2017 Medicare Physician Fee Schedule
Final Rule Summary

On November 2, 2016, the Centers for Medicare and Medicaid Services (CMS) released the CY2017 Medicare Physician Fee Schedule (MPFS) final rule. The final rule updates payment policies and payment rates for services furnished under the MPFS. For the first time, this proposal does not include information on the agency's quality programs. With the passage of the Medicare Access and CHIP Reauthorization Act (MACRA), CMS' existing quality programs will sunset at the end of 2016 and reporting under the new Merit-Based Incentive Payment System (MIPS) will begin in 2017; the requirements for MIPS and Alternative Payment Models (APMs) were outlined in separate rulemaking.

The rule in its entirety and the addenda, including Addendum B, which lists the RVUs for each CPT code, can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/. Provisions of the rule will be effective January 1, 2017 unless stated otherwise. The following summarizes the major payment and quality provisions of the final rule.

Conversion Factor and Specialty Impact

The conversion factor for 2017 is $35.89. The table below, extracted from the rule, shows how the conversion factor was calculated.

Conversion Factor in effect in CY 2016		35.8043
Update Factor	0.50 percent (1.0050)	
CY 2017 RVU Budget Neutrality Adjustment	-0.013 percent (0.9987)	
CY 2017 Target Recapture Amount	-0.18 percent (0.9982)	
CY 2017 Imaging MPPR Adjustment	-0.07 percent (0.9993)	
CY 2017 Conversion Factor		**35.8887**

Table 52 (see Attachment 1), extracted from the rule, provides a summary of the impact of the rule's changes by specialty. The changes in the rule are budget-neutral in the aggregate which explains why the impact for all physicians is shown as zero. The 2017 final rule is showing changes in the range of minus 2% to plus 1% for most specialties, with Neurology seeing no change in 2017.

Attached to this summary are charts showing the 2017 final RVUs and payment rates for epilepsy center and evaluation and management (E/M) services. Most diagnostic and surgical services provided by epilepsy centers, including E/M services, will remain fairly stable in 2017, with minimal increases and decreases.

The final rule also includes updates to the geographic practice cost indices (GPCI's) which accounts for local differences in practice costs. Changes based on the new GPCI's will be phased in over 2017 and 2018. Addenda D and E found at the link provided at the beginning of this summary provide all of the local payment adjustments.

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

CMS is continuing its ongoing, incremental efforts to update and improve the relative values of primary care, care management/coordination, and cognitive services within the MPFS. In the CY 2016 proposed

MPFS, the agency solicited comments on how to improve payment for these services. In response to stakeholder feedback, CMS is finalizing the following proposals that pay separately for services that had previously been assumed to be bundled into the E/M codes billed by primary care and cognitive physicians, including neurologists.

Non-Face-To-Face Prolonged Evaluation and Management Services
CMS finalized its proposal to pay for the non-face-to-face prolonged E/M services (CPT codes 99358 and 99359). These codes are not to be reported for time spent in care plan oversight services or other non-face-to-face services that have more specific codes. The proposal that these services be furnished on the same day by the same physician or other billing practitioner as the companion E/M code was a drafting error and was not finalized. The codes will be adopted as described by CPT.

Establishing Separate Payment for Behavioral Health Integration
CMS finalized its proposal for the new Psychiatric Collaborative Care Model (CoCM). These services will be provided by a primary care team working in collaboration with a psychiatric consultant. The primary care team will provide structured care management with regular assessments of the patient's clinical status using validated tools. The psychiatric consultant will provide regular consultations to the primary care team to review the clinical status and care of patients to make recommendations.

The CPT Panel is developing 3 codes to describe these services that will not be valued by January 1, so CMS will make separate payment for 3 new G codes: G0502, G0503, and G0504 which parallel the CPT codes under development. The G codes will be temporary codes. The agency will determine whether to make adopt and value the new CPT codes potentially for CY 2018.

CMS is also finalizing payment G0507 for care management services for behavioral health conditions that require at least 20 minutes of clinical staff time that is directed by a physician or other qualified health care professional per calendar month. Billing for these services is not being limited to traditional primary care specialties. Any specialist who meets the requirements of the service may bill this code. This service was intended and may be used to report other models of care, where the beneficiary may not receive E/M services from the consultant and the consultant may only be authorized to provide psychotherapy or consultation regarding medications.

Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management Services
Based on an assessment of claims data for CY 2015, CMS has concluded that CCM services may be underutilized. Approximately 275,000 unique Medicare beneficiaries received the service an average of 3 times each, totaling $37 million in allowed charges. CMS finalized changes to these services in hopes of increasing their utilization.

A full list of the final CCM scope of service elements and billing requirements can be found in the table below that was extracted from the rule. All providers can bill for these services regardless of their specialty designation, as long as all of the service's requirements are met. Please note that only one provider can bill this service per patient each month.

TABLE 11: SUMMARY OF CY 2017 Chronic Care Management (CCM) Service Elements and Billing Requirements

Service Element	Billing Requirements
Initiating Visit	Initiation during an AWV, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of chronic care management (CCM) services.
Structured Recording of Patient Information Using Certified EHR Technology	Structured recording of demographics, problems, medications and medication allergies using certified EHR technology. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.
24/7 Access & Continuity of Care	• Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week. • Continuity of care with a designated member of the care team with whom the beneficiary is able to schedule successive routine appointments.
Comprehensive Care Management	Care management for chronic conditions including systematic assessment of the beneficiary's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.
Comprehensive Care Plan	• Creation, revision and/or monitoring (as per code descriptors) of an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. • Must at least electronically capture care plan information, and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the beneficiary's care. • A copy of the plan of care must be given to the patient and/or caregiver.
Management of Care Transitions	• Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. • Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers.
Home- and Community-Based Care Coordination	• Coordination with home and community based clinical service providers. • Communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record.

Enhanced Communication Opportunities	Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.
Beneficiary Consent	• Inform the beneficiary of the availability of CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM services at any time (effective at the end of the calendar month). • Document in the beneficiary's medical record that the required information was explained and whether the beneficiary accepted or declined the services.
Medical Decision-Making	Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner).

Assessment and Care Planning for Patients with Cognitive Impairment
Beginning in 2017, CMS will make separate payment for the assessment and creation of a care plan for beneficiaries with cognitive impairment. The agency has created G-code G0505 for this service, which will be temporary because the CPT Panel has approved a similar CPT code for 2018.

This service will require the following elements:

- Cognitive-focused evaluation including a pertinent history and examination
- Medical decision making of moderate or high complexity
- Functional assessment including decision-making capacity
- Use of standardized instruments to stage dementia
- Medication reconciliation and review for high-risk medications
- Evaluation of neuropsychiatric and behavioral symptoms
- Evaluation of safety
- Identification of caregiver, caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks
- Advance care planning and addressing palliative care needs consistent with bene preference
- Creating of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed; care plan shared with the patient and/or caregiver with initial education and support

Improving Payment Accuracy for Care of Patients with Disabilities
CMS recognizes that E/M visits for patients with a mobility-related disability may exceed the resources required for a typical E/M visit and finalized its proposal to create a new add-on G-code to describe the additional services furnished in conjunction with E/M services. G0501 can be billed for resource-intensive services for patients for whom the use of specialized mobility-assistive technology is medically necessary and used during the provision of an office/outpatient E/M visit; the service can be billed with outpatient E/M codes and TCM codes.

Misvalued Codes
Congress passed several bills, including provisions in the Affordable Care Act, directing CMS to identify "misvalued" services and requiring their re-evaluation. The Protecting Access to Medicare Act (PAMA)

established an annual savings target. If the estimated net reduction in expenditures for a year is equal to or greater than the target for that year, the reduced expenditures attributable to such adjustments will be redistributed in a budget-neutral manner within the PFS. The CY 2017 target of 0.5 percent was not met, so a cut of 0.18 was applied to the conversion factor to account for the difference between the target and the amount of misvalued RVUs identified. The target for CY 2018 is also 0.5 percent.

CMS reiterated the policy that for reductions of 20 percent of more for services that are not new or revised will be phased in over 2 years. None of these services will have a reduction greater than 19 percent in a single year.

Valuation of Specific Codes

CMS addressed the changes the agency has made to RUC-recommended work RVUs when the recommendations do not account for significant changes in time. The agency employs different approaches to identify potential values that reconcile the difference in recommended work RVUs with recommended time values, including survey data, building blocks, and crosswalks to key reference or similar codes, and magnitude estimation. CMS uses the recommended values as a starting point and then applies one of a group of listed methodologies to account for reductions in time that are not reflected in the recommended value. The agency does not require a 1:1 linear decrease in newly valued work RVUs, but believes that efficiencies in time must be accounted for in order to maintain relativity in the fee schedule.

Collecting Data on Resources Used in Furnishing Global Services

In the CY 2015 MFPS, CMS proposed converting all of the 10- and 90-day global surgical codes into single day services (0-day globals). In MACRA, Congress instructed the agency not to proceed with this conversion, and instead to collect data to assess the resources used in furnishing pre- and post-operative care. The agency sought to learn more about the volume and costs of the resources typically used and is proposing a 3-pronged approach for data collection:

1. Certain practitioners are required to participate in claims-based reporting on the number and level of pre- and post-operative visits furnished for 10- and 90-day global services. Based on the comments received, CMS altered the reporting requirements of its proposal in the following ways:
    - CPT code 99024 will be used for reporting post-operative services rather than the proposed set of G-codes. Reporting will not be required for pre-operative visits included in the global package or for services not related to the patient visit.
    - Reporting will be required only for high volume/high cost services (codes reported annually by more than 100 practitioners that are reported more than 10,000 times or have allowed charges in excess of $10 million annually).
    - Practitioners are encouraged to begin reporting post-operative visits for procedures furnished on or after January 1, 2017, but the mandatory requirement to report will be effective for services related to global procedures furnished on or after July 1, 2017.
    - Only practitioners who practice in groups of 10 or more practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island are required to report.

2. CMS will survey a representative sample of practitioners on the activities involved in and the resources used to provide a number of pre- and post-operative visits during a specified period of

time, such as two weeks. In the final rule, CMS finalized this proposal and expects the survey will be in the field mid-2017.

3. CMS plans to undertake a more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, including some ACOs.

CMS chose not to assess the 5 percent penalty on those who do not report the required information, but will consider imposing it in future rulemaking if compliance with the claims-based reporting dictates it.

CMS did not finalize any provisions related to the valuation of global surgical services in the rule and stated that it will address payment for global surgical services in future rulemaking once the data has been collected and analyzed. CMS believes it has the authority through MACRA and the *Protecting Access to Medicare Act of 2014* (PAMA) to expand and enhance data collection if it can be used to improve the accuracy of PFS payments. However, in the rule, CMS did not describe exactly how the required reporting of claims data will be used to value global surgical services.

Reports of Payments or Other Transfers of Value to Covered Recipients: Solicitation of Public Comments

CMS did not propose or finalized any Open Payments program changes. The agency did say that it will consider the public comments received in the future through possible rulemaking or publication of sub-regulatory guidance.

Medicare Advantage (MA) Provider Enrollment

CMS' final rule would require MA organization providers and suppliers to be enrolled in Medicare in an approved status. An "approved status" is a status whereby a provider or supplier is enrolled in, and is not revoked, from the Medicare program. The submission of an enrollment application does not deem a provider or supplier enrolled in an approved status. Out-of-network or non-contract providers and suppliers are not required to enroll in Medicare to meet these requirements.

CMS believes this change is necessary to help ensure that Medicare enrollees receive items or services from providers and suppliers that are fully compliant with the requirements for Medicare enrollment. The process is designed to prevent fraud, waste, and abuse and to protect Medicare enrollees by carefully screening all providers and suppliers. The screening process includes risk-based site visits and in some cases fingerprint-based background checks. Ultimately, this would prohibit payment to individuals or entities that are excluded by the Office of the Inspector General or revoked from the Medicare program. CMS would have the authority to terminate a contract if a MA organization fails to meet Medicare's provider and supplier enrollment requirements. These provisions would be effective the first day of the next plan year that begins 2 years from the November 2, 2016 publication date of the CY 2017 final rule.

Medicare Shared Savings Program

In the rule, CMS makes updates to how Accountable Care Organizations report quality measures and how beneficiaries are assigned to ACOs. The details of these changes can be found on pages 80483-80516.

Medicare Telehealth Services

CMS finalized its proposal to add ESRD-related services (CPT codes 90967, 90968, 90969 and 90970) and advance care planning services (CPT codes 99497 and 99498) to the list of Medicare telehealth services for CY2017. It also finalized adding new coding G0508 and G0509 for critical care consultation services to the list of Medicare telehealth services for CY 2017, and to make payment for the services, limited to once per day per patient.

CMS is not however adding various services primarily furnished by physical therapists, occupational therapists, and speech-language pathologists due to a statutory change being required to allow them to be added to the list of Medicare telehealth services.

The proposal to use the Place of Service (POS) code for telehealth and to use the facility PE RVUs to pay for telehealth service reported by physicians or practitioners with the telehealth POS code for CY 2017 was also finalized as well as the proposed revisions addressing the PE RVUs used in different settings. For CY2017, telehealth originating site facility fee is 80 percent of the lesser of the actual charge, or $ 25.40.

ATTACHMENT 1

TABLE 52: 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	$89,866	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$231	0%	1%	0%	1%
ANESTHESIOLOGY	$1,982	0%	0%	0%	0%
AUDIOLOGIST	$61	0%	0%	0%	0%
CARDIAC SURGERY	$324	0%	0%	0%	0%
CARDIOLOGY	$6,485	0%	0%	0%	0%
CHIROPRACTOR	$784	0%	0%	0%	0%
CLINICAL PSYCHOLOGIST	$734	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	$606	0%	0%	0%	0%
COLON AND RECTAL SURGERY	$161	0%	0%	0%	0%
CRITICAL CARE	$311	0%	0%	0%	0%
DERMATOLOGY	$3,308	0%	0%	0%	0%
DIAGNOSTIC TESTING FACILITY	$754	0%	-1%	0%	-1%
EMERGENCY MEDICINE	$3,145	0%	0%	0%	0%
ENDOCRINOLOGY	$460	0%	0%	0%	0%
FAMILY PRACTICE	$6,110	0%	1%	0%	1%
GASTROENTEROLOGY	$1,747	-1%	0%	0%	-1%
GENERAL PRACTICE	$456	0%	0%	0%	1%
GENERAL SURGERY	$2,172	0%	0%	0%	0%
GERIATRICS	$213	0%	1%	0%	1%
HAND SURGERY	$182	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	$1,751	0%	0%	0%	0%
INDEPENDENT LABORATORY	$706	0%	-5%	0%	-5%
INFECTIOUS DISEASE	$656	0%	0%	0%	0%
INTERNAL MEDICINE	$10,915	0%	1%	0%	1%
INTERVENTIONAL PAIN MGMT	$769	0%	-1%	0%	0%
INTERVENTIONAL RADIOLOGY	$317	-1%	0%	0%	-1%
MULTISPECIALTY CLINIC/OTHER PHYS	$129	0%	0%	0%	1%
NEPHROLOGY	$2,210	0%	0%	0%	0%
NEUROLOGY	$1,521	0%	0%	0%	0%
NEUROSURGERY	$789	-1%	0%	0%	-1%
NUCLEAR MEDICINE	$47	0%	0%	0%	0%
NURSE ANES / ANES ASST	$1,214	0%	0%	0%	0%
NURSE PRACTITIONER	$2,988	0%	0%	0%	0%
OBSTETRICS/GYNECOLOGY	$651	0%	0%	0%	0%
OPHTHALMOLOGY	$5,492	-1%	-2%	0%	-2%
OPTOMETRY	$1,219	0%	-1%	0%	-1%
ORAL/MAXILLOFACIAL SURGERY	$49	0%	-1%	0%	-1%

(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**
ORTHOPEDIC SURGERY	$3,695	0%	0%	0%	0%
OTHER	$27	0%	0%	0%	0%
OTOLARNGOLOGY	$1,210	0%	0%	0%	-1%
PATHOLOGY	$1,135	0%	-2%	0%	-1%
PEDIATRICS	$61	0%	0%	0%	0%
PHYSICAL MEDICINE	$1,068	0%	0%	0%	0%
PHYSICAL/OCCUPATIONAL THERAPY	$3,407	0%	1%	0%	1%
PHYSICIAN ASSISTANT	$1,964	0%	0%	0%	0%
PLASTIC SURGERY	$378	0%	0%	0%	0%
PODIATRY	$1,972	0%	0%	0%	0%
PORTABLE X-RAY SUPPLIER	$106	0%	0%	0%	0%
PSYCHIATRY	$1,265	0%	0%	0%	0%
PULMONARY DISEASE	$1,765	0%	0%	0%	0%
RADIATION ONCOLOGY	$1,726	0%	0%	0%	0%
RADIATION THERAPY CENTERS	$44	0%	0%	0%	0%
RADIOLOGY	$4,683	0%	0%	0%	-1%
RHEUMATOLOGY	$537	0%	0%	0%	0%
THORACIC SURGERY	$357	0%	0%	0%	0%
UROLOGY	$1,772	-1%	0%	0%	-2%
VASCULAR SURGERY	$1,046	0%	0%	0%	-1%

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