hfma
healthcare financial management association

CY14 Medicare Physician Fee Schedule Final Rule Fact Sheet

Submission of Comments

This document provides an overview of changes to the Medicare fee schedule for physician services for calendar year 2014 (CY14), as outlined in a final rule published in the Dec. 10, 2013, *Federal Register*.

The final rule became effective **Jan. 1, 2014**.

Overview

The Centers for Medicare & Medicaid Services (CMS) released a final rule with comment period in December 2013 that revises payment polices under the Medicare Physician Fee Schedule (PFS) and makes other policy changes related to Medicare Part B payment. Unless otherwise noted, these changes are applicable to services furnished in calendar year 2014 (CY14). The rule also finalizes changes to several quality reporting initiatives that are associated with PFS payments, including Physician Quality Reporting System (PQRS) changes to the Physician Compare tool on the Medicare.gov website. The rule continues the phased-in implementation of the physician value-based payment modifier (value modifier), created by the Affordable Care Act (ACA), which will affect payments to certain physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the Medicare fee-for-service program.

Physician Payment

Federal Register, pages 74397-74399

Final Update: The CY14 PFS conversion factor (CF) is **$27.2006.** The PFS update is determined by multiplying the CF for the previous year by the percentage increase in the Medicare economic index (MEI) less productivity, and then multiplying the result by the update adjustment factor (UAF), which is calculated as specified under section 1848(d)(4)(B) of the Social Security Act (the Act). Section 601of the American Taxpayer Relief Act (ATRA) of 2012 provided a 0 percent update for CY13, effective Jan. 1, 2013, through Dec. 31, 2013, and specified that the CFs for subsequent time periods must be computed as if the increases in previous years had not been applied. Therefore, under current law, a CF of $25.0070 would have been in effect in CY13 had the prior increases specified above not applied.

When calculating the PFS CF for a year, section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in relative value units (RVUs) may not cause the amount of expenditures for the year to differ more than $20 million from what it would have been in the absence of these changes. If this threshold is exceeded, CMS must make adjustments to preserve budget neutrality. CMS estimates that CY14 RVU changes would result in a decrease in Medicare physician expenditures of more than $20 million. Therefore, it is increasing the CF by 0.046 percent to offset this estimated decrease in Medicare physician expenditures. Furthermore, CMS is increasing the CF by 4.72 percent to offset the decrease in Medicare physician payments due to the CY14 rescaling of the RVUs so that the proportions of total payments for the work, practice expense (PE), and malpractice (MP) RVUs match the proportions in the final revised MEI for CY14.

The final rule with comment period announces a reduction to payment rates for physicians' services in CY14 under the sustainable growth rate (SGR) formula. The total reduction in the MPFS CF between CY13 and CY14 under the SGR system will be 20.1 percent. CMS is required to make these reductions in accordance with section 1848(d) and (f) of the Act, and only Congress can avert these reductions.

CMS illustrates the calculation of the CY14 PFS CF in Table 44 of the final rule.

TABLE 44—CALCULATION OF THE CY 2014 PFS CF

Conversion Factor in effect in CY 2013		$34.0230
CY 2013 Conversion Factor had statutory increases not applied		$25.0070
CY 2014 Medicare Economic Index	0.8 percent (1.008)	
CY 2014 Update Adjustment Factor	3.0 percent (1.03)	
CY 2014 RVU Budget Neutrality Adjustment	0.046 percent (1.00046)	
CY 2014 Rescaling to Match MEI Weights Budget Neutrality Adjustment	4.718 percent (1.04718)	
CY 2014 Conversion Factor		$27.2006
Percent Change from Conversion Factor in effect in CY 2013 to CY 2014 Conversion Factor.		−20.1%

While Congress works to establish a permanent fix for the SGR formula, included in the Pathway for SGR Reform Act of 2013, is a "patch" that stops the scheduled 24 percent SGR Medicare physician payment reduction from taking effect on Jan. 1, 2014, and instead, establishes a temporary payment update of 0.5 percent until March 31, 2014. The 2014 CF for this time frame is **$35.8228**.

Anesthesia CF

Anesthesia services do not have RVUs like other PFS services. Therefore, CMS accounts for any necessary RVU adjustments through an adjustment to the anesthesia CF to simulate changes to RVUs. The anesthesia CF in effect in CY13 was $ 21.9243. Under current law, had statutory increases not applied, the anesthesia CF in effect in CY13 would have been $16.1236. The percentage change from the anesthesia CF in effect in CY13 to that for CY14 is –21.4 percent. The CY14 national average anesthesia CF is **$17.2283**.

CMS illustrates the calculation of the CY14 anesthesia CF in Table 45 of the final rule.

TABLE 45—CALCULATION OF THE CY 2014 ANESTHESIA CF

2013 National Average Anesthesia Conversion Factor in effect in CY 2013		$21.9243
2013 National Anesthesia Conversion Factor had Statutory Increases Not Applied		$16.1236
CY 2014 Medicare Economic Index	0.8 (1.008)	
CY 2014 Update Adjustment Factor	3.0 (1.003)	
CY 2014 Budget Neutrality Work and Malpractice Adjustment	0.046 (1.00046)	
CY 2014 Rescaling to Match MEI Weights Budget Neutrality Adjustment	4.718 percent (1.4718)	
CY 2014 Anesthesia Fee Schedule Practice Expense Adjustment	.9823 (.9823)	
CY 2014 Anesthesia Conversion Factor		$17.2283
Percent Change from 2013 to 2014		−21.4%

The temporary payment update of 0.5 percent from Jan. 1, 2014, to March 31, 2014, as a result of the temporary SGR temporary "patch" is also applicable to the anesthesia CF. The national unadjusted anesthesia conversion factor will be **$22.62** for this time frame.

Resource-Based Practice Expense (PE) RVUs

Federal Register, pages 74233-74261, 74323

Final Update: Given that the overwhelming majority of comments submitted objected to the CY14 proposed policy, CMS is not finalizing its proposed policy to make changes to the PE RVU methodology in the final rule. CMS will further consider all of the comments received, including those suggesting technical improvements to its proposed methodology. After further

consideration of the comments, CMS expects to develop a revised proposal for using outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) rates in developing practice expense (PE) RVUs, which it will issue through future notice and comment rulemaking.

Background: CMS is required to develop a methodology for a resource-based system for determining PE RVUs for each physician's service. CMS develops PE RVUs by looking at the direct and indirect practice resources involved in furnishing each service. OPPS payment rates are based on auditable hospital data and are updated annually. Given the differences in the validity of the data used to calculate payments under the PFS versus under the OPPS, CMS believes that the nonfacility PFS payment rates for procedures that exceed payment rates for the same procedures when furnished in facilities result from inadequate or inaccurate direct PE inputs, especially in price or time assumptions, as compared with the more accurate OPPS data.

Based on this reasoning, CMS proposed a change in the PE methodology beginning in CY14. To improve the accuracy of PFS nonfacility payment rates for each calendar year, CMS proposed to use the current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services under the PFS. CMS also proposed to limit the nonfacility PE RVUs for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting (hospital outpatient department or ASC). To maintain the greatest consistency and transparency possible, CMS proposed to use the current year PFS conversion factor and the current year OPPS or ASC rates in the comparison.

CMS proposed to address nearly 200 codes that it believes to have incorrectly valued resource inputs. These codes, appearing in Appendix A (Table 27 of the final rule), are those for which the total PFS payment for a service furnished in an office or other nonfacility setting would exceed the total Medicare payment (the combined payment to the facility and the professional) when the service is furnished in a facility, either a hospital outpatient department or an ASC.

Geographic Practice Cost Indices (GPCIs)

Federal Register, pages 74380-74391

Final Update: CMS is finalizing the CY14 geographic practice cost indices (GPCI) update as proposed. CMS is changing the cost share weight for the work GPCI (as a percentage of the total) from 48.266 percent to **50.866 percent**; the cost share weight for the PE GPCI is revised from 47.439 percent to **44.839 percent,** with a change in the employee compensation component from 19.153 to **16.553** percentage points. The cost share weight for the MP GPCI (**4.295 percent**) remains unchanged.

CMS will use updated Bureau of Labor Statistics Occupational Employment Statistics data from 2009 through 2011 in place of 2006-08 data for calculating the work GPCI, the employee compensation component, and the purchased services component of the PE GPCI. It also will use updated ASC data from 2008 through 2010 in place of 2006-08 data for calculating the office rent component of the PE GPCI, and updated MP data from 2011 and 2012 in place of 2006-07 data for calculating the MP GPCI.

The CY14 updated GPCIs and summarized geographic adjustment factors (GAFs) by Medicare PFS locality can be found in Addenda D and E to the CY14 final rule available on the CMS web site under the supporting documents section of the CY14 proposed rule web page. Additional information on the CY14 GPCI update may be found in a report from CMS's contractor, ***Report on the CY14 Update of the Geographic Practice Cost Index for the Medicare Physician Fee Schedule,*** which is available on the CMS web site under the supporting documents section of the CY14 PFS final rule with comment period.

Background: Section 1848(e)(1)(A) of the Act requires CMS to develop separate GPCIs to measure resource cost differences among localities compared with the national average for each of the three fee schedule components (that is, work, PE, and MP). CMS must, if necessary, adjust the GPCIs at least every three years. If more than one year has elapsed since the date of the most recent previous GPCI adjustment, the adjustment to be applied in the first year of the next adjustment is half of the adjustment that otherwise would be made. Therefore, since the previous GPCI update was implemented in CY11 and CY12, CMS proposed to phase in half of the latest GPCI adjustment in CY14.

ATRA extended the 1.0 work GPCI floor only through Dec. 31, 2013. Therefore, the proposed CY14 work GPCIs and summarized geographic adjustment factors do not reflect the 1.0 work floor. However, the 1.5 work GPCI floor for Alaska and the 1.0 PE GPCI floor for frontier states (Montana, North Dakota, Nevada, South Dakota, and Wyoming) are permanent and, therefore, applicable in CY14.

Telehealth Services

Federal Register, pages 74399- 74405

Final Update: CMS is not adopting its proposal to modify its regulations regarding originating sites to define rural health professional shortage areas (HPSAs) as those located in rural census tracts as determined by Office of Rural Health Policy. CMS is adding CPT codes 99495 and 99496 to the list of telehealth services for CY14 on a Category 1 basis. The CY14 payment amount for HCPCS code Q3014 (telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or $24.63. The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 46 of the final rule. CMS is finalizing its proposal to add "transitional care management" to the approved list of Medicare telehealth services.

Background: Medicare telehealth services can be furnished only to an eligible telehealth beneficiary in a qualifying originating site. An *originating site* is defined as one of the specified sites where an eligible telehealth individual is located at the time the service is being furnished via a telecommunications system. Telehealth health services are limited to once every 30 days for any Medicare beneficiary discharged from an inpatient hospital setting, partial hospitalization, observation status in a hospital, or a skilled nursing facility/nursing facility to his or her community setting (home, domiciliary, rest home, or assisted living).

Transitional care management comprises one face-to-face visit within the specified time frames following a discharge in combination with non–face-to-face services that may be performed by a physician or other qualified healthcare professional and/or licensed clinical staff under a physician's direction.

Therapy Caps
Federal Register, pages 74005-74410

Final Update: The Pathway for SGR Reform Act of 2013 extends the exceptions process for outpatient therapy caps through March 31, 2014. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through March 31, 2014. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department. Additional information about the exception process for therapy services may be found in the Medicare Claims Processing Manual, Pub.100-04, Chapter 5, Section 10.3. CMS will increase the CY13 therapy cap of $1,900 by the CY14 MEI of 0.8 percent, resulting in a therapy cap amount for CY14 of **$1,920**.

The therapy caps are determined for a beneficiary on a calendar year basis. A new cap became effective for all beneficiaries for outpatient therapy services received on or after Jan. 1, 2014. For physical therapy (PT) and speech language pathology (SLP) services combined, the 2014 limit for a beneficiary on incurred expenses is $1,920. There is a separate cap for occupational therapy (OT) services, which is $1,920 for 2014. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 1103 also extends the mandate that Medicare perform manual medical review of therapy services furnished Jan. 1, 2014, through March 31, 2014, for which an exception was requested for when the beneficiary reaches a dollar aggregate threshold amount of $3,700 for therapy services, including outpatient therapy services, for a year.

Background: Section 1833(g) of the Act applies annual, per beneficiary, limitations on expenses that can be considered as incurred expenses for outpatient therapy services under Medicare Part B, commonly referred to as "therapy caps." There is one therapy cap for outpatient OT services and another separate therapy cap for PT and SLP services combined. The annual caps are calculated by updating the previous year's cap by the MEI for the upcoming calendar year and rounding to the nearest $10.

An exceptions process for the therapy caps has been in effect since Jan. 1, 2006. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Under section 1833(g)(5)(C) of the Act, which was added by the Middle Class Tax Relief and Job Creation Act of 2012 and extended through 2013 by ATRA, CMS is required to apply a manual medical review process to therapy claims when a beneficiary's incurred expenses exceed a threshold amount of $3,700. There are two separate thresholds of $3,700, just as there

are two therapy caps, and incurred expenses are counted toward the thresholds in the same manner as the caps. These provisions expired Dec. 31, 2013.

"Incident to" Services Billing Requirements

Federal Register, pages 74410-74414

Final Update: CMS will adopt a new condition of payment by requiring compliance with state laws for services furnished incident to a physician's or other practitioner's professional services. Specifically, CMS will add new language to state that services and supplies must be furnished in accordance with applicable state law, and will amend the definition of auxiliary personnel to require that the individual providing "incident to" services meet any applicable requirements to provide the services, including licensure, imposed by the state in which the services are being furnished. CMS believes this requirement will protect the health and safety of Medicare beneficiaries and enhance its ability to recover federal dollars when care is not delivered in accordance with state laws.

Background: To be paid as an "incident to" service under Medicare Part B, the service or supply must be:

- Furnished in a noninstitutional setting to a noninstitutional patient
- An integral, though incidental, part of the service delivered by a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness
- Furnished under direct supervision—as specified under §410.26(a)(2)—of a physician or other practitioner eligible to bill and directly receive Medicare payment
- Furnished by a physician, a practitioner with an "incident to" benefit, or auxiliary personnel ("Incident to" services are treated as if they were furnished by the billing practitioner for purposes of Medicare billing and payment.)

In past years, CMS has been made aware of situations where Medicare was billed for 'incident to" services that were provided by auxiliary personnel who did not meet the state standards for those services in the state in which the services were furnished.

Chronic Care Management

Federal Register, pages 74414-74427

Final Update: CMS finalized the following as the scope of chronic care management services:

- The provision of 24-hours-a-day, 7-days-a-week access to address a patient's acute chronic care needs
- Care management for chronic conditions, including systematic assessment of a patient'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 patient self-management of medications

- Management of care transitions within health care including referrals to other clinicians, visits following a patient visit to an emergency department, and visits following discharges from hospitals and skilled nursing facilities
- Coordination with home and community-based clinical service providers required to support a patient's psychosocial needs and functional deficits
- Enhanced opportunities for a patient and caregiver to communicate with the provider regarding the patient's care not only through the telephone, but also through the use of secure messaging, Internet, or other asynchronous non–face-to-face consultation methods.

CMS intends to establish standards that would be necessary to furnish high-quality, comprehensive, and safe chronic care management services. CMS will develop these standards in 2014 and will implement them in 2015. The standards for the CY15 PFS will be established through notice and comment rulemaking.

Potential standards could include the following:

- The practice must use a certified electronic health record (EHR) for beneficiary care that meets the most recent HHS regulatory standard for meaningful use.
- The practice must employ one or more than one advanced practice registered nurse or physician assistant whose written job description indicates that his or her job role includes and is appropriately scaled to meet the needs for beneficiaries receiving services in the practice who require chronic care management services furnished by the practice.
- The practice must be able to demonstrate the use of written protocols by staff participating in the delivery of services.
- All practitioners, including advanced practice registered nurses or physicians assistants, involved in furnishing chronic care management services must have access at the time of service to an EHR for each beneficiary that includes all of the elements necessary to meet the most recent HHS regulatory standard for meaningful use.

To recognize the additional resources required to provide chronic care management services to patients with multiple chronic conditions, CMS will create the following new separately payable alphanumeric G-code for CY15:

- **GXXX1**: Chronic care management services furnished to patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; 20 minutes or more; per 30 days.

CMS is revising its proposed policy to specify that the chronic care management service may be billed for periods in which the medical needs of the patient require establishing, implementing, revising, or monitoring the care plan, assuming all other billing requirements are met. Allowing multiple practitioners to bill for GXXX1 during a particular billing interval would result in duplicate payment for overlapping care management. Therefore, CMS is finalizing its policy that GXXX1 and any of CPT 99495–99496, HCPCS G0181–G0182, or CPT 90951–90970 cannot be

billed during the same 30-day period; nor can GXXX1 be billed by multiple practitioners for the same time period.

Also, eligible beneficiaries must be informed about the availability of the services from the practitioner and provide written agreement to have the services provided, including agreement to the electronic communication of information with other treating providers as part of care coordination. To bill for the services, the practitioner would be required to document in the patient's medical record that all of the chronic care management services were explained and offered to the patient, noting the patient's decision to accept these services. Additionally, CMS believes that both the practitioner and the beneficiary would benefit if an annual well visit or an initial preventive physical examination were to occur at the outset of chronic care management services.

Background: Under current PFS policy, the payment for non–face-to-face care management services is bundled into the payment for face-to-face evaluation and management (E/M) visits because care management is a component of those E/M services. For CY15, CMS proposed to establish a separate payment under the PFS for chronic care management services furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CMS also intended to develop standards for furnishing chronic care management services to ensure that the physicians and practitioners who bill for these services have the capability to provide them.

Physician Compare Website

Federal Register, pages 74446-74454

Final Update: CMS will continue to phase in an expansion of Physician Compare over the next several years by incorporating quality measures from a variety of sources, as technically feasible. CMS is finalizing its proposal to expand the quality measures posted on Physician Compare by publicly reporting in CY15 performance on all measures collected through the Group Practice Reporting Option (GPRO) web interface for groups of all sizes participating in 2014 under the Physician Quality Reporting System (PQRS) GPRO. Accountable care organizations (ACOs) participating in the Medicare Shared Savings Program will have their performance on ACO GPRO measures reported publicly on Physician Compare in the same manner as group practices have performance on PQRS GPRO measures reported on the website. For data reported for 2014, CMS will continue to publicly report Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) measures for groups of 100 or more eligible professionals who participate in PQRS GPRO, regardless of GPRO submission method, and for Shared Savings Program ACOs reporting through the GPRO web interface or other CMS-approved tool or interface. CMS will also publicly report 2014 PQRS individual measure data in CY15 for individual PQRS quality measures. Additionally, in CY15 CMS will publish on Physician Compare performance on publicly reported measures reported by participants under GPRO through registries and EHRs during 2014, if technically feasible.

Background: The Physician Compare website contains information on physicians enrolled in the Medicare program, as well as information on other eligible professionals who participate in the PQRS. The overarching goal of the site is to provide consumers with quality of care information to make informed decisions about their healthcare, while encouraging clinicians to improve on the quality of care they provide to their patients. In accordance with section 10331 of the ACA, CMS intends to utilize Physician Compare to publicly report physician performance results. CMS launched the first phase of Physician Compare on Dec. 30, 2010, and has continued to build on and improve the website since this initial launch. In 2013, CMS launched a full redesign of Physician Compare that offered significant improvements including a complete overhaul of the underlying database and a new search feature, considerably improving functionality and usability.

CMS is now instituting its plan for a phased approach to public reporting of performance information on Physician Compare. The first phase of this plan was finalized with the 2012 PFS final rule, where CMS established that PQRS GPRO measures collected through the GPRO web interface during 2012 would be publicly reported on Physician Compare. These measures will be publicly reported on the site early in CY14. CMS expanded its plan with the 2013 PFS final rule, which indicated that the specific GPRO web interface measures that would be posted on the site would include the diabetes mellitus and coronary artery disease PQRS GPRO measures.

Also, contained in the CY13 final rule, as part of its public reporting plan, CMS finalized its decision to publicly report CG–CAHPS data for group practices of 100 or more eligible professionals reporting data in 2013 under the GPRO, and for ACOs participating in the Medicare Shared Savings Program. These data would include measure performance rates for measures reported that met the minimum sample size of 20 patients, and that prove to be statistically valid and reliable. CMS will provide a 30-day preview period prior to publication of quality data on Physician Compare so that group practices and ACOs can view their data as it will appear on Physician Compare before it is publicly reported. As such, there will not be a formal appeals process. However, if an error is found in the measure display during the preview period, there will be options to contact the Physician Compare team by both phone and email. CMS anticipates posting these data on Physician Compare as early as 2014.

CMS is required to submit a report to Congress, by Jan. 1, 2015, on Physician Compare development, including information on the efforts and plans to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice.

Physician Quality Reporting System (PQRS)

Federal Register, pages 74454-74753

Final Update: In addition to several technical corrections, this section of the final rule contains many updates to various components of the PQRS. These changes pertain to the following: group practice self-nomination process requirements, reporting mechanisms requirements, criteria changes for reporting, and data registry participation requirements.

Group Practice Self-nomination Process Requirements

Group practices are required to register to participate in the GPRO by Sept. 30 of the year in which the reporting period occurs (that is Sept. 30, 2014, for reporting periods occurring in 2014), as proposed. Group practices of 25 or more individual eligible professionals that wish to report the CG–CAHPS survey measures are required to indicate their intent to do so upon registration. CMS will use a single website whereby a group practice of 25 or more individual eligible professionals may register to participate in the PQRS GPRO and elect to be evaluated for the PQRS GPRO by reporting CG–CAHPS measures.

PQRS Reporting Mechanisms Requirements

The following tables, (48 and 49 of the final rule) provide a summary of the final criteria for satisfactory reporting and satisfactory participation that CMS discusses for IEPs for the 2014 PQRS incentive and 2016 PQRS payment adjustment, respectively.

TABLE 47—SUMMARY OF REQUIREMENTS FOR THE 2014 PQRS INCENTIVE: INDIVIDUAL REPORTING CRITERIA FOR SATISFACTORY REPORTING OF INDIVIDUAL QUALITY MEASURES VIA CLAIMS, QUALIFIED REGISTRIES, AND EHRS AND SATISFACTORY PARTICIPATION CRITERION IN QUALIFIED CLINICAL DATA REGISTRIES

Reporting period	Measure type	Reporting mechanism	Satisfactory reporting criteria/satisfactory participation criterion
12-month (Jan 1–Dec 31).	Individual Measures.	Claims	Report at least 9 measures covering at least 3 NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains, AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

TABLE 47—SUMMARY OF REQUIREMENTS FOR THE 2014 PQRS INCENTIVE: INDIVIDUAL REPORTING CRITERIA FOR SATISFACTORY REPORTING OF INDIVIDUAL QUALITY MEASURES VIA CLAIMS, QUALIFIED REGISTRIES, AND EHRS AND SATISFACTORY PARTICIPATION CRITERION IN QUALIFIED CLINICAL DATA REGISTRIES—Continued

Reporting period	Measure type	Reporting mechanism	Satisfactory reporting criteria/satisfactory participation criterion
			* For an eligible professional who reports fewer than 9 measures covering 3 NQS domains via the claims-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures and/or covering additional NQS domains.
12-month (Jan 1–Dec 31).	Individual Measures.	Qualified Registry	Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
			* For an eligible professional who reports fewer than 9 measures covering 3 NQS domains via the registry-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported on additional measures and/or measures covering additional NQS domains.
** 12-month (Jan 1–Dec 31).	Individual Measures.	Direct EHR product that is CEHRT and EHR data submission vendor that is CEHRT.	Report 9 measures covering at least 3 of the NQS domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is Medicare patient data.
			An eligible professional must report on at least 1 measure for which there is Medicare patient data.
** 12-month (Jan 1–Dec 31).	Measures Groups.	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
** 6-month (Jul 1–Dec 31).	Measures Groups.	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
12-month (Jan 1–Dec 31).	Measures selected by Qualified Clinical Data Registry.	Qualified Clinical Data Registry	Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50 percent of the eligible professional's applicable patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
			Of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure.

* Subject to the MAV process.
** Finalized in the CY 2013 PFS final rule (see Table 91 at 77 FR 69194).

TABLE 48—SUMMARY OF REQUIREMENTS FOR THE 2016 PQRS PAYMENT ADJUSTMENT: INDIVIDUAL REPORTING CRITERIA FOR SATISFACTORY REPORTING OF INDIVIDUAL QUALITY MEASURES VIA CLAIMS, REGISTRIES, AND EHRS AND SATISFACTORY PARTICIPATION CRITERION IN QUALIFIED CLINICAL DATA REGISTRIES

Reporting period	Measure type	Reporting mechanism	Satisfactory reporting criteria/satisfactory participation criterion
12-month (Jan 1–Dec 31).	Individual Measures.	Claims	Report at least 9 measures covering at least 3 NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains, AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
			* For an eligible professional who reports fewer than 9 measures covering 3 NQS domains via the claims-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures and/or covering additional NQS domains.
** 12-month (Jan 1–Dec 31).	Individual Measures.	Claims	Report at least 3 measures, OR, If less than 3 measures apply to the eligible professional, report 1–2 measures*; AND Report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.

TABLE 48—SUMMARY OF REQUIREMENTS FOR THE 2016 PQRS PAYMENT ADJUSTMENT: INDIVIDUAL REPORTING CRITERIA FOR SATISFACTORY REPORTING OF INDIVIDUAL QUALITY MEASURES VIA CLAIMS, REGISTRIES, AND EHRS AND SATISFACTORY PARTICIPATION CRITERION IN QUALIFIED CLINICAL DATA REGISTRIES—Continued

Reporting period	Measure type	Reporting mechanism	Satisfactory reporting criteria/satisfactory participation criterion
12-month (Jan 1–Dec 31).	Individual Measures.	Qualified Registry	Measures with a 0 percent performance rate will not be counted. Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. *For an eligible professional who reports fewer than 9 measures covering at least 3 NQS domains via the registry-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported on additional measures and/or measures covering additional NQS domains.
12-month (Jan 1–Dec 31).	Individual Measures.	Qualified Registry	Report at least 3 measures covering at least 1 of the NQS domains, OR, if less than 3 measures apply to the eligible professional, report 1–2 measures covering at least 1 NQS domain for which there is Medicare patient data, AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. *For an eligible professional who reports fewer than 3 measures covering 1 NQS domain via the registry-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported on additional measures.
**12-month (Jan 1–Dec 31).	Individual Measures.	Direct EHR product that is CEHRT and EHR data submission vendor that is CEHRT.	Report 9 measures covering at least 3 of the NQS domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is Medicare patient data. An eligible professional must report on at least 1 measure for which there is Medicare patient data.
**12-month (Jan 1–Dec 31).	Measures Groups.	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
**6-month (Jul 1–Dec 31).	Measures Groups.	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
12-month (Jan 1–Dec 31).	Measures selected by Qualified Clinical Data Registry.	Qualified Clinical Data Registry	Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50 percent of the eligible professional's applicable patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. Of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure.
12-month (Jan 1–Dec 31).	Measures selected by Qualified Clinical Data Registry.	Qualified Clinical Data Registry	Report at least 3 measures covering at least 1 NQS domain AND report each measure for at least 50 percent of the eligible professional's applicable patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

*Subject to the MAV process.
**Finalized in the CY 2013 PFS final rule (see Table 91 at 77 FR 69194).

Qualified Clinical Data Registry Participation Requirements

ATRA provides for a new standard for individual eligible professionals to satisfy the PQRS beginning in 2014, based on satisfactory participation in a qualified clinical data registry (QCDR). In the CY14 PFS proposed rule, CMS set forth its proposal for implementing this provision, including the proposed requirements for QCDRs and its proposals for individual eligible professionals to satisfactorily participate in a QCDR for the 2014 PQRS incentive and 2016 PQRS payment adjustment. A QCDR is a CMS-approved entity that has self-nominated and successfully completed a qualification process that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. An entity must meet stringent requirements to become a QCDR.

To ensure that CMS can process the self-nomination statements as early as possible, entities must submit their statements by Jan. 31 of the year in which the clinical data registry seeks to be qualified. To meet the criteria for participating in the 2014 PQRS incentive, an eligible professional must, for the 12-month reporting period, report at least nine measures available for reporting under the QCDR covering at least three of the NQS domains, and report each measure for at least 50 percent of the eligible professional's applicable patients. Among the measures the eligible professional reports on via the QCDR, at least one must be an outcome measure. The measures on which the QCDRs may submit quality data are specified in Table 52 (see Appendix B of the final rule).

The final reporting period for individual eligible professionals in a QCDR for the 2016 PQRS payment adjustment is Jan. 1, 2014, through Dec. 31, 2014. CMS finalized less stringent criteria for the 2016 PQRS payment adjustment. For the 2016 PQRS payment adjustment, an individual eligible professional using a QCDR may report on at least three measures for at least 50 percent of his or her applicable patients to satisfy participation requirements. CMS notes that it intends to move fully toward the reporting of nine measures covering at least three domains to meet the criteria for satisfactory participation for the 2017 PQRS payment adjustment. Tables 47 and 48 of the final rule provide a summary of the final criteria for satisfactory reporting and participation for individual eligible professionals for the 2014 PQRS incentive and 2016 PQRS payment adjustment, respectively.

Reporting Criteria for 2014 PQRS Incentive for Group Practices in the GPRO

A summary of the criteria finalized by CMS for group practices in the GPRO reporting individual PQRS quality measures via registry for the 12-month reporting period for the 2014 PQRS incentive are listed in the table below (Table 49 of the final rule).

TABLE 49—SUMMARY OF FINAL REQUIREMENTS FOR THE 2014 PQRS INCENTIVE: CRITERIA FOR SATISFACTORY REPORTING OF DATA ON PQRS QUALITY MEASURES VIA THE GPRO

Reporting period	Reporting mechanism	Group practice size	Proposed reporting criterion
**12-month (Jan 1–Dec 31).	GPRO Web interface	25–99 eligible professionals.	Report on all measures included in the web interface; AND Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.
**12-month (Jan 1–Dec 31).	GPRO Web interface	100+ eligible professionals.	Report on all measures included in the web interface; AND Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries. In addition, the group practice must also report all CG CAHPS survey measures via certified survey vendor.
12-month (Jan 1–Dec 31).	Qualified Registry	2+ eligible professionals.	Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For a group practice who reports fewer than 9 measures covering at least 3 NQS domains via the registry-based reporting mechanism, the group practice will be subject to the MAV process, which would allow us to determine whether a group practice should have reported on additional measures and/or measures covering additional NQS domains.
**12-month (Jan 1–Dec 31).	Direct EHR product that is CEHRT/EHR data submission vendor that is CEHRT.	2+ eligible professionals.	Report 9 measures covering at least 3 of the NQS domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31.	CMS-certified survey vendor + qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.	25+ eligible professionals.	Report all CG CAHPS survey measures via a CMS-certified survey vendor, AND report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.

*Subject to the Measure Application Validity (MAV) process.
**Criteria finalized in the CY 2013 PFS final rule (77 FR 69200).

Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG–CAHPS)

For groups of 25 to 99 eligible professionals, CMS finalizes its proposal to publicly report on Physician Compare the CG–CAHPS measures collected on the following12 summary survey measures when collected via a certified CAHPS vendor, as technically feasible:

- Getting timely care, appointments, and information
- How well providers communicate
- Patient rating of provider
- Access to specialists
- Health promotion and education
- Shared decision making
- Health status/functional status
- Courteous and helpful office staff
- Care coordination
- Between visit communication
- Helping patient to take medication as directed

- Stewardship of patient resources

Reporting Criteria for the 2016 PQRS Payment Adjustment for Group Practices in the GPRO
The table below (Table 50 of the final rule) provides a summary of the criteria for the satisfactory reporting of data on PQRS quality measures via the GPRO for the 2016 PQRS payment adjustment.

TABLE 50—SUMMARY OF FINAL REQUIREMENTS FOR THE 2016 PQRS PAYMENT ADJUSTMENT: CRITERIA FOR SATISFACTORY REPORTING OF DATA ON PQRS QUALITY MEASURES VIA THE GPRO

Reporting period	Reporting mechanism	Group practice size	Proposed reporting criterion
** 12-month (Jan 1–Dec 31).	GPRO Web interface	25–99 eligible professionals.	Report on all measures included in the web interface; AND Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.
** 12-month (Jan 1–Dec 31).	GPRO Web interface	100+ eligible professionals.	Report on all measures included in the web interface; AND Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries. In addition, the group practice must report all CG CAHPS survey measures via certified survey vendor.

TABLE 50—SUMMARY OF FINAL REQUIREMENTS FOR THE 2016 PQRS PAYMENT ADJUSTMENT: CRITERIA FOR SATISFACTORY REPORTING OF DATA ON PQRS QUALITY MEASURES VIA THE GPRO—Continued

Reporting period	Reporting mechanism	Group practice size	Proposed reporting criterion
12-month (Jan 1–Dec 31).	Qualified Registry	2+ eligible professionals.	Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For a group practice who reports fewer than 9 measures via the registry-based reporting mechanism, the group practice would be subject to the MAV process, which would allow us to determine whether a group practice should have reported on additional measures and/or measures covering additional NQS domains.
12-month (Jan 1–Dec 31).	Qualified Registry	2+ eligible professionals.	Report at least 3 measures covering at least 1 of the NQS domains, OR, if less than 3 measures covering 1 NQS domain apply to the group practice, report 1–2 measures covering 1 NQS domain for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For a group practice who reports fewer than 3 measures covering 1 NQS domain via the registry-based reporting mechanism, the group practice would be subject to the MAV process, which would allow us to determine whether a group practice should have reported on additional measures.
**12-month (Jan 1–Dec 31).	Direct EHR product that is CEHRT/EHR data submission vendor that is CEHRT.	2+ eligible professionals.	Report 9 measures covering at least 3 of the NQS domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31.	CMS-certified survey vendor + qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.	25+ eligible professionals.	Report all CG CAHPS survey measures via a CMS-certified survey vendor, AND report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.

*Subject to the Measure Application Validity (MAV) process.
**Criteria finalized in the CY 2013 PFS final rule (77 FR 69200).

2014 PQRS Measures

In the CY14 PFS proposed rule, CMS proposed to include additional measures in the PQRS measure set for 2014 and beyond. In the final rule, CMS did not finalize its proposal to increase the number of individual measures from four to six. Table 52 of the final rule provides the individual quality measures and measures included in the PQRS measures groups that CMS is finalizing for 2014 and beyond.

Background: In the CY13 PFS final rule with comment period, CMS finalized certain requirements for the 2013 and 2014 PQRS incentives, and for the 2015 and 2016 PQRS payment adjustments. CMS also finalized certain requirements for future years, such as the reporting periods for the PQRS payment adjustment, as well as requirements for the various PQRS reporting mechanisms. In the CY14 PFS proposed rule, CMS proposed to change some requirements for the 2014 PQRS incentive and 2016 PQRS payment adjustment, and to make changes to the PQRS measure set. Furthermore, it introduced its proposals for a new PQRS reporting option—satisfactory participation in a QCDR.

Medicare EHR Incentive Program (Meaningful Use)
Federal Register, pages 74753

Final Update: Under the final rule, CMS will allow eligible professionals to submit clinical quality measure (CQM) information beginning with the reporting periods in 2014 using QCDRs. In addition to the criteria that are ultimately established for PQRS, CMS established the following additional criteria that an eligible professional who seeks to report CQMs for the Medicare EHR Incentive Program using a qualified clinical data registry must satisfy:

- The eligible professional must use certified EHR technology (CEHRT) as required under the Medicare EHR Incentive Program;
- CQMs reported must be included in the Stage 2 final rule, and use the same electronic specifications established for the EHR Incentive Program;
- An eligible professional must report on nine CQMs covering at least three domains;
- If an eligible professional's CEHRT does not contain patient data for at least nine CQMs covering at least three domains, then the eligible professional must report the CQMs for which there is patient data and report the remaining CQMs as "zero denominators";
- An eligible professional must have CEHRT that is certified to all of the certification criteria required for CQMs, including certification of the QCDR itself for the functions it will fulfill.

This reporting option is only for eligible professionals who are beyond their first year of demonstrating meaningful use. The registry will need to be certified for the CQM criteria for each CQM that will be submitted. Eligible professionals will still need to include a certified EHR module as part of their CEHRT that is certified to the CQM criteria listed for each of the CQMs that would be submitted to CMS for the purposes of meeting the CQM requirements of the Medicare EHR Incentive Program. If the QCDR is performing the function of data capture for the CQMs that would be submitted to CMS, then the registry would need to be certified to the "capture and export" criteria, and the certified EHR module must be part of the eligible professional's CEHRT. CMS notes that, similar to what is finalized for the PQRS in the final rule with comment period; a qualified clinical data registry would be required to submit quality measures data in a Quality Reporting Document Architecture (QRDA–III) format as proposed and finalized in the final rule.

Group Reporting Option— Comprehensive Primary Care Initiative
The Comprehensive Primary Care (CPC) Initiative, under the authority of section 3021 of the ACA, is a multipayer initiative fostering collaboration between public and private healthcare payers to strengthen primary care. Under this initiative, CMS will pay participating primary care practices a care management fee to support enhanced, coordinated services. Simultaneously, participating commercial, state, and other federal insurance plans are also offering support to primary care practices that provide high-quality primary care. Under the CPC Initiative, CPC practice sites are required to report to CMS a subset of the CQMs that were selected in the EHR Incentive Program Stage 2 final rule for eligible professionals to report under the EHR Incentive

Program beginning in CY14. There are approximately 500 CPC participants across seven healthcare markets in the United States.

In a continuing effort to align quality reporting programs and innovation initiatives, CMS will add a group reporting option for CQMs to the Medicare EHR Incentive Program beginning in CY14 for eligible professionals who are part of a CPC practice site that successfully submits at least nine electronically specified CQMs covering three domains. Each of the eligible professionals in the CPC practice site will satisfy the CQM reporting component of meaningful use for the relevant reporting period if the CPC practice site successfully submits and meets the reporting requirements of the CPC Initiative.

Eligible professionals reporting under the aligned group reporting option can only report on CQMs that were selected for the EHR Incentive Program in the Stage 2 final rule. If a CPC practice site is not successful in reporting, eligible professionals who are part of the site would still have the opportunity to report CQMs in accordance with the requirements established for the EHR Incentive Program in the Stage 2 final rule. Additionally, only those eligible professionals who are beyond their first year of demonstrating meaningful use may use this CPC group reporting option. CMS notes that the CPC practice sites must submit the CQM data in the form and manner required by the CPC Initiative. Therefore, whether the CPC practice site requires electronic submission or attestation of CQMs, it must submit the CQM data in the form and manner required by the CPC Initiative.

Reporting of Electronically Specified Clinical Quality Measures for the Medicare EHR Incentive Program

In the EHR Incentive Program Stage 2 final rule, CMS finalized the CQMs from which eligible professionals would report beginning in CY14 under the EHR Incentive Program. These CQMs are electronically specified and updated annually to account for issues such as changes in billing and diagnosis codes. Eligible professionals who seek to report CQMs electronically under the Medicare EHR Incentive Program must use the most recent version of the electronic specifications for the CQMs and have CEHRT that is tested and certified to the most recent version of the electronic specifications for the CQMs.

CMS is also finalizing the policy that eligible professionals who do not wish to report CQMs electronically using the most recent version of the electronic specifications (for example, if their CEHRT has not been certified for that particular version) will be allowed to report CQM data to CMS by attestation for the Medicare EHR Incentive Program. For attestation, CMS is not requiring that products reporting on older versions of the electronic specifications for the CQMs have CEHRT that is tested and certified to the most recent version of the electronic specifications for the CQMs. Rather, if attesting to older versions of the electronic specifications for the CQMs, it is sufficient that the product is CEHRT-certified to the 2014 edition certification criteria.

For the reporting periods in 2014, EPs who want to report CQM data electronically (through a qualified clinical data registry or other product that is CEHRT) to satisfy the quality measure reporting component of meaningful use must use the June 2013 version of the CQMs electronic specifications. CQM data must be submitted using either the QRDA–I or QRDA–III format as

finalized in the Stage 2 final rule. In addition, eligible professionals must ensure that their CEHRT has been tested and certified to the June 2013 version of the CQMs for purposes of achieving the CQM component of meaningful use in 2014. For 2014 only, CMS is providing one exception to this rule for the measure CMS140v2, Breast Cancer Hormonal Therapy for Stage IC–IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387), because an error was found in the June 2013 logic of this measure.

Reporting Periods

In the Stage 2 final rule, CMS established the EHR reporting periods in CY14 for eligible professionals who have previously demonstrated meaningful use. Specifically, it finalized a three-month CY-quarter EHR reporting period for 2014, which means that Medicare eligible professionals will attest to using an EHR reporting period of Jan. 1, 2014, through March 31, 2014; April 1, 2014, through June 30, 2014; July 1, 2014, through Sept. 30, 2014; or Oct. 1, 2014, through Dec. 31, 2014. CMS also established the reporting periods for CQMs in CY14, which are generally the same as the EHR reporting period. To provide additional flexibility for eligible professionals, CMS will accept reporting periods of different quarters for CQMs and for meaningful use functional measures, as long as the quarters are within CY14. CMS notes that if eligible professionals choose to use a reporting option for the Medicare EHR Incentive Program that aligns with another CMS quality reporting program, the eligible professionals should be mindful of the reporting period required by that program if they seeks to meet the quality measure reporting requirements for both the Medicare EHR Incentive Program and the aligned quality reporting program.

Background: The requirements for meeting the CQM component of achieving meaningful use for the EHR Incentive Program in 2014 were established in a standalone final rule published on Sept. 4, 2012. The American Recovery and Reinvestment Act of 2009 authorizes incentive payments under Medicare and Medicaid for the adoption and meaningful use of CEHRT. To avoid redundant or duplicative reporting, CMS has taken steps to establish alignments among various CQMs. In the final rule, CMS outlines new requirements for meaningful use involving clinical registries, group reporting, electronically specified clinical quality measure reporting, and reporting periods.

Medicare Shared Savings Program

Federal Register, pages 74757-74764

Establishing the Quality Performance Benchmark

CMS will set benchmarks prior to the reporting year for which they would apply. As such, CMS will set the quality performance benchmarks for the 2014 reporting period using data submitted in 2013 for the 2012 reporting period. CMS will continue to use those benchmarks for two reporting years (specifically, the 2014 and 2015 reporting years). CMS will publish the quality performance benchmarks for the 2014 reporting period through subregulatory guidance.

CMS finalizes its proposal to use fee-for-service (FFS) data, including data submitted by the Shared Savings Program and Pioneer ACOs, to set the performance benchmarks for the 2014 and subsequent reporting periods. CMS's approach makes use of a combination of actual data and flat percentages. Specifically, CMS will use all available FFS data to calculate benchmarks,

including ACO data, except where performance at the 60th percentile is equal to or greater than 80 percent for individual measures, regardless of whether the measure is clustered.

In these cases, a flat percentage will be used to set the benchmark for the measure. CMS provides an example of this in Table 81 of the final rule. This policy allows ACOs with high scores to earn maximum or near maximum quality points while allowing room for improvement and rewarding that improvement in subsequent years. CMS chose 80 percent because this level of attainment indicates a high level of performance, and it believes ACOs achieving an 80 percent performance rate should not be penalized as low performers.

Scoring CAHPS Measures Within the Patient Experience of Care Domain
CMS finalizes its proposal to assign two points to each of the six CAHPS survey measure modules (12 points) instead of scoring them as one component worth only two points. Reweighting will take effect for the 2014 reporting period for all Shared Savings Program ACOs, and will increase the value of the patient experience of care domain from four points to 14 points, and result in the six survey measure module in the patient experience of care survey accounting for 86 percent of the domain score. CMS notes that the overall domain's weight would remain the same in relation to the other three domains, and therefore does not believe this reweighting will impact an ACO's ability to "cement" its capabilities.

Background: Requirements for participating in the Medicare Shared Saving Program and the impacts of these requirements were established in the final rule for the Shared Savings Program that appeared in Nov. 2, 2011, *Federal Register*. The proposals for the Shared Savings Program set forth in the CY14 final rule with comment period expand the incorporation of reporting requirements and incentive payments related to PQRS under section 1848 to include reporting requirements related to the payment adjustment.

CMS established the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and reduce the rate of growth in healthcare costs. Eligible groups of providers and suppliers, including physicians, hospitals, and other healthcare providers, may participate in the Shared Savings Program by forming or participating in an ACO. ACOs are required to completely and accurately report on all quality performance measures for all quality measurement reporting periods in each performance year of their agreement period. There are currently 33 quality performance measures under the Shared Savings Program. For Shared Savings Program ACOs that begin their agreement period in April or July, 2012, there will be two reporting periods in the first performance year, corresponding to CY12 and CY13. For ACOs beginning their agreement periods in 2013 or later, both the performance year and reporting period will correspond to the calendar year. Under the final rule, CMS finalized its proposal to align with PQRS GPRO web interface reporting requirements finalized in rule, for eligible professionals and their participant tax identification numbers in ACOs to avoid the payment adjustment in 2016 and subsequent years.

Value-Based Payment Modifier (VBPM)

Federal Register, pages 74764- 74787

Final Update: CMS finalized its proposed policies to continue to phase in implementation of the value-based payment modifier by applying it to smaller groups of physicians, and to increase the amount of payment at risk. CMS is also finalizing its proposals to refine the methodologies used in its quality-tiering approach to calculating the value-based payment modifier to better identify both high and low performers for upward and downward payment adjustments. CMS notes two changes from its proposals that it finalized after considering the public comments received. First, a single plurality attribution approach will be used for the Medicare Spending per Beneficiary (MSPB) cost measure rather than the proposed multiple attribution approach. A threshold of 50 percent (rather than the proposed 70 percent) will be adopted for the percentage of individual eligible professionals in a group of physicians that must meet the criteria to avoid the CY16 PQRS payment adjustment in order to calculate a group quality score. The value-based payment modifier will be phased in by applying it starting Jan. 1, 2015, to payments under the Medicare PFS for physicians in groups of 100 or more eligible professionals.

Group Size

In the CY13 PFS final rule with comment period, CMS stated that it would gradually phase in the value-based payment modifier in CY15 by first applying it to large groups, which it defined as groups of physicians with 100 or more eligible professionals. Under the final rule, the value-based payment modifier will apply to groups of physicians with 10 or more eligible professionals in CY16. CMS will identify groups of physicians that will be subject to the value-based payment modifier using the same procedures that it finalized in the CY13 PFS final rule with comment period. CMS believes this will continue its policy to phase in the value-based payment modifier by ensuring that the majority of physicians are covered in CY16 before it applies to all physicians in CY17.

Setting the Value-Based Payment Modifier Adjustment Based on PQRS Participation

CMS will align the criteria for inclusion in Category 1 with the criteria for the CY16 PQRS payment adjustment as referenced in the PQRS Tables 48 and 50 of the final rule which show the criteria to avoid the CY16 PQRS payment adjustment for group practices reporting through the GPRO and individual eligible professionals. For the CY16 value-based payment modifier, Category 1 will include those groups of physicians that meet the criteria for satisfactory reporting of data on PQRS quality measures through the GPRO for the CY16 PQRS payment adjustment. It will also include those groups of physicians that do not register to participate in the PQRS as a group practice in CY14, and that have at least 50 percent of the their eligible professionals meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the CY16 PQRS payment adjustment or, in lieu of satisfactory reporting, for satisfactory participation in a PQRS QCDR for the CY16 PQRS payment adjustment. For a group of physicians that is subject to the CY16 value-based payment modifier to be included in Category 1, the criteria for satisfactory reporting (or the criteria for satisfactory participation, in the case of the 50 percent option) must be met during the CY14 performance period for the PQRS CY16 payment adjustment. Category 2 will include those groups of physicians that are subject to the CY16 value-based payment modifier and do not fall within Category 1.

Groups of physicians in Category 1 will not have the option to elect quality-tiering for the CY16 value-based payment modifier and, instead, will be subject to mandatory quality-tiering. Also, groups of physicians in Category 1 with between 10 and 99 eligible professionals will be held harmless from any downward adjustments derived from the quality-tiering methodology for the CY16 value-based payment modifier. CMS is finalizing the revision to the regulations at §414.1270 to clarify that for the CY15 payment adjustment period, a group may be determined under the quality-tiering methodology to have low performance based on low quality and high costs, low quality and average costs, or average quality and high costs.

Payment Adjustment Amount

In the CY13 PFS final rule with comment period, CMS adopted a modest payment reduction of 1.0 percent for groups of physicians in Category 1 that elected quality-tiering and were classified as low quality/high cost and for groups of physicians in Category 2. CMS will increase the downward adjustment under the value-based payment modifier from 1.0 percent in CY15 to 2.0 percent for CY16. As such, for CY16, a –2.0 percent value-based payment modifier will apply to groups of physicians subject to the value-based payment modifier that fall in Category 2. In addition, CMS will increase the maximum downward adjustment under the quality-tiering methodology to –2.0 percent for groups of physicians classified as low quality/ high cost and to set the adjustment to –1.0 percent for groups classified as either low quality/average cost or average quality/high cost.

Consistent with the policy adopted in the CY13 PFS final rule with comment period, the upward payment adjustment factor (x) would be determined after the performance period has ended based on the aggregate amount of downward payment adjustments. CMS notes that any funds derived from the application of the downward adjustments to groups of physicians with 100 or more eligible professionals and of the maximum downward adjustment of 2.0 percent applied to those groups of physicians subject to the value-based payment modifier that fall in Category 2 would be available to all groups of physicians eligible for value-based payment modifier upward payment adjustments. The quality-tiering methodology would continue to provide an additional upward payment adjustment of +1.0x to groups of physicians that care for high-risk beneficiaries (as evidenced by the average hierarchical condition category [HCC] risk score of the attributed beneficiary population).

Performance Period

CMS is finalizing a policy to use CY15 as the performance period for the value-based payment modifier adjustments that will apply during CY17. CMS believes it is important to use the performance period for the payment adjustments that will apply in CY17, because section 1848(p)(4)(B)(iii) of the Act requires all physicians and groups of physicians to be subject to the value-based payment modifier beginning not later than Jan. 1, 2017. CMS will continue to consider options to close the gap between the performance period and the payment adjustment period and will continue to provide timely feedback to physician groups through Quality and Resources Use Reports (QRURs).

Quality Measures

In the CY13 PFS final rule with comment period, CMS aligned its policies for the value-based payment modifier for CY15 with the PQRS reporting mechanisms available to groups of physicians in CY13, such that data that a group of physicians submitted for quality reporting purposes through any of the PQRS group reporting mechanisms in CY13 would be used for calculating the quality composite under the quality-tiering approach for the value-based payment modifier for CY15. All of the quality measures for which groups of physicians were eligible to report under the PQRS in CY13 are used to calculate the group of physicians' value-based payment modifier for CY15, to the extent the group of physicians submits data on such measures. CMS also established a policy to include three additional quality measures (outcome measures) for all groups of physicians subject to the value-based payment modifier:

- A composite of rates of potentially preventable hospital admissions for heart failure, chronic obstructive pulmonary disease, and diabetes
- A composite rate of potentially preventable hospital admissions for dehydration, urinary tract infections, and bacterial pneumonia
- Rates of an all-cause hospital readmissions measure

PQRS Reporting Mechanisms

For the CY16 value-based payment modifier, all of the PQRS GPRO reporting mechanisms will be available to group practices and individual eligible professionals for the PQRS reporting periods in CY14. In addition, groups of physicians with 25 or more eligible professionals will be able to elect to include the patient experience of care measures collected through the PQRS CAHPS survey for CY14 in their value-based payment modifier for CY16.

PQRS Quality Measures

CMS will use all of the quality measures that are available to be reported under the various PQRS reporting mechanisms to calculate a physician group's CY16 value-based payment modifier to the extent that the group (or individual eligible professionals in the group, in the case of the 50 percent threshold option) submits data on those measures. For those physician groups availing themselves of the "50 percent threshold option", CMS will calculate the group's performance rate for each measure reported by at least one eligible professional in the group of physicians by combining the weighted average of the performance rates of those eligible professionals reporting the measure. Additionally, for those groups assessed under the "50 percent threshold option," CMS will classify a group's quality composite score as "average" under the quality-tiering methodology, if all of the eligible professionals in the group satisfactorily participate in a PQRS qualified clinical data registry in CY14, and CMS is unable to receive quality performance data for those eligible professionals.

Including the MSPB Measure

CMS is finalizing inclusion of the MSPB measure as proposed in the cost composite beginning with the CY16 value-based payment modifier, with a CY14 performance period. CMS will use the MSPB amount as the measure's performance rate rather than converting it to a ratio, as is done under the Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs. The MSPB measure will be added to the total per capita costs for all attributed beneficiaries domain

and equally weighted with the total per capita cost measure. It will not be added to the total per capita costs for all attributed beneficiaries with specific conditions domain. CMS also is finalizing the method under which an MSPB episode will be attributed to a single group of physicians that provides the plurality of Part B services during the index admission, for the purpose of calculating that group's MSPB measure rate. CMS is finalizing a minimum of 20 MSPB episodes for inclusion of the MSPB measure in a physician group's cost composite.

Physician Feedback Program

CMS is required to provide confidential reports to physicians that measure the resources involved in furnishing care to Medicare FFS beneficiaries. CMS is also authorized to include information on the quality of care furnished to Medicare FFS beneficiaries. On Sept. 16, 2013, CMS made CY12 QRURs available to 6,779 physician groups nationwide with 25 or more eligible professionals. CMS anticipates publicly releasing a full experience report of the CY12 QRURs that will include how quality-tiering would apply to groups of physicians to ensure stakeholders understand the methodologies of the value-based payment modifier. The report will be available on the Physician Feedback Program website. Given the policies that it adopted in the final rule, CMS anticipates that as long as a group of physicians participates in the PQRS in 2014 and meets the criteria to avoid the 2016 PQRS payment adjustment, it will be able to produce a complete QRUR, including their quality-tiering designation, in CY14 for most groups.

CMS will continue to develop and refine the annual QRURs in an iterative manner. In the summer of 2014, CMS plans to disseminate the QRURs based on CY13 data to all physicians (that is, tax identification numbers [TINs] of any size) even though groups of physicians with fewer than 100 eligible professionals will not be subject to the value-based payment modifier in CY15. These reports will contain performance on the quality and cost measures used to score the composites, and additional information to help physicians coordinate care and improve the quality of care furnished. The reports will be based on the value-based payment modifier policies that CMS is finalizing in the final rule that will take effect Jan. 1, 2014, and that will affect physician payment starting Jan. 1, 2016. Groups of physicians will, therefore, have an opportunity to determine how the policies adopted in the final rule will apply to them.

Background: Section 1848(p) of the Act requires that CMS establish a value-based payment modifier and apply it to specific physicians and groups of physicians the HHS Secretary determines appropriate starting Jan. 1, 2015, and to all physicians and groups of physicians by Jan. 1, 2017. The value-based payment modifier has the potential to help transform Medicare from a passive payer to an active purchaser of higher-quality, more-efficient, and more-effective health care by providing upward payment adjustments under the PFS to high-performing physicians (and groups of physicians) and downward adjustments for low-performing physicians (and groups of physicians). The value-based payment modifier is budget neutral.

More Information

The final rule was published in the Dec. 10, 2013, *Federal Register*. Additional information regarding the MPFS is available on the CMS website.

Appendix A

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
10030	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous.	New	3.00	3.00	No.
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion.	0.65	0.61	0.61	No.
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (list separately in addition to code for first lesion).	0.07	0.04	0.04	No.
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions.	1.85	1.37	1.37	No.
17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks.	6.20	6.20	6.20	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
17312	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure).	3.30	3.30	3.30	No.
17313	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks.	5.56	5.56	5.56	No.
17314	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure).	3.06	3.06	3.06	No.
17315	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure).	0.87	0.87	0.87	No.
19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance.	New	3.29	3.29	No.
19082	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (list separately in addition to code for primary procedure).	New	1.65	1.65	No.
19083	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance.	New	3.10	3.10	No.
19084	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (list separately in addition to code for primary procedure).	New	1.55	1.55	No.
19085	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance.	New	3.64	3.64	No.
19086	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (list separately in addition to code for primary procedure).	New	1.82	1.82	No.
19281	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance.	New	2.00	2.00	No.
19282	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (list separately in addition to code for primary procedure).	New	1.00	1.00	No.
19283	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance.	New	2.00	2.00	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
19284	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (list separately in addition to code for primary procedure).	New	1.00	1.00	No.
19285	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance.	New	1.70	1.70	No.
19286	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (list separately in addition to code for primary procedure).	New	0.85	0.85	Yes.
19287	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance.	New	3.02	2.55	No.
19288	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (list separately in addition to code for primary procedure).	New	1.51	1.28	No.
23333	Removal of foreign body, shoulder; deep (subfascial or intramuscular).	New	6.00	6.00	No.
23334	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component.	New	18.89	15.50	No.
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder).	New	22.13	19.00	No.
24164	Removal of prosthesis, includes debridement and synovectomy when performed; radial head.	6.43	10.00	10.00	No.
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft.	21.79	19.60	20.72	Yes.
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement.	17.61	17.61	17.61	Yes.
27446	Arthroplasty, knee, condyle and plateau; medial or lateral compartment.	16.38	17.48	17.48	No.
27447	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	23.25	19.60	20.72	Yes.
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure).	2.98	2.60	2.60	No.
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage.	3.26	2.74	2.74	No.
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	9.33	9.04	9.04	No.
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	2.61	2.61	2.61	No.
33282	Implantation of patient-activated cardiac event recorder	4.80	3.50	3.50	No.
33284	Removal of an implantable, patient-activated cardiac event recorder.	3.14	3.00	3.00	No.
33366	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; transapical exposure (eg, left thoracotomy).	New	40.00	35.88	No.
34841	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery).	New	C	C	N/A.
34842	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
34843	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.
34844	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.
34845	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery).	New	C	C	N/A.
34846	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.
34847	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.
34848	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.
35301	Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision.	19.61	21.16	21.16	No.
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family.	4.67	4.90	4.90	No.
37217	Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation.	New	22.00	20.38	No.
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery.	New	9.00	9.00	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
37237	Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (list separately in addition to code for primary procedure).	New	4.25	4.25	No.
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein.	New	6.29	6.29	No.
37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (list separately in addition to code for primary procedure).	New	3.34	2.97	No.
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles).	New	9.00	9.00	No.
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms).	New	11.98	10.05	No.
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction.	New	14.00	11.99	No.
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation.	New	14.00	14.00	No.
43191	Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure).	New	2.78	2.00	No.
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance.	New	3.21	2.45	No.
43193	Esophagoscopy, rigid, transoral; with biopsy, single or multiple	New	3.36	3.00	No.
43194	Esophagoscopy, rigid, transoral; with removal of foreign body	New	3.99	3.00	No.
43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter).	New	3.21	3.00	No.
43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire.	New	3.36	3.30	No.
43197	Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing or washing when performed (separate procedure).	New	1.59	1.48	Yes.
43198	Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.	New	1.89	1.78	Yes.
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).	1.59	1.59	1.50	No.
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance.	2.09	1.90	1.80	No.
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple.	1.89	1.89	1.80	No.
43204	Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices.	3.76	2.89	2.40	No.
43205	Esophagoscopy, flexible, transoral; with band ligation of esophageal varices.	3.78	3.00	2.51	No.
43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection.	New	4.58	4.21	No.
43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed).	New	3.73	3.38	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS tir refinem
43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed).	New	5.00	4.73	No.
43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed).	New	3.78	3.38	No.
43215	Esophagoscopy, flexible, transoral; with removal of foreign body.	2.60	2.60	2.51	No.
43216	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery.	2.40	2.40	2.40	No.
43217	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique.	2.90	2.90	2.90	No.
43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter).	2.10	2.10	2.10	No.
43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire.	2.34	2.34	2.34	No.
43227	Esophagoscopy, flexible, transoral; with control of bleeding, any method.	3.59	3.26	2.99	No.
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed).	New	3.72	3.54	No.
43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination.	3.19	3.19	2.90	No.
43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s).	4.47	3.83	3.54	No.
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed).	New	4.45	4.05	No.
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).	2.39	2.26	2.17	No.
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance.	2.92	2.57	2.47	No.
43237	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures.	3.98	3.85	3.57	No.
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures).	5.02	4.50	4.11	No.
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple.	2.87	2.56	2.47	No.
43240	Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed).	6.85	7.25	7.25	No.
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter.	2.59	2.59	2.59	No.
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis).	7.30	5.39	4.68	No.
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices.	4.56	4.37	4.37	No.
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices.	5.04	4.50	4.50	No.
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie).	3.18	3.18	3.18	No.
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube.	4.32	4.32	3.66	No.
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body.	3.38	3.27	3.18	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS t refinem
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire.	3.15	3.01	3.01	No.
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter).	2.90	2.77	2.77	No.
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery.	3.20	3.07	3.07	No.
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique.	3.69	3.57	3.57	No.
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis).	New	5.39	4.68	No.
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection.	New	5.25	4.88	No.
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method.	4.81	4.20	3.66	No.
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease.	5.50	4.25	4.11	No.
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis.	5.19	4.74	4.14	No.
43260	Endoscopic retrograde cholangiopancreatography (ercp); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).	5.95	5.95	5.95	No.
43261	Endoscopic retrograde cholangiopancreatography (ercp); with biopsy, single or multiple.	6.26	6.25	6.25	No.
43262	Endoscopic retrograde cholangiopancreatography (ercp); with sphincterotomy/papillotomy.	7.38	6.60	6.60	No.
43263	Endoscopic retrograde cholangiopancreatography (ercp); with pressure measurement of sphincter of oddi.	7.28	7.28	6.60	No.
43264	Endoscopic retrograde cholangiopancreatography (ercp); with removal of calculi/debris from biliary/pancreatic duct(s).	8.89	6.73	6.73	No.
43265	Endoscopic retrograde cholangiopancreatography (ercp); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy).	10.00	8.03	8.03	No.
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed).	New	4.40	4.05	No.
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed).	New	4.39	4.21	No.
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (list separately in addition to code(s) for primary procedure).	2.24	2.24	2.24	No.
43274	Endoscopic retrograde cholangiopancreatography (ercp); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent.	New	8.74	8.48	No.
43275	Endoscopic retrograde cholangiopancreatography (ercp); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s).	New	6.96	6.96	No.
43276	Endoscopic retrograde cholangiopancreatography (ercp); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged.	New	9.10	8.84	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS refine
43277	Endoscopic retrograde cholangiopancreatography (ercp); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct.	New	7.11	7.00	No.
43278	Endoscopic retrograde cholangiopancreatography (ercp); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed.	New	8.08	7.99	No.
43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes.	1.38	1.38	1.38	No.
43453	Dilation of esophagus, over guide wire	1.51	1.51	1.51	No.
49405	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous.	New	4.25	4.25	No.
49406	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous.	New	4.25	4.25	No.
49407	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal.	New	4.50	4.50	No.
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy.	40.90	40.90	39.88	No.
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, gibbons or double-j type).	2.82	2.82	2.82	No.
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, gibbons or double-j type).	New	8.00	8.00	No.
62310	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic.	1.91	1.68	1.18	No.
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal).	1.54	1.54	1.17	No.
62318	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic.	2.04	2.04	1.54	No.
62319	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal).	1.87	1.87	1.50	No.
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar.	15.37	15.37	15.37	No.
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure).	3.47	3.47	3.47	No.
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis).	New	1.79	1.53	No.
64617	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed.	New	2.06	1.90	No.
64642	Chemodenervation of one extremity; 1–4 muscle(s)	New	1.65	1.65	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
64643	Chemodenervation of one extremity; each additional extremity, 1–4 muscle(s) (list separately in addition to code for primary procedure).	New	1.32	1.22	No.
64644	Chemodenervation of one extremity; 5 or more muscle(s)	New	1.82	1.82	No.
64645	Chemodenervation of one extremity; each additional extremity, 5 or more muscle(s) (list separately in addition to code for primary procedure).	New	1.52	1.39	No.
64646	Chemodenervation of trunk muscle(s); 1–5 muscle(s)	New	1.80	1.80	No.
64647	Chemodenervation of trunk muscle(s); 6 or more muscle(s)	New	2.11	2.11	No.
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach.	New	13.20	13.20	No.
67914	Repair of ectropion; suture	3.75	3.75	3.75	No.
67915	Repair of ectropion; thermocauterization	3.26	2.03	2.03	No.
67916	Repair of ectropion; excision tarsal wedge	5.48	5.48	5.48	No.
67917	Repair of ectropion; extensive (eg, tarsal strip operations)	6.19	5.93	5.93	No.
67921	Repair of entropion; suture	3.47	3.47	3.47	No.
67922	Repair of entropion; thermocauterization	3.14	2.03	2.03	No.
67923	Repair of entropion; excision tarsal wedge	6.05	5.48	5.48	No.
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation).	5.93	5.93	5.93	No.
69210	Removal impacted cerumen requiring instrumentation, unilateral.	0.61	0.58	0.61	No.
70450	Computed tomography, head or brain; without contrast material.	0.85	0.85	0.85	No.
70460	Computed tomography, head or brain; with contrast material(s)	1.13	1.13	1.13	No.
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material.	1.48	1.48	1.48	No.
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s).	1.78	1.78	1.78	No.
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences.	2.36	2.36	2.29	No.
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material.	1.60	1.48	1.48	No.
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s).	1.92	1.78	1.78	No.
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material.	1.60	1.48	1.48	No.
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s).	1.92	1.78	1.78	No.
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material.	1.48	1.48	1.48	No.
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s).	1.78	1.78	1.78	No.
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical.	2.57	2.29	2.29	No.
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic.	2.57	2.29	2.29	No.
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar.	2.36	2.29	2.29	No.
77280	Therapeutic radiology simulation-aided field setting; simple	0.70	0.70	0.70	No.
77285	Therapeutic radiology simulation-aided field setting; intermediate.	1.05	1.05	1.05	No.
77290	Therapeutic radiology simulation-aided field setting; complex	1.56	1.56	1.56	No.
77293	Respiratory motion management simulation (list separately in addition to code for primary procedure).	New	2.00	2.00	No.
77295	3-dimensional radiotherapy plan, including dose-volume histograms.	4.56	4.29	4.29	No.
81161	Dmd (dystrophin) (eg, duchenne/becker muscular dystrophy) deletion analysis, and duplication analysis, if performed.	New	1.85	X	N/A
88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal.	1.18	0.56	0.56	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS t refinen
88342	Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide.	0.85	0.60	I	N/A
88343	Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (list separately in addition to code for primary procedure).	New	0.24	I	N/A
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	New	1.75	1.75	No.
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria).	New	1.50	1.50	No.
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language).	New	3.36	3.00	No.
92524	Behavioral and qualitative analysis of voice and resonance	New	1.75	1.50	No.
93000	Electrocardiogram, routine ecg with at least 12 leads; with interpretation and report.	0.17	0.17	0.17	No.
93010	Electrocardiogram, routine ecg with at least 12 leads; interpretation and report only.	0.17	0.17	0.17	No.
93582	Percutaneous transcatheter closure of patent ductus arteriosus	New	14.00	12.56	No.
93583	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed.	New	14.00	14.00	No.
93880	Duplex scan of extracranial arteries; complete bilateral study	0.60	0.80	0.60	No.
93882	Duplex scan of extracranial arteries; unilateral or limited study	0.40	0.50	0.40	No.
95816	Electroencephalogram (eeg); including recording awake and drowsy.	1.08	1.08	1.08	No.
95819	Electroencephalogram (eeg); including recording awake and asleep.	1.08	1.08	1.08	No.
95822	Electroencephalogram (eeg); recording in coma or sleep only	1.08	1.08	1.08	No.
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour.	0.21	0.21	0.21	No.
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure).	0.18	0.18	0.18	No.
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (list separately in addition to code for primary procedure).	0.19	0.19	0.19	No.
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (list separately in addition to code for primary procedure).	0.17	0.17	0.17	No.
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug.	0.28	0.28	0.28	No.
96415	Chemotherapy administration, intravenous infusion technique; each additional hour (list separately in addition to code for primary procedure).	0.19	0.19	0.19	No.
96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (list separately in addition to code for primary procedure).	0.21	0.21	0.21	No.
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day.	New	C	C	N/A
98940	Chiropractic manipulative treatment (cmt); spinal, 1–2 regions	0.45	0.46	0.46	No.
98941	Chiropractic manipulative treatment (cmt); spinal, 3–4 regions	0.65	0.71	0.71	No.
98942	Chiropractic manipulative treatment (cmt); spinal, 5 regions	0.87	0.96	0.96	No.
99446	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5–10 minutes of medical consultative discussion and review.	New	0.35	B	No.
99447	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11–20 minutes of medical consultative discussion and review.	New	0.70	B	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
99448	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21–30 minutes of medical consultative discussion and review.	New	1.05	B	No.
99449	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review.	New	1.40	B	No.
99481	Total body systemic hypothermia in a critically ill neonate per day (list separately in addition to code for primary procedure).	New	C	C	N/A
99482	Selective head hypothermia in a critically ill neonate per day (list separately in addition to code for primary procedure).	New	C	C	N/A
G0461	Immunohistochemistry or immunocytochemistry, per specimen; first separately identifiable antibody.	New	N/A	0.60	No.
G0462	Immunohistochemistry or immunocytochemistry, per specimen; each additional separately identifiable antibody (List separately in addition to code for primary procedure).	New	N/A	0.24	No.