CMS Releases CY 2016 Physician Fee Schedule Proposed Rule

On July 8, CMS released the Proposed Rule for the CY 2016 Physician Fee Schedule. Comments are due to the agency by September 8, 2015.

OVERVIEW

Major changes in the Proposed Rule relate to decreases to radiation oncology and gastroenterology due to revisions to the inputs used to develop RVUs while other specialties, such as pathology and independent laboratories, will experience increases to payments. Overall, however, CMS indicates that the impact of the Final Rule for most specialties is roughly flat. This is true for those specialties chiefly involved in the treatment of peripheral artery disease such as cardiology and interventional radiology.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>0 %</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>1 %</td>
</tr>
</tbody>
</table>

Conversion Factor

CMS notes in the Proposed Rule that the 2015 conversion factor is estimated to be $35.9335 and the 2016 conversion factor is estimated to be $36.1096.

KEY CODES

Key PAD codes also are relatively flat in the 2016 PFS Proposed Rule.
A. Using OPPS and ASC Rates in Developing PE RVUs

In the 2014 PFS Proposed Rule, CMS proposed to limit the nonfacility practice expense RVUs (PE RVUs) for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined amount (OPPS technical plus PFS professional) Medicare would pay for the same code in the facility setting. In the 2014 PFS Final Rule, CMS decided not to implement this policy given broad stakeholder concern with the proposal.

<table>
<thead>
<tr>
<th>CPT</th>
<th>Procedure Description</th>
<th>Non-Facility Payment (Final)</th>
<th>Non-Facility Payment (Proposed)</th>
<th>2015 Final vs 2016 Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>36147</td>
<td>Access av dial grft for eval</td>
<td>$854</td>
<td>$863</td>
<td>1.08%</td>
</tr>
<tr>
<td>37220</td>
<td>Iliac revasc</td>
<td>$3,231</td>
<td>$3,262</td>
<td>0.95%</td>
</tr>
<tr>
<td>37224</td>
<td>Fem/popl revas w/tla</td>
<td>$3,920</td>
<td>$3,957</td>
<td>0.94%</td>
</tr>
<tr>
<td>37225</td>
<td>Fem/popl revas w/ather</td>
<td>$11,276</td>
<td>$11,377</td>
<td>0.90%</td>
</tr>
<tr>
<td>37226</td>
<td>Fem/popl revasc w/stent</td>
<td>$9,273</td>
<td>$9,352</td>
<td>0.86%</td>
</tr>
<tr>
<td>37227</td>
<td>Fem/popl revasc stnt &amp; ather</td>
<td>$15,227</td>
<td>$15,365</td>
<td>0.91%</td>
</tr>
<tr>
<td>37228</td>
<td>Tib/per revasc w/tla</td>
<td>$5,575</td>
<td>$5,623</td>
<td>0.86%</td>
</tr>
<tr>
<td>37229</td>
<td>Tib/per revasc w/ather</td>
<td>$11,125</td>
<td>$11,208</td>
<td>0.75%</td>
</tr>
<tr>
<td>37230</td>
<td>Tib/per revasc w/stent</td>
<td>$8,506</td>
<td>$8,572</td>
<td>0.78%</td>
</tr>
<tr>
<td>37231</td>
<td>Tib/per revasc stnt &amp; ather</td>
<td>$13,666</td>
<td>$13,793</td>
<td>0.93%</td>
</tr>
<tr>
<td>37234</td>
<td>Revsc opn/prq tib/pero stent</td>
<td>$3,967</td>
<td>$4,006</td>
<td>0.97%</td>
</tr>
<tr>
<td>37235</td>
<td>Tib/per revasc stnt &amp; ather</td>
<td>$4,261</td>
<td>$4,216</td>
<td>-1.05%</td>
</tr>
</tbody>
</table>
In the 2015 PFS Final Rule, CMS stated it continues to believe there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology. The agency noted, “we continue to believe that the routinely updated, auditable resource cost information submitted contemporaneously by a wide array of providers across the country 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.”

Notwithstanding CMS’ discussion in prior rulemaking, in the CY 2016 PFS Proposed Rule, CMS’s discussion was limited. Stated CMS, “In CY 2014, we also considered a proposal to limit Medicare PFS payments for services furnished in a non-facility setting when the PFS payment would exceed the combined Medicare payment made to the practitioner under the PFS and facility payment made to either the ASC or hospital outpatient. Based upon extensive public comment we did not finalize this proposal.”

**B. Maintenance Factor**

CMS notes in the 2016 PFS Final Rule that several stakeholders suggested the maintenance factor should be variable and the agency has solicited comments regarding reliable data on maintenance costs that vary for particular equipment items. However, in the Final Rule, the agency states it would like to receive “multiple invoices containing equipment prices that are accompanied by maintenance contracts” to provide support for a maintenance cost other than the currently assumed 5 percent “[r]ather than assertions that a particular maintenance rate is typical.”

In the CY 2016 PFS Proposed Rule, CMS noted “it is clear that the relationship between maintenance costs and the price of equipment is not necessarily uniform across equipment. However, based on our review of comments, we have been unable to identify a systematic way of varying the maintenance cost assumption relative to the price or useful life of equipment.” CMS raises “longstanding difficulties” in acquiring accurate pricing information for equipment items and asserts that maintenance cost information would be similarly questionable.

**C. Non-facility PERVUs for Intravascular Ultrasound (IVUS)**

In the CY 2015 Proposed Rule, CMS noted that a stakeholder requested that the agency establish non-facility PE RVUs for CPT codes 37250 and 37251. CMS sought comment regarding whether it is appropriate to have non-facility PE RVUs for these codes and, if so, what inputs should be assigned to these codes. The CVC supported the establishment of non-facility PE RVUs for IVUS in the freestanding setting.

In the CY 2016 PFS Proposed Rule, although nonfacility PE RVUs are not established for 37250 and 37251, new IVUS codes are established through 3725A (Intrvasc us noncoronary 1st) at $1,440 and 3725B (Intrvasc us noncoronary addl) at $221.
D. Alternative Payment Models

CMS notes in the rule that it intends to publish specific questions in a forthcoming Request for Information (RFI) relating to the following:

- the criteria for assessing physician-focused payment models;
- the criteria and process for the submission of physician-focused payment models eligible APMS, qualifying APM participants;
- the Medicare payment threshold option and the combination all-payer and Medicare payment threshold option for qualifying and partial CMS-qualifying APM participants;
- the time period to use to calculate eligibility for qualifying and partial-qualifying APM participants, eligible APM entities, quality measures and EHR use requirements; and
- the definition of nominal financial risk for eligible APM entities.

In anticipation of the future RFI and subsequent notice and comment rulemaking, CMS requests comments on approaches to implementing any of the topics listed in this section, including in provisions not enumerated above, and any other related concerns.

E. Potential Changes to the Conversion Factor or other Codes in the Final Rule

In the Protecting Access to Medicare Act of 2014 (PAMA), Congress set a target for adjustments to misvalued codes in the fee schedule for calendar years 2017 through 2020, with a target amount of 0.5 percent of the estimated expenditures under the PFS for each of those four years. Subsequently, the Achieving a Better Life Experience Act of 2014 (ABLE) accelerated the application of the target by specifying it would apply for calendar years 2016 through 2018, and increasing the target to 1 percent for 2016. If the net reductions in misvalued codes in 2016 are not equal to or greater than 1 percent of the estimated expenditures under the fee schedule, a reduction equal to the percentage difference between 1 percent and the estimated net reduction in expenditures resulting from misvalued code reductions must be made to all PFS services (i.e. to the conversion factor).

In this proposed rule, CMS is proposing a methodology for the implementation of this provision, which includes how net reductions in misvalued codes would be calculated. Based on that methodology, CMS has identified changes that achieve 0.25 percent in net reductions. However, CMS could make further misvalued code changes in the final rule to move closer to the statutory goal of 1 percent based on public comment and new recommendations.

CMS notes that because CY 2016 represents a transition year in its new process of proposing values in the proposed rule rather than the final, it will establish interim final values for any codes received after the February 10th deadline but in time for CMS to value for the final rule. CMS states that for CY 2016, there will still be a significant number of codes valued not in the proposed rule but in the final rule with comment period. Therefore, for CY 2016, unlike for the targets for CY 2017 and CY 2018, because CMS will not be able to calculate a realistic estimate of the target amount at the time the proposed rule is published, the agency will not incorporate the impact of the target into the calculation of the proposed PFS payment rates.
MEDCAC Examines Improved Outcomes for PAD in Meeting

The Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) convened a meeting on July 22 in order to explore how to improve health outcomes for Medicare populations with peripheral artery disease (PAD).

At the meeting, a MEDCAC panel sought insight from experts in the cardiovascular care community and addressed discussion questions released in May. MEDCAC stated that clinical outcomes of interest to the Medicare program include:

- Reduction in pain;
- Avoidance of amputation;
- Improvement in quality of life and/or functional capacity including walking distance;
- Wound healing;
- Avoidance of cardiovascular events (including myocardial infarction, stroke, cardiovascular death, and all-cause mortality); and
- Avoidance of harms from interventions.

MEDCAC posted the following information and official documents on its website:

- Agenda
- Roster
- Speakers list
- Presentations
- Written comments
- Technology Assessment: Treatment Strategies for Patients With Peripheral Artery Disease
- Appendix to Technology Assessment
- 2008 Technology Assessment: Horizon Scan of Invasive Interventions for Lower Extremity Peripheral Artery Disease and Systematic Review of Studies Comp

For more details about the meeting, click here.
Study Examines Volume of Peripheral Endovascular Procedures, Outcomes

In a new study published in the American Journal of Cardiology, researchers examined the relationship between the volume of peripheral endovascular procedures performed in hospitals and patient outcomes. Overall, they concluded that hospitals performing a greater number of lower-extremity endovascular interventions have better in-hospital outcomes and fewer complications than those with lower volumes.

In the study, entitled “Impact of Hospital Volume on Outcomes of Lower Extremity Endovascular Interventions,” the study’s authors also discovered that hospitalization costs were lower in the highest-volume hospitals compared to the lowest-volume centers.

Researchers examined the results of 92,714 adult patients with peripheral vascular disease who underwent an endovascular intervention between 2006 and 2011. Specifically, their findings included:

<table>
<thead>
<tr>
<th>In-Hospital Outcomes of Peripheral Endovascular Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest-Volume Centers (&gt; 126 cases/year)</td>
</tr>
<tr>
<td>Mortality</td>
</tr>
<tr>
<td>Complications</td>
</tr>
<tr>
<td>Mortality/Complications</td>
</tr>
<tr>
<td>Amputation</td>
</tr>
</tbody>
</table>

The study’s authors called for additional research, expressly noting that up to 39 percent of endovascular procedures were performed in the outpatient setting, which they did not examine.

“Our study evaluated critical outcomes like in-hospital mortality, amputation rates, and complications, which are more likely to occur in patients with critical limb ischemia rather than those undergoing elective procedures for intermittent claudication,” said Dr. Badheka, one of the study’s authors. “We... encourage other authors to investigate volume-outcome relationships for outpatient procedures and see if they differ from our results.”

The study is available here.
21st Century Cures Bill Passes House

On July 10, the House approved the 21st Century Cures bill (H.R. 6) by a vote of 344-77. Lawmakers are currently preparing to introduce the bill in the Senate for consideration.

The updated bill also maintains two key provisions:

- **Improvements in the Medicare Local Coverage Determination Process.** The local coverage determination (LCD) process is an important means by which seniors can access treatments that would not otherwise be covered by Medicare due to the length of time it takes for the national process to conclude its work. However, improvements are needed. This section would increase transparency around the LCD process and begin the process of bringing greater accountability to the actions of those contracting with the Centers for Medicare and Medicaid Services to manage the operation of the Medicare program.

- **Medicare Site-of-Service Price Transparency.** The Medicare benefit currently pays varying rates for the same services depending on where they are delivered. As a result, seniors’ out of pocket costs can be higher or lower for a given procedure based upon where the service is provided. This section would give seniors the ability to shop among certain sites of service for certain services so that they can identify the most cost-effective treatments.

For the full text of H.R. 6, [click here](#).

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CMS Announces 12-Month Safe Harbor Period for ICD-10 Implementation

The Centers for Medicare & Medicaid Services (CMS), in coordination with the American Medical Association (AMA), announced new efforts to help prepare physicians for the looming transition from ICD-9 to the updated ICD-10 medical coding system, which is set to take place on October 1.

CMS also released [additional guidance](#) that will allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set.

For 12 months beginning on October 1, Medicare claims will not be denied or audited if physicians submit incorrect ICD-10 codes, as long as the ICD-10 code is in the correct broad category. The new guidance also states that CMS will not penalize providers reporting quality programs if the agency has problems calculating quality scores because of the new codes.
An ICD-10 Ombudsman will be available to help receive and triage physician and provider issues, according to the CMS guidance. Specifically, the Ombudsman will work with CMS’ regional offices to address physicians’ concerns. The agency will release guidance about how to submit issues to the Ombudsman in the coming months.

Together, AMA and CMS will also provide webinars, on-site training, educational articles, and national provider calls to help physicians and care providers to learn about the updated codes and prepare for the transition. Additional help is available at the website “Road to 10,” which specifically aims to help provide resources to smaller physician practices and specialty-specific providers during the implementation.

For the full CMS press release, click here.