submitting robust data regarding costs for these and other services (81 FR 80294). We have continued to receive feedback from stakeholders regarding the work valuation of these codes. Stakeholders have expressed concerns regarding the typical patient for these procedures as reflected in the information included in the RUC recommendations for CY 2017 and the importance of appropriate payment for ensuring access to care for Medicare beneficiaries. Therefore, we are seeking additional comment and continuing to request robust data regarding the potentially misvalued work RVUs for CPT codes 36901 through 36909 and considering alternate work valuations for CY 2018, such as the RUC-recommended work RVUs from CY 2017, or other potential values based on submission of data through the public comment process. We note that the RUC-recommended work RVUs for these services are displayed in the CY 2017 PFS final rule (81 FR 80290 through 80296). We have received conflicting information about the direct PE inputs for CPT codes 88184 (Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker) and 88185 (Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)), and we are proposing these codes as potentially misvalued so that they can be reviewed again because some stakeholders have suggested the clinical labor and supplies that were previously finalized are no longer accurate.

We have received information suggesting that the work RVUs for emergency department visits may not appropriately reflect the full resources involved in furnishing these services. Specifically, stakeholders have expressed concerns that the work RVUs for these services have been undervalued given the increased acuity of the patient population and the heterogeneity of the sites, such as freestanding and off-campus emergency departments. Emergency department visits are furnished. We are, therefore, seeking comment on whether CPT codes 99281-99285 (Emergency department visits for the evaluation and management of a patient) should be reviewed under the misvalued code initiative.

For over a decade, CMS has collaborated with the RUC to regularly prioritize codes for review by using the categories specified in the statute or as determined appropriate. We generally have referred to these categories as “misvalued code screens.” To supplement ongoing RUC identification of potentially misvalued codes through established screens, CMS regularly uses PFS rulemaking to identify other screens for use in identifying potentially misvalued codes. For example, in recent years, CMS has prioritized the following screens:

- Codes with low work RVUs commonly billed in multiple units per single encounter.
- Codes with high volume and low work RVUs.
- Codes with site-of-service- anomalies.
- E/M codes.
- PFS high expenditure services.
- Services with standalone PE procedure time.
- Services with anomalous time.
- Contractor Medical Director identified potentially misvalued codes.
- Codes with higher total Medicare payments in office than in hospital or ASC.
- Publicly nominated potentially misvalued codes.
- 0-day global services that are typically billed with an evaluation and management (E/M) service with modifier 25.

Although we are not proposing a new screen for CY 2018, we continue to believe that it is important to prioritize codes for review under the misvalued code initiative. As a result, we are seeking public comment on the best approach for developing screens, as well as what particular new screens we might consider. We will consider these comments for future rulemaking.

F. Payment Incentive for the Transition From Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services

Section 502(a)(1) of Division O, Title V of the Consolidated Appropriations Act of 2016 (Pub. L. 114–113) amended section 1848(b) of the Act by establishing a new paragraph (9) of subsection (b). Section 1848(b)(9)(B) of the Act provides for a 7 percent reduction in payments for the technical component (TC) for imaging services made under the PFS that are X-rays (including the technical component portion of a global service) taken using computed radiography technology during CYs 2018 through 2022 and for a 10 percent reduction for the technical component of such imaging services furnished during CY 2023 or a subsequent year. Computed radiography technology is defined for purposes of this paragraph as cassette-based imaging that utilizes an imaging plate to create the image involved. Section 1848(b)(9) of the Act also requires implementation of the reduction in payments through appropriate mechanisms, which can include the use of modifiers. In accordance with section 1848(c)(2)(B)(v)(X) of the Act, the adjustments under section 1848(b)(9)(A) of the Act are exempt from the budget neutrality requirement.

We stated in the CY 2017 PFS proposed rule that because the required reductions in PFS payment for the TC of imaging services (including the TC portion of a global service) that are X-rays taken using computed radiography technology did not apply for CY 2017, we would address implementation of section 1848(b)(9)(B) of the Act in future rulemaking. Therefore, to implement the provisions of section 1848(b)(9)(B) of the Act relating to the payment reduction for the TC (including the TC portion of a global service) of X-rays taken using computed radiography technology during CY 2018 or subsequent years, we are proposing to establish a new modifier to be used on claims for these services.

We are proposing that beginning January 1, 2018, this modifier would be required to be used when reporting imaging services for which payment is made under the PFS that are X-rays (including the X-ray component of a packaged service) taken using computed radiography technology. The modifier would be required on claims for the technical component of the X-ray service, including when the service is billed globally because the PFS payment adjustment is made to the technical component regardless of whether it is billed globally, or billed separately using the TC modifier. The modifier must be used to report the specific services that are subject to the payment reduction and accurate use is subject to audit. The use of this proposed modifier to indicate an X-ray taken using computed radiography would result in a 7 percent reduction for CYs 2018 through 2022 and a 10 percent reduction for CY 2023 or a subsequent calendar year to the payments for the TC for such imaging services furnished as specified under section 1848(b)(9)(B) of the Act.

G. Proposed Payment Rates Under the Medicare Physician Fee Schedule for Nonexceptional Items and Services Furnished by Nonexceptional Off-Campus Provider-Based Departments of a Hospital

1. Background

Sections 1833(t)(1)(B)(v) and (t)(21) of the Act require that certain items and services furnished by certain off-campus
provider-based departments (PBDs) (collectively referenced here as nonexcepted items and services furnished by nonexcepted off-campus PBDs) shall not be considered covered OPD services for purposes of payment under the OPPS, and payment for those nonexcepted items and services furnished on or after January 1, 2017 shall be made under the applicable payment system. In the CY 2017 OPPS/ASC final rule with comment period (81 FR 79720 through 79729) to establish payment policies under the PFS for nonexcepted items and services furnished on or after January 1, 2017. In the following paragraphs, we propose the payment policies under the PFS for nonexcepted items and services furnished during CY 2018. The CY 2017 interim final rule can be found on the Internet at https://www.gpo.gov/fdsys/pkg/FR-2016-11-14/pdf/2016-26515.pdf. We anticipate responding to public comments and finalizing the CY 2017 interim final rule in future PFS rulemaking.

2. Payment Mechanism

Coding and payment policies under the PFS have long recognized the differences between the portions of services for which direct costs generally are incurred by practitioners and the portions of services for which direct costs generally are incurred by facilities. At present, the coding and RVUs established for particular groups of services under the PFS generally reflect such direct cost differences. As described in section II.B of this proposed rule, we establish separate nonfacility and facility RVUs for many HCPCS codes describing particular services paid under the PFS. For many other services, we establish separate RVUs for the professional component and the technical component of the service described by the same HCPCS code. For other services, we establish RVUs for the different HCPCS codes that segregate and describe the discrete professional and technical aspects of particular services.

Because hospitals with nonexcepted off-campus PBDs that furnish nonexcepted items and services are likely to furnish a broader range of services than other provider or supplier types for which there is a separately valued technical component under the PFS, for CY 2017, we established a new set of payment rates under the PFS that reflected the relative resource costs of furnishing the technical component of a broad range of services to be paid under the PFS specific to the off-campus PBD of a hospital with packaging (bundling) rules that are unique to the hospital outpatient setting under the OPPS.

In principle, the coding and billing mechanisms required to make appropriate payment to hospitals for nonexcepted items and services furnished by nonexcepted off-campus PBDs are parallel to those used to make payment for the technical component services for a range of supplier types paid under the PFS. That is, payments to hospitals are made for the technical aspect of services, while physicians and other practitioners report the professional aspect of these same services. In some cases, the entities reporting the technical aspect of services use the same coding that is used by the individuals reporting the professional services. In other cases, different coding applies. We are proposing to maintain this mechanism for CY 2018.

3. Establishment of Payment Rates

Using the relativity among OPPS payments to establish rates for the nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by hospitals under the PFS was only one aspect of establishing the necessary relativity of these services under the PFS more broadly. It was necessary to estimate the relativity of these services compared to PFS services furnished in other settings. For CY 2017, we used our best estimate of the more general relativity between the technical component of PFS services furnished in nonexcepted off-campus PBDs and all other PFS services furnished in other settings using the limited information available to us at that time. As described in the CY 2017 interim final rule (81 FR 79722 through 79726), we estimated that for CY 2017, scaling the OPPS payment rates by 50 percent would strike an appropriate balance that avoided potentially understimating the relative resources involved in furnishing services in nonexcepted off-campus PBDs as compared to the services furnished in other settings for which payment was made under the PFS. Specifically, we established site-specific rates under the PFS for the technical component of the broad range of nonexcepted items and services furnished by nonexcepted off-campus PBDs to be paid under the PFS that was based on the OPPS payment amount for the same items and services, scaled downward by 50 percent. We called this adjustment the “PFS Relativity Adjuster.” The PFS Relativity Adjuster refers to the percentage of the OPPS payment amount paid under the PFS for a nonexcepted item or service to the nonexcepted off-campus PBD under this policy.

a. Methodology for Establishing CY 2017 PFS Relativity Adjuster

In developing the CY 2017 interim final rule, we began by analyzing hospital outpatient claims data from January 1 through August 26, 2016, that contained the “PO” modifier signifying that they were billed by an off-campus department of a hospital paid under the OPPS other than a remote location, a satellite facility, or a dedicated emergency department (ED). We noted that the use of the “PO” modifier was a new mandatory reporting requirement for CY 2016. We limited our analysis to those claims billed on the 13X Type of Service (TOS) Code for Medicare Part B billing under the OPPS. We then identified the top (most frequently billed) 25 major codes that were billed by claim line; that is, items and services that were separately payable or conditionally packaged. Specifically, we restricted our analysis to codes with OPPS status indicators “J1”, “J2”, “Q1”, “Q2”, “Q3”, “S”, “T”, or “V”. We did not include separately payable drugs or biologicals in this analysis because those drugs or biologicals were not paid under the PFS under the CY 2017 interim final rule. As such, under the CY 2017 interim final rule, the PFS Relativity Adjuster did not apply to separately payable drugs and biologicals furnished by a nonexcepted PBD. Similarly, we excluded codes assigned an OPPS status indicator “A” because the services described by those codes were already paid at a rate under a fee schedule other than the OPPS and payment for those nonexcepted items and services was not changed by the rates established under the CY 2017 interim final rule. Next, for the same major codes (or analogous codes in the rare instance that different coding applies under the OPPS than the PFS), we compared the CY 2016 payment rate under the OPPS to a CY 2016 payment rate under the PFS attributable to the nonprofessional relative resource costs involved in furnishing the services. The most frequently billed service with the “PO” modifier was described by HCPCS code G0463 (Hospital outpatient clinic visit for assessment by HCPCS code G0463).
of CY 2016 claim lines for that service was approximately 6.7 million as of August 2016. In CY 2016, the OPPS payment rate for APC 5012 was $102.12. Because there were multiple CPT codes (CPT codes 99201 through 99215) used under the PFS for billing that service, an exact comparison between the $102.12 OPPS payment rate for APC 5012 and the payment rate for a single CPT code billed under the PFS was not possible. However, for purposes of the analysis, we examined the difference between the nonfacility payment rates and the facility payment rates under the PFS for CPT codes 99213 and 99214, which were the billing codes for a Level III and a Level IV office visit. While we did not have data to precisely determine the equivalent set of PFS visit codes to use for the comparison, we believed that, based on the distribution of services billed for the visit codes under the PFS and the distribution of the visit codes under the OPPS from the last time period the CPT codes were used under the OPPS in CY 2014, those two codes provided reliable points of comparison. For CPT code 99213, the difference between the nonfacility payment rate and the facility payment rate under the PFS in CY 2016 was $21.86, which was 21 percent of the OPPS payment rate for APC 5012 of $102.12. For CPT code 99214, the difference between the nonfacility payment rate and the facility payment rate under the PFS in CY 2016 was $29.02, which was 28 percent of the OPPS payment rate for APC 5012. However, we recognized that, due to the more extensive packaging that occurred under the OPPS for services provided along with clinic visits relative to the more limited packaging that occurred under the PFS for office visits, those payment rates were not entirely comparable.

We then assessed the next 24 major codes most frequently billed on the 13X claim form by hospitals. We removed HCPCS code 36591 (Collection of blood specimen from a completely implantable venous access device) because, under current PFS policies, the code is used only to pay separately under the PFS when no other service was on the claim. We also removed HCPCS code G0009 (Administration of Pneumococcal Vaccine) because there was no payment for the code under the PFS. For the remaining 22 major codes most frequently billed, we estimated the amount that would have been paid to the physician in the office setting under the PFS for practice expenses not associated with the professional component of the service. As indicated in Table 9, this amount reflected (1) the difference between the PFS nonfacility payment rate and the PFS facility rate, (2) the technical component, or (3) in instances where payment would have been made only to the facility or only to the physician, the full nonfacility rate. This estimate ranged from zero percent to 137.8 percent of the OPPS payment rate for a code. Overall, the average (weighted by claim line volume times rate) of the nonfacility payment rate estimate for the PFS compared to the estimate for the OPPS for the 22 remaining major codes was 45 percent.

<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Code description</th>
<th>Total claim lines</th>
<th>CY 2016 OPPS payment rate</th>
<th>CY 2016 applicable PFS technical payment amount estimate</th>
<th>Col (5) as a percent of OPPS</th>
<th>PFS estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>96372 ..</td>
<td>Injection beneath the skin or into muscle for therapy, diagnosis, or prevention.</td>
<td>338,444</td>
<td>$42.31</td>
<td>$25.42</td>
<td>60.1</td>
<td>Single rate paid exclusively to either practitioner or facility: Full nonfacility rate.</td>
</tr>
<tr>
<td>71020 ..</td>
<td>X-ray of chest, 2 views, front and side.</td>
<td>333,203</td>
<td>60.80</td>
<td>16.83</td>
<td>27.7</td>
<td>Technical component: Full nonfacility rate.</td>
</tr>
<tr>
<td>93005 ..</td>
<td>Routine electrocardiogram (EKG) with tracing using at least 12 leads.</td>
<td>318,099</td>
<td>55.94</td>
<td>8.59</td>
<td>15.4</td>
<td>Technical component: Full nonfacility rate.</td>
</tr>
<tr>
<td>96413 ..</td>
<td>Infusion of chemotherapy into a vein up to 1 hour.</td>
<td>254,704</td>
<td>280.27</td>
<td>136.41</td>
<td>48.7</td>
<td>Single rate paid exclusively to either practitioner or facility: Full nonfacility rate. Nonfacility rate—Facility rate.</td>
</tr>
<tr>
<td>93798 ..</td>
<td>Physician services for outpatient heart rehabilitation with continuous EKG monitoring per session.</td>
<td>203,926</td>
<td>103.92</td>
<td>11.10</td>
<td>10.7</td>
<td></td>
</tr>
<tr>
<td>96375 ..</td>
<td>Injection of different drug or substance into a vein for therapy, diagnosis, or prevention.</td>
<td>189,140</td>
<td>42.31</td>
<td>22.56</td>
<td>53.3</td>
<td>Single rate paid exclusively to either practitioner or facility: Full nonfacility rate.</td>
</tr>
<tr>
<td>93306 ..</td>
<td>Ultrasound examination of heart including color-depicted blood flow rate, direction, and valve function.</td>
<td>179,840</td>
<td>416.80</td>
<td>165.77</td>
<td>39.8</td>
<td>Technical component: Full nonfacility rate.</td>
</tr>
<tr>
<td>77080 ..</td>
<td>Bone density measurement using dedicated X-ray machine.</td>
<td>155,513</td>
<td>100.69</td>
<td>31.15</td>
<td>30.9</td>
<td>Technical component: Full nonfacility rate.</td>
</tr>
<tr>
<td>77412 ..</td>
<td>Radiation treatment delivery ....</td>
<td>137,241</td>
<td>194.35</td>
<td>267.86</td>
<td>137.8</td>
<td>Technical component (Full nonfacility rate) based on weighted averages for the following PFS codes: G6011; G6012; G6013; and G6014.</td>
</tr>
</tbody>
</table>
TABLE 9—COMPARISON OF CY 2016 OPPS PAYMENT RATE TO CY 2016 PFS PAYMENT RATE FOR TOP HOSPITAL CODES BILLED USING THE “PO” MODIFIER—Continued

<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Code description</th>
<th>Total claim lines</th>
<th>CY 2016 OPPS payment rate</th>
<th>CY 2016 applicable PFS technical payment amount estimate</th>
<th>Col (5) as a percent of OPPS</th>
<th>PFS estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>90853</td>
<td>Group psychotherapy ............</td>
<td>123,282</td>
<td>69.65</td>
<td>0.36</td>
<td>0.5</td>
<td>Nonfacility rate—Facility rate.</td>
</tr>
<tr>
<td>96365</td>
<td>Infusion into a vein for therapy, prevention, or diagnosis up to 1 hour.</td>
<td>122,641</td>
<td>173.18</td>
<td>69.82</td>
<td>40.3</td>
<td>Nonfacility rate—Facility rate.</td>
</tr>
<tr>
<td>20610</td>
<td>Aspiration and/or injection of large joint or joint capsule.</td>
<td>106,769</td>
<td>223.76</td>
<td>13.96</td>
<td>6.2</td>
<td>Nonfacility rate—Facility rate.</td>
</tr>
<tr>
<td>11042</td>
<td>Removal of skin and tissue first 20 sq cm or less.</td>
<td>99,134</td>
<td>225.55</td>
<td>54.78</td>
<td>24.3</td>
<td>Nonfacility rate—Facility rate.</td>
</tr>
<tr>
<td>96367</td>
<td>Infusion into a vein for therapy prevention or diagnosis additional sequential infusion up to 1 hour.</td>
<td>98,930</td>
<td>42.31</td>
<td>30.79</td>
<td>72.8</td>
<td>Single rate paid exclusively to either practitioner or facility: Full nonfacility rate.</td>
</tr>
<tr>
<td>93017</td>
<td>Exercise or drug-induced heart and blood vessel stress test with EKG tracing and monitoring.</td>
<td>96,312</td>
<td>220.35</td>
<td>39.74</td>
<td>18.0</td>
<td>Technical component: Full nonfacility rate.</td>
</tr>
<tr>
<td>77386</td>
<td>Radiation therapy delivery ....</td>
<td>81,925</td>
<td>505.51</td>
<td>347.30</td>
<td>68.7</td>
<td>Technical component: Nonfacility rate for CPT code G6015 (analogous code used under the PFS).</td>
</tr>
<tr>
<td>78452</td>
<td>Nuclear medicine study of vessels of heart using drugs or exercise multiple studies.</td>
<td>79,242</td>
<td>1,108.46</td>
<td>412.82</td>
<td>37.2</td>
<td>Technical component: Full nonfacility rate.</td>
</tr>
<tr>
<td>74177</td>
<td>CT scan of abdomen and pelvis with contrast.</td>
<td>76,393</td>
<td>347.72</td>
<td>220.20</td>
<td>63.3</td>
<td>Technical component: Full nonfacility rate.</td>
</tr>
<tr>
<td>71260</td>
<td>CT scan chest with contrast ....</td>
<td>75,052</td>
<td>236.86</td>
<td>167.21</td>
<td>70.6</td>
<td>Technical component: Full nonfacility rate.</td>
</tr>
<tr>
<td>71250</td>
<td>CT scan chest ....................</td>
<td>74,570</td>
<td>112.49</td>
<td>129.61</td>
<td>115.2</td>
<td>Technical component: Full nonfacility rate.</td>
</tr>
<tr>
<td>73030</td>
<td>X-ray of shoulder, minimum of 2 views.</td>
<td>71,330</td>
<td>60.80</td>
<td>19.33</td>
<td>31.8</td>
<td>Technical component: Full nonfacility rate.</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient and/or family member.</td>
<td>70,524</td>
<td>125.04</td>
<td>0.36</td>
<td>0.3</td>
<td>Nonfacility rate—Facility rate.</td>
</tr>
</tbody>
</table>

Weighted Average (claim line volume*rate) of the PFS payment compared to OPPS payment for the 22 major codes: 45%

As noted with the clinic visits, we recognized that there were limitations to our data analysis, including that OPPS payment rates include the costs of packaged items or services billed with the separately payable code, and therefore the comparison to rates under the PFS was not a one-to-one comparison. Also, we included only a limited number of services, and noted that additional services may have different patterns than the services described. After considering the payment differentials for major codes billed by off-campus departments of hospitals with the “PO” modifier and based on the data limitations of our analysis, we adopted, with some exceptions noted below, a set of PFS payment rates that were based on a 50-percent PFS Relativity Adjuster to the OPPS payment rates (inclusive of packaging) for nonexcepted items and services furnished by nonexceptioned off-campus PBDs in the CY 2017 interim final rule. Generally speaking, we arrived at the 50 percent PFS Relativity Adjuster by examining the 45-percent comparison noted above, the ASC payment rate—which was roughly 55 percent of the OPPS payment rate on average—and the payment rate differential for the large number of OPPS and PFS evaluation and management services, as described above. We recognized that the equivalent PFS nonfacility rates may be higher or lower on a code-specific basis than the rates that result from applying the overall PFS Relativity Adjuster to the OPPS payment rates on a code specific basis. However, we believed that, on the whole, the percentage reduction did not underestimate the overall relativity between the OPPS and the PFS based on the limited data that was available. We were concerned, however, that the 50 percent PFS Relativity Adjuster might overestimate PFS nonfacility payments relative to OPPS payments. For example, if we were able at the time to sufficiently estimate the effect of the packaging differences between the OPPS and PFS, we suspected that the equivalent portion of PFS payments for evaluation and management codes, and for PFS services on average, would likely have been less than 50 percent for the same services. We considered the 50 percent PFS Relativity Adjuster for CY 2017 to be a transitional policy until such time that we had more precise data to better
identify and value nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by hospitals.

We established several significant exceptions to the application of the 50 percent PFS Relativity Adjuster. For example, we did not apply the 50 percent PFS Relativity Adjuster to services that are currently paid under the OPPS based on payment rates from other Medicare fee schedules (including the PFS) on an institutional claim. The items and services that are assigned status indicator “A” in Addendum B to the CY 2017 OPPS/ASC final rule with comment period (available on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1656-FC.zip) continue to be reported on an institutional claim and paid under the PFS, the CLFS, or the Ambulance Fee Schedule (ASC) without a payment reduction. Similarly, drugs and biologicals that are separately payable under the OPPS (identified by status indicator “G” or “K” in Addendum B to the CY 2017 OPPS/ASC final rule with comment period) are paid in accordance with section 1847A of the Act (that is, typically ASP + 6 percent), consistent with payment rules in the physician office setting. Drugs and biologicals that are unconditionally packaged under the OPPS and are not separately payable (that is, those drugs and biologicals assigned status indicator of “N” in Addendum B to the CY 2017 OPPS/ASC final rule with comment period) are bundled into the PFS payment and are not separately paid to hospitals billing for nonexcepted items and services furnished by nonexcepted off-campus PBDs. The full range of exceptions and adjustments to the otherwise applicable OPPS payment rate that were adopted in the new PFS site-of-service payment rates in the CY 2017 interim final rule can be found on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1656-FC-2017-OPPS-Status-Indicator.zip.

All nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by a hospital on an institutional claim with modifier “PN” (Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital) are currently paid under the PFS at the rate established in the CY 2017 interim final rule. Nonexcepted off-campus PBDs must report modifier “PN” on each UB-04 claim line to indicate a nonexcepted item or service, and otherwise continue to bill as they currently do. Further billing instructions on the PN modifier can be found in the January 2017 OPPS Quarterly Update (transmittal 3685, Change Request 9930) released December 22, 2016, available on the CMS Web site at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3685CP.pdf. b. PFS Relativity Adjuster

As noted in the CY 2017 interim final rule, we considered the CY 2017 50 percent PFS Relativity Adjuster to be a transitional policy until such time that we had more precise data to better identify and value nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by hospitals. At present, we do not have more precise data than were available when we established the PFS Relativity Adjuster in the CY 2017 interim final rule, and we do not anticipate having such data until after the end of CY 2017, at the earliest. However, in developing a proposed policy for CY 2018, we have continued to explore options for modifying the calculation of the CY 2018 PFS Relativity Adjuster. There is no consensus among stakeholders regarding the appropriate PFS Relativity Adjuster. Many stakeholders have suggested that making separate facility fee payments to hospitals under the PFS for all services that are separately paid under the OPPS itself undermines site-neutral payment because practitioners are only paid a single combined fee for many services when furnished in an office setting. We acknowledge that there are many cases where single fees are paid to practitioners for services furnished in an office setting while fees for comparable services when furnished in the hospital setting are paid to both the professional and facility entities. However, we do not agree that this necessarily means that overall payment cannot be site neutral. We point out that the sum of the professional and the facility portions of payment for a service furnished in a nonexcepted off-campus PBD or in a different institutional setting could be equivalent to a single fee paid to the professional in the office setting. In the case of some services, in fact, the single payment made under the PFS at the nonfacility rate exceeds the sum of the separate payments Medicare made to the facility at the facility rate under the PFS and to the facility under the OPPS. We also note that there are many separately reportable services under the PFS (for example, the vast majority of services described by add-on codes) for which separate payment is made to physician offices but no separate payment is made under either the OPPS or under the site-specific PFS payments made to hospitals billing for nonexcepted items and services furnished by nonexcepted off-campus PBDs. For these reasons, we believe that the overall total payment made for services is more relevant to the goal of site neutrality than the quantity of individual payments made. Nonetheless, we continue to recognize and share stakeholders’ concerns regarding the importance of equivalent overall payment for services, regardless of setting.

In considering the appropriate PFS Relativity Adjuster for CY 2018, we continue to believe that claims data from CY 2017, which are not yet available, are needed to guide potential changes to our general approach. In the absence of such data, however, we have continued to consider the appropriate PFS Relativity Adjuster based on the information that is available. In the analysis we used to establish the PFS Relativity Adjuster for CY 2017, we attempted to identify the appropriate value by comparing OPPS and PFS payment rates for services frequently reported in PBDs and described by the same codes under the two payment systems. As we acknowledged in the CY 2017 interim final rule, that data analysis did not include the most frequently billed service furnished in nonexcepted off-campus hospital PBDs, outpatient visits. Outpatient visits are reported using a single code under the OPPS and by one of ten different codes under the PFS.

Consistent with our previously stated concern that the PFS Relativity Adjuster for CY 2017 might be too small, generally resulting in greater overall payments to hospitals for services furnished by nonexcepted off-campus PBDs than would otherwise be paid under the nonfacility setting, we believe it is appropriate to propose changing the PFS Relativity Adjuster in order to ensure that payment made to these nonexcepted PBDs better aligns with these services that are the most frequently furnished in this setting.

For CY 2018, we propose to revise the PFS Relativity Adjuster for nonexcepted items and services furnished by nonexcepted off-campus PBDs to be 25 percent of the OPPS payment rate. We arrived at this proposed PFS Relativity Adjuster by making a code-level comparison for the service most
commonly billed in the off-campus PBD setting under the OPPS. A clinic visit reported using HCPCS code G0463. In order to determine the analogous payment for the technical aspects of this service under the PFS in nonfacility settings, we compared the CY 2017 OPPS national payment rate for HCPCS code G0463 ($102.12) to the difference between the nonfacility and facility PFS payment amounts under the PFS using CY 2017 rates for the weighted average of outpatient visits (CPT codes 99201–99205 and CPT codes 99211–99215) billed by physicians and other professionals in an outpatient hospital place of service.

This proposed 25 percent PFS Relativity Adjuster is based solely on the comparison for the visit services that reflect greater than 50 percent of services billed in off-campus PBDs. We continue to recognize that the comparison between the OPPS and PFS rates for other services varies greatly, and that there are other factors, including the specific mix of services furnished in off-campus PBDs, policies related to packaging of codes under OPPS, and payment adjustments like MPPRs and bundling under the PFS that rely on empirical information about whether or not codes are billed on the same day, that contribute to the differences in aggregate payment amounts for a broader range of services. However, for CY 2018, as for CY 2017, we must set the PFS Relativity Adjuster prior to studying the CY 2017 claims data that might allow us to consider and incorporate many more factors, including the ones stated above. When we established the 50 percent PFS Relativity Adjuster for CY 2017, we stated that we did so with the goal of ensuring adequate payment but remained concerned that the resulting reduction was too small. For CY 2018, we are focused on ensuring that we do not overestimate the appropriate overall payments for these services. Until we are able to study claims data, we believe that the comparison between PFS and OPPS payment for the most common services furnished in off-campus PBDs, outpatient visits, is a better proxy than our previous approach.

We welcome stakeholder input with regard to this analysis and the resulting rate. We also request comment on whether we should adopt a different PFS Relativity Adjuster, such as 40 percent, that represents a relative middle ground between the CY 2017 PFS Relativity Adjuster, selected to ensure adequate payment to hospitals and our proposed CY 2018 PFS Relativity Adjuster, selected to ensure that hospitals are not paid more than others would be paid through the PFS nonfacility rate. We intend to continue to study this issue and welcome comments regarding potential future refinements to payment rates for non-excepted items and services furnished by non-excepted off-campus PBDs as we gain more experience with these new site-of-service PFS rates.

Finally, we note that for CY 2018, as in recent years, the proposed annual update to OPPS payments exceeds the proposed annual update to PFS payments. Because we are proposing to make a single, across-the-board and, by necessity, imprecise adjustment to OPPS payment rates to establish PFS payment rates for nonexcepted items and services furnished by nonexcepted off-campus PBDs, we expect that the actual difference between OPPS and PFS payment rates for nonexcepted items and services furnished by nonexcepted off-campus PBDs falls in a range which includes our proposed PFS Relativity Adjuster (that is, the actual differential may differ from our proposed PFS Relativity Adjuster). As such, taking into account the differential between the OPPS and PFS annual updates by making an adjustment to the PFS Relativity Adjuster our proposal for CY 2018 would presume a level of precision in our estimates that is simply not present in our analysis. Therefore, we will not adjust our proposal to reflect the relative updates to OPPS and PFS between CY 2017 and CY 2018, and instead note that the differential between the OPPS and PFS payment update factors is a factor that suggests that the proposed PFS Relativity Adjuster may overestimate PFS nonfacility payment relative to OPPS payments; in future years, we intend to more precisely account for any differential between these two update factors.

c. Geographic Adjustments

For CY 2017, we established class-specific geographic practice cost indices (GPCIs) under the PFS exclusively used to adjust these site-specific, technical component rates for nonexcepted items and services furnished in nonexcepted off-campus PBDs. These class-specific GPCIs are parallel to the geographic adjustments made under the OPPS based on the hospital wage index. We believed it was appropriate to adopt the hospital wage index areas for purposes of geographic adjustment because nonexcepted off-campus PBDs are still considered to be part of a hospital, and the PFS payments to these entities will be lower than the OPPS service furnished by hospitals. We also believed it was appropriate, as an initial matter for CY 2017, to adopt the actual wage index values for these hospitals in addition to the wage index areas. The PFS GPCIs that would otherwise currently apply are not based on the hospital wage index areas. For CY 2018, we are proposing to continue using the authority under section 1848(c)(1)(B) of the Act to maintain a class-specific set of GPCIs for these site-specific technical component rates that are based both on the hospital wage index areas and the hospital wage index value themselves. For purposes of payment to hospitals, this means that the geographic adjustments used under the OPPS continue to apply.

d. Coding Consistency

For most services, the same HCPCS codes are used to describe services paid under both the PFS and the OPPS. There are two notable exceptions that describe high-volume services. The first is the set of codes that describe evaluation and management (E/M) services which are reported under the PFS using the 5 levels of CPT codes describing new or established patient visits (for a total of 10 codes). However, since CY 2014, these visits have been reported under the OPPS using the single HCPCS code G0463 (Hospital Outpatient Clinic Visit) (see 78 FR 75042). We are proposing to maintain the current PFS payment rate for HCPCS code G0463 based on the OPPS payment rate modified by the PFS Relativity Adjuster.

The second is a set of radiation treatment delivery and imaging guidance services that are reported using different codes under the PFS and the OPPS. CMS established HCPCS Level II G codes to describe radiation treatment delivery services when furnished in the physician office setting (see 79 FR 67666 through 67667). However, these HCPCS G codes are not recognized under the OPPS; rather, CPT codes are used to describe these services when furnished in the HOPD. Both sets of codes were implemented for CY 2015 and were maintained for CY 2016. Under the PFS, there is a particular statutory provision under section 1848(c)(2)(K) of the Act that required maintenance of the CY 2016 coding and payment inputs for these services for CY 2017 and also for CY 2018. Accordingly, the proposed CY 2018 PFS rates for these services are calculated based on the maintenance of the CY 2016 coding and payment inputs. Because nonexcepted items and services furnished by a nonexcepted off-campus PBD are paid under the PFS, and we are required to maintain the CY 2016 coding and payment inputs for these services under
the CY 2018 PFS, we are proposing to maintain payment amounts for nonexcepted items and services furnished by a nonexcepted off-campus PBD consistent with the payments that would be made to other facilities under the PFS. That is, nonexcepted off-campus PBDs submitting claims for these nonexcepted items and services will continue to bill the HCPCS G codes established under the PFS to describe radiation treatment delivery services. Under this proposal, the nonexcepted off-campus PBD must append modifier PN to each applicable claim line for these nonexcepted items and services, even though the PFS Relativity Adjuster will not apply. The payment amount for these services would be set to reflect the technical component rate for the code under the PFS.

4. OPPS Payment Adjustments

In the CY 2017 interim final rule, we adopted the packaging payment rates and multiple procedure payment reductions that applied under the OPPS to establish the PFS payment rates for nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by hospitals. That is, the claims processing logic that was used for payments under the OPPS for comprehensive APCs (C–APCs), conditionally and unconditionally packaged items and services, and major procedures, was incorporated into the newly established PFS rates. We continue to believe it is necessary to incorporate the OPPS payment policies for C–APCs, packaged items and services, and the MPPR in order to maintain the integrity of the PFS Relativity Adjuster because the adjuster is intended in part to account for the methodological differences between the OPPS and the PFS rates that would otherwise apply. We also direct interested stakeholders to related proposed policies under the OPPS, since prospective changes in the applicable adjustments and policies would generally apply to non-excepted items and services furnished by nonexcepted off-campus PBDs for CY 2018. We are interested in comments regarding the applicability of particular prospective OPPS adjustments to nonexcepted items and services.

In order to apply these OPPS payment policies and adjustments to nonexcepted items and services, we propose that hospitals continue to bill on an institutional claim form that will pass through the Outpatient Code Editor and into the Global Compensatory Adjustment for calculation of payment. This approach will yield data based on claims for non-excepted items and services furnished by nonexcepted off-campus PBDs, which can be used to refine PFS payment rates for these services in future years.

There were several OPPS payment adjustments that we did not adopt in the CY 2017 interim final rule, including, but not limited to, outlier payments, the rural sole community hospital (SCH) adjustment, the cancer hospital adjustments, transitional outpatient payments, the hospital outpatient quality reporting payment adjustment, and the inpatient hospital deductible cap to the cost-sharing liability for a single hospital outpatient service. We believed these payment adjustments were expressly authorized for, and should be limited to, hospitals that are paid under the OPPS for covered OPD services in accordance with section 1833(t) of the Act. We continue to believe that these policies should not apply to non-excepted items and services furnished by nonexcepted off-campus PBDs, and are not proposing that they apply for CY 2018.

5. Partial Hospitalization Services

With respect to partial hospitalization programs (PHP) (intensive outpatient psychiatric day treatment programs furnished to patients as an alternative to inpatient psychiatric hospitalization or as a stepdown to shorten an inpatient stay and transition a patient to a less intensive level of care), section 1861(ff)(3)(A) of the Act specifies that a PHP is a program furnished by a hospital, to its outpatients, or by a CMHC. In the CY 2017 OPPS/ASC proposed rule (81 FR 45681), in the discussion of the proposed implementation of section 603 of Public Law 114–74, we noted that because CMHCs also furnish PHP services and are ineligible to be provider-based to a hospital, a nonexcepted off-campus PBD would be eligible for PHP payment if the entity enrolls and bills as a CMHC in order to receive payment for PHP services. These commenters stated that hospital-based PHPs and CMHCs are inherently different in structure, operation, and payment, and noted that the conditions of participation for hospital departments and CMHCs are different. Several commenters requested that CMS find a mechanism to pay hospital-based PHPs in nonexcepted off-campus PBDs.

Because we shared the commenters’ concerns, in the CY 2017 OPPS/ASC final rule with comment period and the CY 2017 interim final rule (81 FR 79727), we adopted payment for partial hospitalization items and services furnished by nonexcepted off-campus hospital-based PBDs under the PFS. When billed in accordance with the CY 2017 interim final rule, these partial hospitalization services are paid at the CMHC per diem rate for APC 5853, for providing three or more partial hospitalization services per day (81 FR 79727).

In the CY 2017 OPPS/ASC proposed rule (81 FR 45681), the CY 2017 OPPS/ASC final rule with comment period, and the CY 2017 interim final rule (81 FR 79727), we noted that when a beneficiary receives outpatient services in an off-campus department of a hospital, the total Medicare payment for those services is generally higher than when those same services are provided in a physician’s office. Similarly, when partial hospitalization services are provided in a hospital-based PHP, Medicare pays more than when those same services are provided by a CMHC. Our rationale for adopting the CMHC per diem rate for APC 5853 as the PFS payment amount for nonexcepted off-campus PBDs providing PHP services is because CMHCs are freestanding entities that are not part of a hospital, but they provide the same PHP services as hospital-based PHPs (81 FR 79727). This is similar to the differences between freestanding entities paid under the PFS that furnish other services also provided by hospital-based entities. Similar to other entities currently paid for their technical component services under the PFS, we believe CMHCs would typically have lower cost structures than hospital-based PHPs, largely due to lower overhead costs and other indirect costs such as administration, personnel, and security. We believe that paying for nonexcepted hospital-based partial hospitalization services at the lower CMHC per diem rate aligns with section 603 of Public Law 114–74, while also maintaining access to PHP services. In addition, nonexcepted off-campus PBDs will not be required to enroll as CMHCs
in order to bill and be paid for providing partial hospitalization services. However, a nonexcepted off-campus PBD that wishes to provide PHP services may still enroll as a CMHC if it chooses to do so and meets the relevant requirements. Finally, we recognize that because hospital-based PHPs are providing partial hospitalization services in the hospital outpatient setting, they can offer benefits that CMHCs do not have, such as an easier patient transition to from inpatient care, and easier sharing of health information between the PHP and the inpatient staff. We are not proposing to require these PHPs to enroll as CMHCs but instead we are proposing to continue to pay nonexcepted off-campus PBDs providing PHP items and services under the PFS. Further, we are proposing to continue to adopt the CMHC per diem rate for APC 5853 as the PFS payment amount for nonexcepted off-campus PBDs providing three or more PHP services per day in CY 2018.

6. Supervision Rules

The supervision rules that apply for hospitals continue to apply for nonexcepted off-campus PBDs that furnish nonexcepted items and services. The amendments made by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114–74, enacted November 2, 2015) did not change the status of these PBDs, only the status of, and payment mechanism for, the services they furnish. These supervision requirements are specified in §410.27.

7. Beneficiary Cost-Sharing

Under the PFS, the beneficiary copayment is generally 20 percent of the fee schedule amount, unless there is an applicable exception in accordance with the statute. All cost-sharing rules that apply under the PFS in accordance with section 1848(g) of the Act and section 1866(a)(2)(A) of the Act continue to apply for all nonexcepted items and services furnished by nonexcepted off-campus PBDs, regardless of the cost-sharing obligation under the OPPS.

8. CY 2019 and Future Years

We continue to believe the amendments made to the statute by section 603 of the Bipartisan Budget Act of 2015 intended to eliminate the Medicare payment incentive for hospitals to purchase physician offices, convert them to off-campus PBDs, and bill under the OPPS for items and services they furnish there. Therefore, we continue to believe the payment policy under this provision should ultimately equalize payment rates between nonexcepted off-campus PBDs and physician offices to the greatest extent possible, while allowing nonexcepted off-campus PBDs to bill in a straight-forward way for services they furnish.

We note that a full year of claims data regarding the mix of services reported using the “PN” modifier (from CY 2017) will first be available for use in PFS ratesetting for CY 2019. Under the current methodology, we would expect to use that data in order to ensure that Medicare payment to hospitals billing for nonexcepted items and services furnished by nonexcepted off-campus PBDs under the PFS would reflect the relative resources involved in furnishing the items and services relative to other PFS services. We recognize that under our current approach, the payment rates would not be equal on a procedure-by-procedure basis, application of the PFS Relativity Adjuster would move toward equalizing payment rates in the aggregate between physician offices and nonexcepted off-campus PBDs to the extent appropriate. Therefore, for certain specialties, service lines, and nonexcepted off-campus PBD types, total Medicare payments for the same services might be either higher or lower when furnished by a nonexcepted off-campus PBD rather than in a physician office.

Depending on the mix of services for particular off-campus PBDs, we remain concerned that such specialty-specific patterns in payment differentials could result in continued incentives for hospitals to buy certain types of physician offices and convert them to nonexcepted off-campus PBDs; these are the incentives we believe Congress intended to avoid. However, continuing a policy similar to the one we are proposing in this proposed rule would allow hospitals to continue billing through a facility claim form and would allow for continuation of the packaging rules and cost report-based relative payment rate determinations under OPPS, which we believe are preferable to using the current methodologies under the PFS that are not well-suited for nonexcepted items and services furnished by nonexcepted off-campus PBDs. Therefore, for CY 2019 and for future years, we intend to examine the claims data in order to determine not only the appropriate PFS Relativity Adjuster(s), but also to determine whether additional adjustments to the methodology are appropriate—especially with the goal of attaining site neutral payments to promote the level playing field under Medicare between physician office settings and nonexcepted off-campus PBD settings, without regard to the kinds of services furnished by particular off-campus PBDs. We solicit comments on potential changes to our methodology that would better account for these specialty-specific patterns.

H. Proposed Valuation of Specific Codes

1. Background: Process for Valuing New, Revised, and Potentially Misvalued Codes

Establishing valuations for newly created and revised CPT codes is a routine part of maintaining the PFS. Since inception of the PFS, it has also been a priority to revalue services regularly to make sure that the payment rates reflect the changing trends in the practice of medicine and current prices for inputs used in the PE calculations. Initially, this was accomplished primarily through the 5-year review process, which resulted in revised work RVUs for CY 1997, CY 2002, CY 2007, and CY 2012, and revised PE RVUs in CY 2001, CY 2006, and CY 2011. Under the 5-year review process, revisions in RVUs were proposed and finalized via rulemaking. In addition to the 5-year reviews, beginning with CY 2009, CMS and the RUC have identified a number of potentially misvalued codes each year using various identification screens, as discussed in section I.E.4 of this proposed rule. Historically, when we received RUC recommendations, our process had been to establish interim final RVUs for the potentially misvalued codes, new codes, and any other codes for which there were coding changes in the final rule for a year. Then, during the 60-day period following the publication of the final rule, we accepted public comment about those valuations. For services furnished during the calendar year following the publication of interim final rates, we paid for services based upon the interim final values established in the final rule. In the final rule with comment period for the subsequent year, we considered and responded to public comments received on the interim final values, and typically made any appropriate adjustments and finalized those values.

In the CY 2015 PFS final rule with comment period, we finalized a new process for establishing values for new, revised and potentially misvalued codes. Under the new process, we include proposed values for these services in the proposed rule, rather than establishing them as interim final in the final rule with comment period. Beginning with the CY 2017 PFS proposed rule, the new process was applicable to all codes, except for new codes that describe truly new services.