CMS Releases Final 2016 Physician Fee Schedule Rule

On October 30, 2015, CMS released the Final Rule for the CY 2016 Physician Fee Schedule (“Final Rule”).

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, interventional radiology and vascular surgery.

<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>
<tr>
<td>Vascular Surgery</td>
<td>-1%</td>
</tr>
</tbody>
</table>

CONVERSION FACTOR

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 the Final Rule, CMS notes that the CY 2016 Target Recapture Amount pursuant to the PAMA/ABLE Act provision will produce a gross reduction to the CF of -0.77 percent. This is partially offset by the 0.5% update to the conversion factor under the Medicare Access and CHIP Reauthorization Act of 2015. The net of these policies (along with minor adjustments due to budget neutrality for RVU adjustments) results in an estimated 2016 conversion factor of $35.8279.

**OPD/ASC CAP CODES**

Key CVC codes that were cut by the OPD/ASC cap proposal in the CY 2014 Physician Fee Schedule Proposed Rule also are relatively flat in the 2016 PFS Proposed Rule as evidenced by the table below.

<table>
<thead>
<tr>
<th>CPT</th>
<th>Procedure Description</th>
<th>2015 Non-Facility Payment (Final)</th>
<th>2016 Non-Facility Payment (Final)</th>
<th>2015 Final vs. 2016 Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>36147</td>
<td>Access ac dial grft for eval</td>
<td>$854</td>
<td>$853</td>
<td>0%</td>
</tr>
<tr>
<td>37220</td>
<td>Iliac revasc</td>
<td>$3,231</td>
<td>$3,219</td>
<td>0%</td>
</tr>
<tr>
<td>37224</td>
<td>Fem/popl revas w/tla</td>
<td>$3,920</td>
<td>$3,905</td>
<td>0%</td>
</tr>
<tr>
<td>37225</td>
<td>Fem/popl revas w/ather</td>
<td>$11,276</td>
<td>$11,377</td>
<td>-1%</td>
</tr>
<tr>
<td>37226</td>
<td>Fem/popl revasc w/stent</td>
<td>$9,273</td>
<td>$9,224</td>
<td>-1%</td>
</tr>
<tr>
<td>37227</td>
<td>Fem/popl revasc stnt &amp; ather</td>
<td>$15,227</td>
<td>$15,151</td>
<td>-1%</td>
</tr>
<tr>
<td>37228</td>
<td>Tib/per revasc w/tla</td>
<td>$5,575</td>
<td>$5,548</td>
<td>0%</td>
</tr>
<tr>
<td>37229</td>
<td>Tib/per revasc w/ather</td>
<td>$11,125</td>
<td>$11,055</td>
<td>-1%</td>
</tr>
<tr>
<td>37230</td>
<td>Tib/per revasc w/stent</td>
<td>$8,506</td>
<td>$8,456</td>
<td>-1%</td>
</tr>
<tr>
<td>37231</td>
<td>Tib/per revasc stnt &amp; ather</td>
<td>$13,666</td>
<td>$13,604</td>
<td>0%</td>
</tr>
<tr>
<td>37234</td>
<td>Revasc opn/prq tib/pero stent</td>
<td>$3,967</td>
<td>$3,950</td>
<td>0%</td>
</tr>
<tr>
<td>37235</td>
<td>Tib/per revasc stnt &amp; ather</td>
<td>$4,261</td>
<td>$4,159</td>
<td>-2%</td>
</tr>
</tbody>
</table>
OTHER ISSUES

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 (PERVUs) 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.

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 Final Rule, CMS’s discussion was limited. Stated CMS, “After considering the many comments we received regarding our proposal, the majority of which urged us to withdraw the proposal for a variety of reasons, we decided not to finalize the policy. However, we continue to believe that using PE data that are auditable, comprehensive, and regularly updated would contribute to the accuracy of PE calculations.”

B. Maintenance Factor

CMS notes in the Final Rule that the agency solicited comments during CY 2015 rulemaking regarding the availability of reliable data on maintenance costs that vary for particular equipment items. In reviewing comments, the agency found “it is clear that the relationship between maintenance costs and the price of equipment is not necessarily uniform across equipment.” However, the agency states it has been “unable to identify a systematic way of varying the maintenance assumption relative to the price or useful life of equipment” and expressed concerns regarding the use of single invoices to price maintenance costs.

The agency continues to seek a source of publicly available data on actual maintenance costs for medical equipment.

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 code 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 this code. The CVC supported the establishment of non-facility PERVUs for IVUS in the freestanding setting.

In the CY 2016 PFS Final Rule, although nonfacility PERVUs are not established for 37250 and 37251, new IVUS codes are established through 37252 (Intrvasc us noncoronary 1st) at $1,422.37 and 37253 (Intrvasc us noncoronary addl) at $221.06.
Provider Groups Submit Comments to CMS on MACRA Implementation

On November 16, dozens of physician and provider groups outlined broad principles they urge the Centers for Medicare & Medicaid Services (CMS) to follow as it implements the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which overhauls Medicare physician reimbursement. Led by the American Medical Association (AMA), the letter urges CMS to implement new payment models in a manner that helps physicians transition to new care and delivery models, and assures physicians can choose from an array of alternative payment models (APMs) to ensure access to high-quality care for all patients.

Specifically, the organizations urged the Administration to adopt the following 10 principles:

- Support delivery system improvements;
- Avoid administrative and cost burdens for patients;
- Reduce administrative burdens for physicians;
- Improve current quality and reporting systems;
- Recognize patient diversity;
- Provide choice of payment models;
- Be equitable;
- Be relevant and actionable;
- Provide stability and resources; and
- Be transparent.

The letter also states that ongoing dialogue with physicians will promote smooth and successful implementation of Merit-Based Incentive Programs (MIPS) and APMs.

For the full letter to CMS, click here.

JAMA Study finds Endovascular Revascularization & Exercise Raises Quality of Life

A new study by JAMA published on November 10, 2015 found that among patients with intermittent claudication, the combination of endovascular revascularization and supervised exercise significantly improved walking distances and health-related quality of life scores compared with just supervised exercise only.

The study was conducted with randomized clinic trials that included 212 patients who underwent either endovascular revascularization plus supervised exercise or just exercise only.
While supervised exercise is recommended as a first-line treatment for intermittent claudication, the study sought to fill a gap in data about the benefits of combining the two therapies available.

For the full study, click here.

### AMA & CHQPF Release Guide to Physician-Focused APMs

The American Medical Association and the Center for Healthcare Quality & Payment Reform recently released “A Guide to Physician-Focused Alternative Payment Models (APMs)” describing seven different APMs that can enable physicians in every specialty to redesign the way they deliver care in order to control spending and improve quality for their patients.

The APMs can provide a way of overcoming the two most common barriers in current payment systems preventing physicians from redesigning the way they deliver services in order to provide higher quality patient care at a lower cost, which are financial penalties for delivering a different mix of services and a lack of payment or inadequate payment for high-value services.

The APMs include:

1. Payment for a high-value service;
2. Condition-based payment for physician services;
3. Multi-physician bundled payment;
4. Physician-facility procedure bundle;
5. Warranted payment for physician services;
6. Episode payment for a procedure; and
7. Condition-based payment

Each of the seven APMs outlined would be eligible to meet the criteria for APMs specified in the Medicare Access and CHIP Reauthorization Act (MACRA), and includes nineteen different examples of how the APMs could be applied to different types of patients, conditions, and procedures.

For the full guide, click here.

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The CardioVascular Coalition (CVC), established in 2014, is a nonprofit organization representing freestanding cardiovascular centers. CVC members are comprised of national organizations representing providers and manufacturers.

The mission of the CVC is to advance patient access to community-based cardiovascular and endovascular care. Recognizing that cardiovascular disease is a leading – and preventable – cause of death in the United States, the physicians, care providers, advocates, and manufacturers who comprise the Coalition are dedicated to community-based solutions designed to improve awareness and prevention of cardiovascular disease and peripheral artery disease, reduce geographic disparities in access to care, and secure patient access to high-quality, cost-effective, community-based interventional treatment across America.