FACT SHEET FOR THE CY 2016 FINAL RULE FOR MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) PAYMENT SYSTEM

On October 30, 2015, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that updates payment policies and rates under the Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2016.

The following fact sheet highlights key payment and policy changes described in the final rule. A more in-depth analysis of payment and policy changes can be found in the attached detailed summary.

For questions regarding the CY 2016 MPFS Final Rule policies, reviewing the relative value units (RVUs) used by CMS to set payment rates, or in formulating and submitting a comment, contact Quorum by sending an email to info@quorumconsulting.com.

MPFS Conversion Factor Updates
- For MPFS payments, CMS has finalized a conversion factor (CF) of $35.8279 for CY 2016, which represents a decrease of 0.3% from the previous year ($35.9335). Due to the Protecting Access to Medicare Act (PAMA) of 2014, there will be a 0.5% increase which will continue on an annual basis from 2017 to 2019. The CF will stay at a 0.0% change from 2020 to 2025. After that, there will be an annual 0.25% increase in the CF for 2026 and beyond.

Changes to Malpractice Relative Value Units (MP RVUs)
- CMS is finalizing their proposal to begin conducting an annual malpractice (MP) RVU update to adjust MP RVUs for risk, and reflecting changes in the mix of practitioners providing services.

Phase-in of Significant RVU Reductions
- Based on guidelines by PAMA, if the total RVUs for a CPT code are decreased by an estimated amount equal to or greater than 20% as compared to the total RVUs for the previous year, then the adjustments must be phased in over a two-year period. CMS is finalizing their proposal to phase in these reductions by reducing the value of a service by the maximum allowed amount of 19% in the first year, and to phase in the percent remainder of the reduction in the second year.

Misvalued Code Target
- Under PAMA, Congress set a target for adjustments to misvalued CPT codes for 2017 through 2020, with a target amount of 0.5% of the estimated expenditures under the fee schedule for each of those four years. If the estimated net reduction in expenditures is equal or greater than the target that year, the provision specifies that reduced expenditures shall be redistributed in a budget-neutral manner within the fee schedule as a whole. To accelerate the application of these targets, Congress amended this provision by having CMS set a 1% target for reduced expenditures for 2016 and 0.5% target for 2017 and 2018.

Physician Quality Reporting System (PQRS)
- CMS finalized the requirements for the 2018 Physician Quality Reporting System (PQRS) payment adjustment consistent with the 2017 PQRS payment adjustment requirements. From the proposed 300 PQRS measures, CMS narrowed the PQRS measure set to 281 by filling in gaps in measures, such as ones that are duplicative or are being replaced with more robust measures.
Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services

- PAMA requires that providers that order advanced diagnostic imaging services must do so based on appropriate-use criteria via a clinical decision support mechanism. The four components of the AUC program are:
  1. Establishment of AUC by November 15, 2015
  2. Mechanisms for consultation with AUC by April 1, 2016
  3. AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals by January 1, 2017
  4. Annual identification of outlier ordering professionals for services furnished after January 1, 2017
- CMS is confirming implementation of the first component of the AUC by establishing which organizations are eligible to develop or endorse appropriate use criteria, evidence-based requirements for AUC development, and the process for qualifying provider-led entities.

Physician Value-Based Payment Modifier

- CMS will use CY 2016 as the performance period for the CY 2018 Value Modifier, apply the Value Modifier to non-physician EP-only groups (e.g., Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetists (CRNAs), and non-physician EP solo practitioners, beginning with the CY 2018 payment adjustment period, and apply the quality-tiering methodology to all group and solo practitioners that satisfactorily report PQRS and are determined to be in Category 1 (groups of physicians that meet criteria for satisfactory reporting of data on PQRS) for the CY 2018 payment adjustment period (note: Category 2 includes those groups of physicians that are subject to the CY 2016 value-based payment modifier and do not fall within Category 1).
- CMS will continue to set the maximum upward adjustment for the CY 2018 Value Modifier at:
  - +4.0 times an adjustment factor for groups of physicians of 10 or more EPs
  - +2.0 times an adjustment factor for groups of physicians with 2-9 EPs and physician solo practitioners
  - +2.0 times an adjustment factor for groups that consist of non-physician EPs and solo practitioners who are PAs, NPs, CNSs, and CRNAs
- CMS will also set the amount of payment at risk under the CY 2018 Value Modifier to:
  - -4.0% for groups of physicians with 10 or more EPs
  - -2.0% for groups of physicians with 2-9 EPs and physician solo practitioners
  - -2.0% for groups that consist of non-physician EPs and solo practitioners who are PAs, NPs, CNSs, and CRNAs

“Incident to” Services

- CMS is finalizing their proposal to clarify that billing providers for “incident to” services must also be the supervising provider. CMS is also finalizing the requirement that auxiliary personnel providing “incident to” services and supplies cannot have been excluded from Medicare, Medicaid, or other federal health care programs.

Advanced Care Planning

- CMS is finalizing that they will establish separate payment rates for two advanced care planning (ACP) services (CPT code 99497 and 99498), in order to recognize the additional practitioner time to conduct these conversations.

Part B Drugs/Payment for Biosimilar Biological Products

- CMS is finalizing their proposal to update the regulations to clarify that the payment amount for a billing code for a biosimilar biological drug product is based on the average sales price (ASP) of all biosimilar biological products that reference a common biological product’s license application.
Updates Regarding Physician Self-Referral Requirements

- The physician self-referral law creates regulatory exceptions for financial relationships that pose no risk of program or patient abuse. Specifically, this rule updates regulations related to delivery and payment system reform, reducing burden, and facilitating compliance.

- In the final rule, CMS has provided clarification on the following:
  - Compensation paid to a physician organization cannot take into account the referrals of any physician in the physician organization, not just a physician who may have a compensation arrangement with the physician organization.
  - The writing required in the exceptions to the physician self-referral law’s referral and billing prohibitions can be a collection of documents.
  - The term of a lease or personal service arrangement does not need to be in writing if the arrangement lasts at least one year. CMS also allows a 90-day grace period to obtain missing signatures.
  - Financial relationship does not exist when a physician provides services to hospital patients in the hospital setting if both the hospital and the physician bill independently for their services.

- CMS has also expanded regulations to establish two new exceptions to enhance care in rural and underserved areas:
  - To permit payment by hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) to physicians for the purpose of compensating non-physician practitioners under certain conditions
  - To permit timeshare arrangements for the use of office space, equipment, personnel, items, supplies, and other services
DETAILED SUMMARY OF THE CY 2016 FINAL RULE FOR THE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)

On October 30, 2015, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that will update payment policies and rates under the Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2016. A full publication of the final rule is published by the Federal Register, and can be found here: https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-28005.pdf

For questions regarding the CY 2016 MPFS Final Rule policies, reviewing the relative value units (RVUs) used by CMS to set payment rates, or in formulating and submitting a comment, contact Quorum by sending an email to info@quorumconsulting.com.

MPFS TECHNICAL RVU/PAYMENT CALCULATION/METHODOLOGY CHANGES

I. Changes to the Conversion Factor (CF)

This Conversion Factor will be set at $35.8279 from the beginning of the next calendar year until December 31, 2016.

For MPFS payments, based on provisions by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, CMS will set the conversion factor (CF) at $35.8279 for CY 2016. This represents a decrease of 0.3% from the previous year’s CF of $35.9335. Afterward, there will be a 0.5% increase which will continue on an annual basis from 2017 to 2019. The CF will stay at a 0.0% change from 2020 to 2025. From 2026 onward, CMS will implement an annual 0.25% increase annually.

II. Work Relative Value Units (RVUs)

There are no significant changes or updates to the methodology behind the physician work RVUs.

III. Changes to Practice Expense Relative Value Units (PE RVUs)

For 2016, CMS has incorporated utilization data for interventional cardiology PE relative value units (RVU). Since there is no Physician Practice Expense Information Survey (PPIS) data for this specialty, CMS is finalizing their proposal to use practice expense per hour (PE/HR) value for interventional cardiology by crosswalking the PE/HR for cardiology. There are no other significant PE RVU changes under the rule.

IV. Changes to Malpractice Relative Value Units (MP RVUs)

CMS is finalizing their proposal to begin conducting an annual malpractice (MP) RVU update to adjust MP RVUs for risk, and reflect changes in the mix of practitioners providing services. Under this approach, the specialty-specific risk factors would continue to be updated every five years using premium updated data, but would remain unchanged between the 5-year reviews. To ensure that MP RVUs are as current as possible, CMS will recalibrate all MP RVUs on an annual basis to reflect the specialty mix based on claims data. Commenters, including the AMA RVS Update Committee (RUC), supported CMS’ proposal to update MP RVUs on an annual basis and the use of the three most recent years of available data for the specialty mix assignment.
V. Phase-in of Significant RVU Reductions

Based on guidelines by the Protecting Access to Medicare Act (PAMA), if the total RVUs for a CPT code are decreased by an estimated amount equal to or greater than 20% as compared to the total RVUs for the previous year, that the adjustments must be phased-in over a two-year period.

CMS is finalizing their proposal to phase in these reductions by reducing the value of a service by the maximum allowed amount of 19% in the first year, and to phase in the percent remainder of the reduction in the second year. CMS believes this avoids differential treatment due to an arbitrary cut off of 20%.

VI. Geographic Practice Cost Indices (GPCIs)

There are no significant changes or updates to the methodology behind the Geographic Practice Cost Indices (GPCIs).

VII. Global Period

There are no significant changes or updates to the global period.

---

MPFS DISEASE/SPECIALTY SPECIFIC POLICY CHANGES

I. Misvalued Codes

By using the existing high expenditure screen, CMS identified 118 CPT and HCPCS codes as potentially misvalued. CMS selected the misvalued codes by excluding codes with 10- and 90-day global periods and with less than $10 million in allowed changes. CMS also identified a set of codes for review as potentially misvalued, which are described below.

**Radiation Therapy Misvalued Codes:**
In 2012, CMS identified radiation therapy codes as potentially misvalued. The American Medical Association RVS Update Committee (AMA RUC) recommended values for the new codes issued in 2015, including changes to services that are furnished with capital equipment.

After review of public comments, CMS is not finalizing their proposal to implement the new code set for payment of radiation therapy treatment and will continue to work on reviewing these codes and payment rates in future years. However, CMS is finalizing their proposal on the utilization rate assumption used to determine the “per minute cost” of the capital equipment used for radiation therapy (equipment is generally used for 35 hours per week, a 70% utilization rate). CMS will implement this change over two years and seeks comment on additional sources of accurate data regarding the price of linear accelerators used in radiation therapy, including how often these machines are in use.

**Lower GI Endoscopy Misvalued Codes:**
The AMA CPT Editorial Panel revised the lower gastrointestinal endoscopy code set for CY 2015 following codes which were identified as potentially misvalued. The review includes revaluing codes that include moderate sedation and anesthesia procedure CPT codes 00740 and CPT 00810. After consideration of feedback from the AMA RUC and public comments, CMS is finalizing implementation of the revised set of codes, including revised values. CMS is also finalizing the payment rates to be more closely tied to the values recommended by the AMA RUC.
II. Changes for Computed Tomography (CT) under PAMA

PAMA requires that CMS reduce payment for the technical component (TC) of services and hospital outpatient prospective payment system (OPPS) payment (5% in 2016 and 15% in 2017 and subsequent years) for computed tomography (CT) services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) standard.

Beginning in 2016, claims for certain CT scans for certain CT related CPT codes must include modifier “CT”\(^1\) in order to result in an applicable payment reduction for the service. Although the American College of Radiology requested that CMS delay implementation for one year, CMS is moving forward to implement the “CT” modifier on January 1, 2016.

III. Appropriate Use Criteria for Advanced Diagnostic Imaging Services

PAMA requires that providers which order advanced diagnostic imaging services must do so based on appropriate use criteria (AUC) via a clinical decision support mechanism. In the proposed rule, CMS proposed to establish a process for identifying clinical areas of priority, specify appropriate use criteria, and lay out a timeline to accomplish these goals. Per PAMA requirements, there are four components of the AUC program:

1. Establishment of AUC by November 15, 2015
2. Mechanisms for consultation with AUC by April 1, 2016
3. AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals by January 1, 2017
4. Annual identification of outlier ordering professionals for services furnished after January 1, 2017

In the final rule, CMS confirmed implementing the first component of the AUC by establishing which organizations are eligible to develop or endorse appropriate use criteria, evidence-based requirements for AUC development, and the process for qualifying provider-led entities.

IV. Medicare Telehealth Services

CMS is confirming that it will add prolonged service inpatient CPT codes 99356 and 99357 and end stage renal disease (ESRD)-related services CPT 90933 through CPT 90936 to the list of Medicare telehealth services beginning in CY 2016 on a category 1 basis (services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services). Further, CMS finalized that it will add certified registered nurse anesthetists to the list of qualified telehealth providers for health care services.

MPFS GENERAL POLICY CHANGES

I. Physician Quality Reporting System (PQRS)

The Physician Quality Reporting System (PQRS) encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare. In the final rule, CMS finalized the requirements for the 2018 Physician Quality Reporting System (PQRS) payment adjustment consistent with the 2017 PQRS payment adjustment requirements. Hence, the same criteria to require reporting of nine measures covering three National Quality Strategy domains will be implemented.

---

\(^1\) Modifier “CT”: Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard
Quorum Consulting

Key Final Rule Changes to the MPFS Payment Systems for CY 2016

NQS domains:
1. Community/Population Health
2. Effective Clinical Care, Patient Safety, and Communication
3. Care Coordination

From the proposed 300 PQRS measures, CMS narrowed the PQRS measure set to 281 by filling in gaps in measures, such as ones that are duplicative or are being replaced with more robust measures. There will also be 18 measures in the group practice reporting option (GPRO) Web Interface for 2016. Following the 2018 PQRS payment adjustment, additional adjustments will be made under Merit-Based Incentive Payment System (MIPS), as required by MACRA.

For more details on PQRS (including the list of PQRS measures), please see the following link:

II. Medicare Shared Savings Program

The Medicare Shared Savings Program was established to promote accountability of providers to patients, coordinate items/services under part A and B, and encourage investment in infrastructure and processes for high quality and efficiency through provider and supplier participation in an Accountable Care Organization (ACO).

CMS is finalizing the following changes to specific sections of the Shared Savings Program regulations:

- Adding a measure of Statin Therapy for the Prevention and Treatment of Cardiovascular Disease in the Preventive Health domain to align with PQRS
- Preserving flexibility to maintain or revert measures to pay for reporting in a measure owner determines the measure no longer aligns with updated clinical practice or causes patient harm
- Clarifying how PQRS-eligible professionals participating within an ACO meet their PQRS reporting requirements when their ACO satisfactorily reports quality measures
- Amending the definition of primary care services to include claims submitted by Electing Teaching Amendment hospitals and to exclude certain claims for services furnished in Skilled Nursing Facilities

III. Electronic Clinical Quality Measures (eCQM) and Electronic Health Records (EHR) Incentive Program

CMS is finalizing revision of the definition of certified electronic health records (EHR) technology to require certification of EHR technology in accordance with criterion proposed by the Office of the National Coordination for Health Information Technology. This revision is due to CMS’ form and manner requirements for electronic submission of Clinical Quality Measure (CQM) EHR technology.

For more details on EHR, please see the following link:

IV. “Incident to” Services

In 2014, CMS required that, as a condition for Part B payment, all “incident to” services and supplies must be furnished in accordance with applicable state law. For 2016, CMS is finalizing their proposal to clarify that billing providers for “incident to” services must also be the supervising provider. CMS is also finalizing the requirement that auxiliary personnel providing “incident to” services and supplies cannot have been excluded from Medicare, Medicaid, or other federal health care programs by the Office of Inspector General (OIG), or have had their enrollment revoked for any reason at the time they provided services or supplies.
V. Misvalued Code Target

Under PAMA, Congress set a target for adjustments to misvalued CPT codes for 2017 through 2020, with a target amount of 0.5% of the estimated expenditures under the fee schedule for each of those four years. If the estimated net reduction in expenditures is equal or greater than the target that year, the provision specifies that reduced expenditures shall be redistributed in a budget-neutral manner within the fee schedule. However, if the amount exceeds the target, it shall be treated as a reduction in expenditures for the subsequent year for determining whether the target for the subsequent year has been met. The Achieving a Better Life Experience Act of 2014 (ABLE) accelerated these targets by applying it to 2016 through 2018 instead, including increasing the target to 1% for 2016 and maintaining the 0.5% target for 2017 and 2018.

In this final rule, commenters suggested different frequencies of review (e.g. every 10 years) and alternative methodologies for the misvalued code target process; however, CMS believes that their existing process effectively evaluates codes in order to improve the accuracy of RVUs. Therefore, CMS is adopting a methodology to implement this provision, and has identified changes that achieve 0.23% in net reductions (which requires a 0.77% reduction to all physician fee schedule services).

VI. Physician Value-Based Payment Modifier

The Value-Based Payment Modifier (Value Modifier) provides for differential payments to physicians, groups of physicians, and other EPs based on the quality and cost of care provided. Under this program, EPs who provide high quality, efficient care may receive payment incentives, while EPs who underperform maybe subject to a downward adjustment. This program is set to expire in CY 2018, as a new program, required by MACRA, called the Merit-Based Incentive Program (MIPS) begins in CY 2019.

For 2016, CMS finalizes the following:

- CY 2016 will be the performance period for the CY 2018 Value Modifier
- Apply the Value Modifier to non-physician EP-only groups (e.g., Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetists (CRNAs), and non-physician EP solo practitioners, beginning with the CY 2018 payment adjustment period
- Apply the quality-tiering methodology to all group and solo practitioners that satisfactorily report PQRS and are determined to be in Category 1 for the CY 2018 payment adjustment period
- Continue to set the maximum upward adjustment for the CY 2018 Value Modifier at:
  - +4.0 times an adjustment factor for groups of physicians of 10 or more EPs
  - +2.0 times an adjustment factor for groups of physicians with 2-9 EPs and physician solo practitioners
  - +2.0 times an adjustment factor for groups that consist of non-physician EPs and solo practitioners who are PAs, NPs, CNSs, and CRNAs
- Set the amount of payment at risk under the CY 2018 Value Modifier to:
  - -4.0% for groups of physicians with 10 or more EPs
  - -2.0% for groups of physicians with 2-9 EPs and physician solo practitioners
  - -2.0% for groups that consist of non-physician EPs and solo practitioners who are PAs, NPs, CNSs, and CRNAs
- To waive application of the Value Modifier for groups and solo practitioners if at least one EP who billed for physician fee schedule items/services (during the performance period) participated in the Pioneer ACO model, Comprehensive Primary Care Initiative (CPCI), or other innovation center model
- Beginning with the CY 2017 payment adjustment period, CMS is increasing the minimum episode size for the Medicare spending per beneficiary measure to 125 episodes for all groups and solo practitioners
VII. Updates Regarding Physician Self-Referral Requirements

Physician Self-Referral

The physician self-referral law creates regulatory exceptions for financial relationships that pose no risk of program or patient abuse. Specifically, this rule updates regulations related to delivery and payment system reform, reducing burden, and facilitating compliance. The physician self-referral law prohibits both:

1. A physician from making referrals for certain “designated health services” (DHS) payable by Medicare to an entity with which he or she has a financial relationship, unless the requirements of an applicable exception are satisfied; and
2. The entity from filing claims with Medicare for those DHS furnished as a result of a prohibited referral.

Quorum has provided updates on select topics related to physician self-referrals, which provides clarification on compliance, regulation, and documentation related issues that apply to physicians and hospitals. CMS has finalized the proposed regulations to establish two new exceptions clarification on regulatory terminology and requirements, which are included below.

Clarifying Terminology and Providing Policy Guidance

The ACA established a self-disclosure protocol that allows CMS to settle overpayments resulting from physician self-referral law violations. The revisions also include clarifying requirements on leases of space and equipment and to agreements for personal services, substituting “arrangement” for “agreement” and “contract” in compensation exception requirements, and documentation requirements for Stark exceptions that require a term of at least a year.

In the proposed rule, CMS clarifies that “split-bill” arrangements (physician provides a service in the hospital department and bills for professional fees while the hospital bills for facility fees) does not constitute as remuneration. Per CMS, arrangements where global billing (in which the professional and technical components are not billed separately) with a non-Medicare payer would be considered remuneration.

In the final rule, CMS provides clarification on the following items:

- Compensation paid to a physician organization cannot take into account the referrals of any physician in the physician organization, not just a physician who seeks direct and indirect compensation arrangements with the physician organization.
- The writing required in the exceptions to the physician self-referral law’s referral and billing prohibitions can be a collection of documents.
- The term of a lease or personal service arrangement does not need to be in writing if the arrangement lasts at least one year. CMS also allows a 90-day grace period to obtain missing signatures.
- Financial relationship does not exist when a physician provides services to hospital patients in the hospital setting if both the hospital and the physician bill independently for their services.

Updating Physician-Owned Hospital Requirements

The ACA established new restrictions on physician-owned hospitals, including setting a baseline physician ownership percentage and requiring physicians to indicate that the hospital is owned by physicians. CMS finalized conforming to changes that align their regulations to the statute so that the baseline and future calculations of a hospital’s physician ownership percentage includes all physicians rather than only those physicians who refer to the hospital. This physician ownership calculation change will take effect on January 1, 2017.
New exceptions created for hospitals in rural and underserved areas

Based on feedback from stakeholders, review of literature, and reviewing the self-referral law further, CMS is interested in expanding access to needed health care services. CMS expanded regulations to establish two new exceptions to enhance care in rural and underserved areas:
- To permit payment by hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) to physicians for the purpose of compensating non-physician practitioners under certain conditions
- To permit timeshare arrangements for the use of office space, equipment, personnel, items, supplies, and other services

VIII. Physician Compare

CMS will continue to make all 2016 individual eligible professional (EP) and group practice PQRS measures available for public reporting. A CMS-specified certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor will allow for public reporting, which includes all Accountable Care Organization (ACO) measures.

CMS will continue its phased approach to public reporting on Physician Compare. CMS will finalize the following new policies:
- Include an indicator for individual eligible professionals (EPs) who satisfactorily report the new PQRS Cardiovascular Prevention measures group
- Make individual-level QCDR measures available for public reporting
- Publicly report an item (or measure)-level benchmark derived using the Achievable Benchmark of Care (ABC) methodology
- Include in the downloadable database the Value Modifier for cost and quality, noting if the group practice or EP is high, low, or neutral on cost and quality, a notation of the payment adjustment received, and an indication if the individual EP or group practice was eligible to but did not report quality measures to CMS

For more details on Physician Compare, please see the following link:

IX. Potential Expansion of Comprehensive Primary Care Initiative (PCI)

Through the Comprehensive Primary Care Initiative (CPCI), the CMS Innovation Center is testing the impact of collaborating with 38 other payers (private and public), to better coordinate care for beneficiaries by providing population-based care management fees and shared savings opportunities for about 480 primary care practice sites in seven markets. CMS received over 90 comments on potential expansion of PCI, which includes feedback on engagement of electronic health record vendors, coaching on leadership and change management, documentation, beneficiary cost-sharing, care management, further testing of the CPC initiative, eligibility for incentive payments for participation in Alternative Payment Models under MACRA, auditing requirements, aggregation of payer and clinical data, and engagement with providers across the broader medical neighborhood.

For more information on PCI, please see the following link:
http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/
X. Advanced Care Planning

Advanced care planning is a service that includes conversations between a patient and providers, both before an illness progresses and during the course of treatment, in order to decide on the type of care that is right for the patient. CMS is finalizing that they will establish separate payment rates for two advanced care planning (ACP) services (CPT code 99497\(^2\) and 99498\(^3\)), in order to recognize the additional practitioner time to conduct these conversations. CMS will also finalizing payment for ACP services when it is included as an optional element of the “Annual Wellness Visit.”

CMS allows for billing these codes with other Evaluation and Management (E/M) services, including those provided during the same service period as Transitional Care Management (TCM) and Chronic Care Management (CCM) services. CMS has also clarified that the “incident to” rule still applies to these services, which refers to a minimum of direct supervision.

XI. Part B Drugs/Payment for Biosimilar Biological Products

In 2010, CMS issued regulations on payments for biosimilar biological products using a payment approach specified by the ACA. For CY 2016, CMS is finalizing their proposal to update the regulations to clarify that the payment amount for a billing code for a biosimilar biological drug product is based on the average sales price (ASP) of all biosimilar biological products that reference a common biological product’s license application. Hence, the payment determination for a biosimilar biological product is applied to a biosimilar biological product for all National Drug Code (NDCs) assigned to the product.

CMS anticipates that biosimilar biological products will have lower average sales prices (ASPs) than corresponding reference products; however, CMS has not yet received ASP data for any biosimilar biological products. Hence, in order to assess the potential savings to Part B, CMS is waiting to see what the cost differences are between each of the biosimilars and the prices differences between the biosimilars and reference products.

---

Quorum Consulting, Inc. is a medical consulting firm located in San Francisco, California. The mission of Quorum is to help medical innovators improve people’s lives by enabling payment for their products and services. Quorum staff consists of experts who approach reimbursement by aligning clinical, regulatory, and commercial strategies throughout the product life cycle.

For more information about Quorum, or for questions regarding the CY 2016 MPFS Final Rule or a more in-depth look at finalized policies, please feel free to visit our website at www.quorumconsulting.com, or send an email to info@quorumconsulting.com.

---

\(^2\) CPT code 99497: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate.

\(^3\) CPT code 99498: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes (List separately in addition to code for primary procedure).