical specialty and could have a particular impact on primary care physicians since their scope of practice can be quite vast.”

The 2016 final Medicare physician fee schedule addressed the initial component of the AUC program, by outlining requirements to use an evidence-based, transparent process for developing AUC and establishing a process to identify provider-led entities to become qualified to develop, modify, or endorse AUC. In late June, CMS posted an [initial list](#) of qualified entities. These include:

- American College of Cardiology Foundation
- American College of Radiology
- Brigham and Women's Physicians Organization
- CDI Quality Institute
- Intermountain Healthcare
- Massachusetts General Hospital, Department of Radiology
- National Comprehensive Cancer Network
- Society for Nuclear Medicine and Molecular Imaging
- University of California Medical Campuses
- University of Washington Physicians
- Weill Cornell Medicine Physicians Organization

### Proposed Changes

The regulation focuses on the next component of the Medicare AUC program and includes proposals for priority clinical areas, clinical decision-support mechanism (CDSM) requirements, the CDSM application process, and exceptions for ordering professionals for whom consultation with AUC would pose a significant hardship. CDSMs are the electronic tools through which a clinician consults AUC to determine the level of clinical appropriateness for an advanced diagnostic imaging service for that particular patient's clinical scenario.

CMS developed and proposed eight priority, clinical areas that it believes reflect both the significance and prevalence of some of the most disruptive diseases in the Medicare population. They are:

- Chest pain
- Abdominal pain
- Headache, traumatic and non-traumatic
- Low back pain
- Suspected stroke
- Altered mental status
- Lung cancer
- Cervical or neck pain

These eight clinical areas account for roughly 40 percent of Part B advanced diagnostic imaging services paid for by Medicare in 2014. Included at the end of the AAFP summary is Table 34 that further details the cost and utilization of these eight proposed priority clinical areas. CMS seeks feedback on the proposed list of priority clinical areas and recommendations for other clinical areas that should be included in the future.

Noting that a list of qualified CDSMs is not yet available and will not be available by January 1, 2017, CMS will not require ordering professionals to meet this requirement by that date. At the earliest, the first qualified CDSMs will be specified on June 30, 2017. CMS anticipates that providers may begin reporting as early as January 1, 2018.

CMS proposes three exceptions to the AUC consultation and reporting requirements:

- For an applicable imaging service ordered for an individual with an emergency medical condition;
- For applicable imaging services ordered for an inpatient and for which payment is made under Medicare Part A; and
- For an ordering professional who CMS determines, on a case-by-case basis and subject to annual renewal, that consultation with applicable AUC would result in a significant hardship, such as in the case of a professional practicing in a rural area without sufficient Internet access.

## **Medicare Shared Savings Program**

### Background

The Medicare Shared Savings Program is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

### Proposed Changes

CMS proposes to make several policy changes to the Medicare Shared Savings Program regulations, including:

- Updates to ACO quality reporting, including:
  - Changes to the quality measure set to better align with the QPP proposed rule and recommendations from the Core Quality Measures Collaborative, a public-private effort aimed at aligning quality measures for reporting across payers to reduce provider reporting burden;
  - Changes to the quality validation audit, revisions to terminology used in quality assessment, revisions that would permit eligible professionals in ACOs to report quality apart from the ACO, and updates to align with the Physician Quality Reporting System (PQRS) and the proposed QPP, such as technical modifications to the EHR quality measure;
- Modifications to the assignment algorithm to align beneficiaries to an ACO when a beneficiary has prospectively (and voluntarily) designated an ACO professional as their “main doctor” responsible for their overall care using an automated approach;
- Establishing beneficiary protection policies related to use of the SNF 3-day waiver; and,
- Technical changes to certain rules related to merged and acquired TINs and for reconciliation of ACOs that fall below 5,000 beneficiaries.

## **Value-Based Payment Modifier and Physician Feedback Program**

### Background

Starting in 2015, CMS was required to establish a value-based payment modifier (VM) and apply it to specific physicians and groups of physicians. CMS is required to apply the VM to all physicians and groups of physicians by January 1, 2017. The VM is required to be budget neutral.

In the 2016 final Medicare physician fee schedule, CMS discussed how MACRA stipulates that the VM shall not be applied to payments for items and services furnished on or after January 1, 2019, since MACRA establishes that the Merit-based Incentive Payment System (MIPS) shall apply to payments for items and services furnished on or after January 1, 2019.

Proposed Changes

The agency proposes to update the VM informal review policies and establish how the quality and cost composites under the VM would be affected if unanticipated program issues arise. In addition, CMS is proposing to permit eligible professionals that participate in a Medicare Shared Savings Program to report to the PQRS outside the ACO for purposes of the PQRS payment adjustment.

**Tables**

**TABLE 34: Proposed Priority Clinical Areas with Corresponding Claims Data**

Proposed Priority Clinical Area	Total Services	% Total Services <sup>1</sup>	Total Payments	% Total Payments/l
Chest Pain (includes angina, suspected myocardial infarction, and suspected pulmonary embolism)	4,435,240.00	12%	\$ 470,395,545	14%
Abdominal Pain (any locations and flank pain)	2,973,331.00	8%	\$ 235,424,592	7%
Headache, traumatic and non-traumatic	2,107,868.00	6%	\$ 89,382,087	3%
Low back pain	1,883,617.00	5%	\$ 180,063,352	5%
Suspected stroke	1,810,514.00	5%	\$ 119,574,141	4%
Altered mental status	1,782,794.00	5%	\$ 83,296,007	3%
Cancer of the lung (primary or metastatic, suspected or diagnosed)	1,114,303.00	3%	\$ 154,872,814	5%
Cervical or neck pain	1,045,381.00	3%	\$ 83,899,299	3%

<sup>1</sup> Percentage of 2014 Part B non-institutional claim line file for advanced imaging services from Medicare claims for beneficiaries who are enrolled in the fee-for-service (FFS) program (source: CMS Chronic Conditions Data Warehouse).

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

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

TABLE 43: CY 2017 PFS Estimated Impact on Total Allowed Charges by Specialty\*

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
TOTAL	\$89,467	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	\$230	0%	1%	0%	2%
ANESTHESIOLOGY	\$1,977	0%	-1%	0%	0%
AUDIOLOGIST	\$61	0%	0%	0%	1%
CARDIAC SURGERY	\$322	0%	0%	0%	0%
CARDIOLOGY	\$6,461	0%	0%	0%	1%
CHIROPRACTOR	\$779	0%	0%	0%	0%
CLINICAL PSYCHOLOGIST	\$727	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	\$601	0%	0%	0%	0%
COLON AND RECTAL SURGERY	\$160	0%	0%	0%	0%
CRITICAL CARE	\$308	0%	0%	0%	0%
DERMATOLOGY	\$3,305	0%	0%	0%	1%
DIAGNOSTIC TESTING FACILITY	\$750	0%	-2%	0%	-2%
EMERGENCY MEDICINE	\$3,133	0%	0%	0%	0%
ENDOCRINOLOGY	\$458	1%	1%	0%	2%
FAMILY PRACTICE	\$6,087	1%	1%	0%	3%
GASTROENTEROLOGY	\$1,744	0%	0%	0%	-1%
GENERAL PRACTICE	\$451	1%	1%	0%	2%
GENERAL SURGERY	\$2,157	0%	0%	0%	0%
GERIATRICS	\$211	1%	1%	0%	2%
HAND SURGERY	\$182	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	\$1,746	1%	1%	0%	2%
INDEPENDENT LABORATORY	\$701	0%	-5%	0%	-5%
INFECTIOUS DISEASE	\$652	0%	0%	0%	1%
INTERNAL MEDICINE	\$10,849	1%	1%	0%	2%
INTERVENTIONAL PAIN MGMT	\$767	1%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	\$315	-1%	-5%	0%	-7%
MULTISPECIALTY CLINIC/OTHER PHYS	\$128	1%	1%	0%	1%
NEPHROLOGY	\$2,205	0%	-1%	0%	-1%
NEUROLOGY	\$1,514	1%	1%	0%	1%
NEUROSURGERY	\$784	-1%	0%	0%	-1%
NUCLEAR MEDICINE	\$47	0%	0%	0%	0%
NURSE ANES / ANES ASST	\$1,211	0%	0%	0%	0%
NURSE PRACTITIONER	\$2,974	1%	1%	0%	2%
OBSTETRICS/GYNECOLOGY	\$647	0%	1%	0%	1%
OPHTHALMOLOGY	\$5,493	0%	-2%	0%	-2%
OPTOMETRY	\$1,213	0%	-1%	0%	-1%
ORAL/MAXILLOFACIAL SURGERY	\$48	0%	0%	0%	0%
ORTHOPEDIC SURGERY	\$3,685	0%	0%	0%	0%
OTHER	\$26	0%	0%	0%	0%
OTOLARNGOLOGY	\$1,208	0%	0%	0%	0%
PATHOLOGY	\$1,127	0%	-2%	0%	-2%
PEDIATRICS	\$61	1%	1%	0%	2%
PHYSICAL MEDICINE	\$1,062	0%	0%	0%	1%
PHYSICAL/OCCUPATIONAL THERAPY	\$3,395	0%	0%	0%	1%
PHYSICIAN ASSISTANT	\$1,959	0%	1%	0%	1%
PLASTIC SURGERY	\$374	0%	0%	0%	0%
PODIATRY	\$1,954	0%	0%	0%	1%
PORTABLE X-RAY SUPPLIER	\$104	0%	-1%	0%	-1%
PSYCHIATRY	\$1,250	1%	1%	0%	1%
PULMONARY DISEASE	\$1,759	0%	0%	0%	1%
RADIATION ONCOLOGY	\$1,720	0%	0%	0%	0%
RADIATION THERAPY CENTERS	\$43	0%	-1%	0%	-1%
RADIOLOGY	\$4,670	0%	-1%	0%	-1%
RHEUMATOLOGY	\$536	1%	1%	0%	2%
THORACIC SURGERY	\$356	0%	0%	0%	0%
UROLOGY	\$1,764	-1%	0%	0%	-1%
VASCULAR SURGERY	\$1,045	0%	-2%	0%	-2%

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

**TABLE 7: 0-day Global Services that are Typically Billed with an Evaluation and Management (E/M) Service with Modifier 25**

HCP/PCS	Long Descriptor
11000	Removal of inflamed or infected skin, up to 10% of body surface
11100	Biopsy of single growth of skin or tissue
11300	Shaving of 0.5 centimeters or less skin growth of the trunk, arms, or legs
11301	Shaving of 0.6 centimeters to 1.0 centimeters skin growth of the trunk, arms, or legs
11302	Shaving of 1.1 to 2.0 centimeters skin growth of the trunk, arms, or legs
11305	Shaving of 0.5 centimeters or less skin growth of scalp, neck, hands, feet, or genitals
11306	Shaving of 0.6 centimeters to 1.0 centimeters skin growth of scalp, neck, hands, feet, or genitals
11307	Shaving of 1.1 to 2.0 centimeters skin growth of scalp, neck, hands, feet, or genitals
11310	Shaving of 0.5 centimeters or less skin growth of face, ears, eyelids, nose, lips, or mouth
11311	Shaving of 0.6 centimeters to 1.0 centimeters skin growth of face, ears, eyelids, nose, lips, or mouth
11312	Shaving of 1.1 to 2.0 centimeters skin growth of face, ears, eyelids, nose, lips, or mouth
11740	Removal of blood accumulation between nail and nail bed
11755	Biopsy of finger or toe nail
11900	Injection of up to 7 skin growths
11901	Injection of more than 7 skin growths
12001	Repair of wound (2.5 centimeters or less) of the scalp, neck, underarms, trunk, arms or legs
12002	Repair of wound (2.6 to 7.5 centimeters) of the scalp, neck, underarms, genitals, trunk, arms or legs
12004	Repair of wound (7.6 to 12.5 centimeters) of the scalp, neck, underarms, genitals, trunk, arms or legs
12011	Repair of wound (2.5 centimeters or less) of the face, ears, eyelids, nose, lips, or mucous membranes
12013	Repair of wound (2.6 to 5.0 centimeters) of the face, ears, eyelids, nose, lips, or mucous membranes
17250	Application of chemical agent to excessive wound tissue
20526	Injection of carpal tunnel
20550	Injections of tendon sheath, ligament, or muscle membrane
20551	Injections of tendon attachment to bone
20552	Injections of trigger points in 1 or 2 muscles
20553	Injections of trigger points in 3 or more muscles
20600	Aspiration or injection of small joint or joint capsule
20604	Arthrocentesis, aspiration or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting
20605	Aspiration or injection of medium joint or joint capsule
20606	Arthrocentesis, aspiration or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting
20610	Aspiration or injection of large joint or joint capsule
20611	Arthrocentesis, aspiration or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting
20612	Aspiration or injection of cysts
29105	Application of long arm splint (shoulder to hand)
29125	Application of non-moveable, short arm splint (forearm to hand)
29515	Application of short leg splint (calf to foot)
29540	Strapping of ankle or foot
29550	Strapping of toes
30901	Simple control of nose bleed
30903	Complex control of nose bleed
31231	Diagnostic examination of nasal passages using an endoscope
31238	Control of nasal bleeding using an endoscope
31500	Emergent insertion of breathing tube into windpipe cartilage using an endoscope
31575	Diagnostic examination of voice box using flexible endoscope
31579	Examination to assess movement of vocal cord flaps using an endoscope

HCPCS	Long Descriptor
31645	Aspiration of lung secretions from lung airways using an endoscope
32551	Removal of fluid from between lung and chest cavity, open procedure
32554	Removal of fluid from chest cavity
40490	Biopsy of lip
43760	Change of stomach feeding, accessed through the skin
45300	Diagnostic examination of rectum and large bowel using an endoscope
46600	Diagnostic examination of the anus using an endoscope
51701	Insertion of temporary bladder catheter
51702	Insertion of indwelling bladder catheter
51703	Insertion of indwelling bladder catheter
56605	Biopsy of external female genitals
57150	Irrigation of vagina or application of drug to treat infection
57160	Fitting and insertion of vaginal support device
58100	Biopsy of uterine lining
64405	Injection of anesthetic agent, greater occipital nerve
64418	Injection of anesthetic agent, collar bone nerve
64455	Injections of anesthetic or steroid drug into nerve of foot
65205	Removal of foreign body in external eye, conjunctiva
65210	Removal of foreign body in external eye, conjunctiva or sclera
65222	Removal of foreign body, external eye, cornea with slit lamp examination
67515	Injection of medication or substance into membrane covering eyeball
67810	Biopsy of eyelid
67820	Removal of eyelashes by forceps
68200	Injection into conjunctiva
69100	Biopsy of ear
69200	Removal of foreign body from ear canal
69210	Removal of impact ear wax, one ear
69220	Removal of skin debris and drainage of mastoid cavity
92511	Examination of the nose and throat using an endoscope
92941	Insertion of stent, removal of plaque or balloon dilation of coronary vessel during heart attack, accessed through the skin
92950	Attempt to restart heart and lungs
98925	Osteopathic manipulative treatment to 1-2 body regions
98926	Osteopathic manipulative treatment to 3-4 body regions
98927	Osteopathic manipulative treatment to 5-6 body regions
98928	Osteopathic manipulative treatment to 7-8 body regions
98929	Osteopathic manipulative treatment to 9-10 body regions
G0168	Wound closure utilizing tissue adhesive(s) only
G0268	Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing

Enhanced Payment Proposed for Primary Care, Care Management, and Patient-Centered Services					
Code	Short Description	Medicare Allowances		Notes	
		2016	2017		
99354	Prolonged E/M Outpatient	\$ 100.97	\$ 130.94	Non-facility rate	
99355	Prolonged E/M Outpatient add-on	\$ 98.10	\$ 98.74	Non-facility rate	
99356	Prolonged service inpatient	\$ 92.73	\$ 93.02	Facility rate	
99357	Prolonged service inpatient add-on	\$ 92.02	\$ 92.66	Facility rate	
99358	Prolonged service non face-to-face	\$ -	\$ 113.41	Bundled in 2016; non-facility payment rate in 2017	
99359	Prolonged service non face-to-face add-on	\$ -	\$ 54.38	Bundled in 2016; non-facility payment rate in 2017	
99487	Complex Chronic Care Management without patient visit	\$ -	\$ 92.66	Bundled in 2016; non-facility payment rate in 2017	
99489	Complex Chronic Care Management additional 30 minutes	\$ -	\$ 46.87	Bundled in 2016; non-facility payment rate in 2017	
GDDD1	Intensive service during E/M for mobility-related impairments	n/a	\$ 44.36	New for 2017; non-facility rate	
GPPP1	Initial psychiatric care management	n/a	\$ 135.95	New for 2017; non-facility rate	
GPPP2	Subsequent psychiatric care management	n/a	\$ 119.85	New for 2017; non-facility rate	
GPPP3	Initial/Subsequent psychiatric care management	n/a	\$ 59.74	New for 2017; non-facility rate	
GPPP6	Assessment for cognitive impairment	n/a	\$ 217.51	New for 2017; non-facility rate	
GPPP7	Assessment for Chronic Care Management care plan	n/a	\$ 63.68	New for 2017; non-facility rate	
GPPPX	Behavioral health care month	n/a	\$ 44.00	New for 2017; non-facility rate	