CY 2016 Proposed Rule Summary
Medicare Physician Fee Schedule (MPFS)

Provided To:
Revenue Cycle Inc. Client

Prepared On:
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Introductory Summary
On July 8, 2015, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the Medicare Physicians Fee Schedule (MPFS) for CY 2016.

MPFS Proposed Rule Highlights

The CY 2016 may be located in its entirety by following the link below:

This document in PDF form is 815 pages in length. The format of the information on the following pages is intended to summarize information contained within the proposed rules pertinent to radiation oncology services.

CY 2016 MPFS Proposed Rule Highlights

The highlights and expanded summary of the Proposed Rule are provided below.

- Conversion Factor = $36.1096, accounting for the 0.5% increase from the final six months of CY 2015 conversion factor and applying the budget neutrality factor of 0.9999
- Estimated Impact on Total Allowed Charges by Specialty
  - Highest decreases seen in radiation oncology, radiation therapy centers and gastroenterology (these had the largest creation of G-codes by CMS due to coding changes by AMA for CY 2015)
  - Radiation Oncology = -3%
  - Radiation Therapy Centers = -9%
- Potentially misvalued codes
  - Excluded codes with 10 and 90 day global period from revaluation and codes reviewed since CY 2010
  - Potentially misvalued code 31626 (insertion of radiation therapy markers into lung airways using an endoscope)
  - Potentially misvalued codes identified through high expenditure by specialty screen
    - 31575 – diagnostic laryngoscopy
    - 77263 – radiation therapy planning
    - 77334 – radiation treatment aid(s)
    - 77470 – special radiation treatment
- RVUs for new codes
  - CY 2016 will have significant number of codes valued which do not appear in the proposed rule but will be present in the final rule expected by the first of November.
  - Future years (exception of entirely new services) all codes changes CMS does not receive from the RUC by the February 10th deadline, will still be released in the proposed rule for the subsequent year. CMS will not wait until the final rule to release any codes changes or creation of G-codes for the coming year.
  - New or revised codes are not subject to the phase-in over 2 years changes to RVUs that other codes will be subject to when estimated change is 20% or more
- Malpractice RVUs
Proposing to review on annual basis, rather than every 5 years and use average of 3 most recent years of available data instead of one

- Implement process similar to valuation of practice expense (PE) RVUs
  - 10 and 90 day global periods
    - CMS must develop method to gather information needed to value surgical services and data collection to begin no later than January 1, 2017
    - Seeking comment on most efficient means of gathering data and what kind of data to gather
  - Proposed elimination of Refinement Panel and instead publish the proposed rates for all interim final codes in the PFS proposed rule for the subsequent year
    - Panel was designed to assist with the review of comments presented by stakeholders on CPT® codes with interim final work RVUs for a year and develop final work values for subsequent year
  - New Work RVUs proposed
    - Accepted without refinement (accepted values presented by the RUC)
      - 31626 = 4.16
      - 77387 = 0.58
      - 7778B = 1.4
      - 7778C = 1.95
      - 7778D = 3.8
      - 7778E = 5.4
    - Accepted with refinement (changed from RUC recommendation). These codes are also on the crosswalk list of potentially misvalued Malpractice RVUs
      - 77385, 77386, 77402, 77407 and 77412

- Radiation Treatment and Related Image Guidance Services
  - Issues with RUC valuation of codes
    - Invoices used to price the capital equipment included onboard imaging, the cost of the imaging equipment was already reflected in the price per minute associated with the capital equipment. However, the Direct PE Inputs were not included separately even though the RUC lists them as such.
  - Seeking comment on 3 additional issues related to valuation of codes
    - Image Guidance Services
      - The RUC assumed CT Guidance would be the modality used most for IGRT, however, CY 2013 Medicare claims indicate stereotactic guidance was furnished more frequently
      - Seeking comment as to appropriate work time associated with code 77387
      - Code 77014 expected to drop in utilization dramatically once 77387 fully implemented. CPT and/or the RUC to address 77014 when this happens
      - RUC stated older lower-dose external beam radiation machines are no longer manufactured and the image guidance technology is integrated into the single kind of linear accelerator used for all the radiation treatment services.
      - CPT Editorial Panel did not foresee the RUC would recommend CMS develop PE RVUs for all radiation treatment delivery codes based on assumption that the same capital equipment is typically furnishing the entire range of external beam
treatments. Portion of the resource costs for technical portion of IGRT already allocated into PE RVUs for all treatment delivery codes, not just IMRT and Stereotactic in which the CPT guidelines state that image guidance is bundled into the treatment.

- Proposing to allow for professional and technical component billing for these services, as reflected in CPT guidance, and CMS is proposing to use the RUC recommended direct PE inputs for these services

  - Equipment Utilization Rate for Linear Accelerators

    - The cost of the capital equipment is the primary determining factor in the payment rates for these services. For each CPT code, the equipment costs are estimated based on multiplying the assumed number of minutes the equipment is used for that procedure by the per minute cost of the particular equipment item.

    - Based on the RUC recommendations, CMS does not feel default assumptions for equipment usage are accurate. The RUC stated that the same type of linear accelerator is used to furnish all levels and types of EBRT, previous machines used in valuation are no longer manufactured.

    - Proposing to adjust equipment utilization rate assumption for linear accelerator to account for significant increase in usage. Instead of default 50% assumption, proposing 70% assumption based on machines used for broader range of services and would increase usage.

    - CMS has information that the utilization may be even higher, but for now proposing change to 70% assumption

    - CMS believes that in years 2013 to 2016, the majority of the rest of the obsolete machines will have been replaced with the single linear accelerator

    - Due to this, CMS proposes to implement the 70% utilization rate over 2 years to allow for transition to new equipment. Proposing to use 60% for CY 2016 and 70% for CY 2017

  - Superficial Radiation Treatment Delivery

    - The RUC did not evaluate inputs before making recommendations for CPT® code 77401 for superficial radiation therapy treatments for CY 2015

    - Stakeholders weighed in and suggested radiation therapists rarely treat the patients for superficial treatments, this is primarily performed by physicians. Asked CMS to include work values for physician and consider adding nursing time and updating the price of equipment.

    - Seeking input on possible inclusion of nurse time and physician work

    - Proposing to update equipment item ER045 “orthovoltage radiotherapy system” by renaming it “SRT-100 superficial radiation therapy system” and updating the price from $140,000 to $216,000, on the basis of the submitted invoices

  - Deletion of Endobronchial Ultrasound code 31620 (ultrasound of lung airways using an endoscope) and creation of three new codes, CPT 3160A-3160C, to describe bronchoscopic procedures that are inherently performed with endobronchial ultrasound (EBUS).

  - Incident-to Changes
Billing Physician as the Supervising Physician

- Incident to services require direct supervision of the auxiliary personnel providing the service by the physician or other practitioner
- CMS proposing to revise the regulations specifying the requirements for which physicians or other practitioners can bill for incident to services
- In response to commenters seeking clarification regarding which physician to bill under for an incident to service, CMS states “the Medicare billing number of the ordering physician or other practitioner should not be used if that person did not directly supervise the auxiliary personnel.”
- Additionally CMS states, “To be certain that the incident to services furnished to a beneficiary are in fact an integral, although incidental, part of the physician’s or other practitioner’s personal professional service that is billed to Medicare, we believe that the physician or other practitioner who bills for the incident to service must also be the physician or other practitioner who directly supervises the service. It has been our position that billing practitioners should have a personal role in, and responsibility for, furnishing services for which they are billing and receiving payment as an incident to their own professional services. This is consistent with the requirements that all physicians and billing practitioners attest on each Medicare claim that he or she “personally furnished” the services for which he or she is billing.”
- Proposing to amend previous statement that a service need not be supervised by the same physician upon whose professional service the incident to service is based and replace it with, “…the physician or other practitioner who bills for incident to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident to services.”
- Additionally Auxiliary personnel who have been excluded or revoked from Medicare cannot provide incident to services to Medicare, Medicaid or any other federally funded health care programs by OIG

- PQRS Measure proposed for removal
  - 0386/194 - Effective Clinical Care – Oncology: Cancer Care Stage Documented
    - Proposed to remove as the clinical concept does not add clinical value to PQRS because documenting cancer stage is a basic standard of care documented early in patient’s care before treatment options are discussed

- Locum Tenens Physicians
  - Propose to revise definition of locum tenens physician to remove the reference to “stand in the shoes.” CMs believes definition of locum tenens is clear without it
**Conversion Factor and Overall Payment Impacts**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which became law on April 16, 2015, made several changes which impacted and will continue to impact physician and freestanding cancer center reimbursement, and was a main focus of the MPFS CY 2016 Proposed Rules. The MACRA repealed the sustainable growth rate (SGR), revised and established PFS updates for CY 2015 and subsequent years as well as established a Merit-based Incentive Payment System (MIPS).

Based on the changes made into law by the MACRA the conversion factor (CF) for the final six months of 2015 was set at $35.9335. Effective January 1, 2016 the conversion factor is supposed to increase 0.5% from the current CF. To allow CMS to maintain the necessary budgetary neutrality in which the overall estimated Medicare expenditures are no more than $20 million above or below the estimated total, a budget neutrality factor is applied to the overall conversion factor calculation. Applying a budget neutrality factor of 0.9999 to the 0.5% increase of current 2015 conversion factor results in a proposed conversion factor of $36.1096 for CY 2016; this is ultimately dependent on the final rule which may still make necessary adjustments to the final values pending stakeholder comments.

In 2015 physicians and freestanding cancer centers saw very little change in the reimbursement and RVUs for many of the codes utilized in radiation oncology from those of 2014. This was due in part to the delay of changes to the daily treatment and imaging codes. Instead of implementing the new CPT codes released by the AMA, CMS created G-codes which were a direct crosswalk to the 2014 codes; so the values remained unchanged. When the new codes were then accepted and valued for 2016, due to the significant changes and recommendations in the valuation by the RUC, the overall payment impacts reflect a proposed negative impact, some of the highest as compared to other specialties. Gastroenterology is the only other specialty with a comparably high negative impact. This is also due to the fact CMS created many G-codes for 2015 with direct crosswalks to deleted codes from 2014 for the gastroenterology specialty. The table below reflects the proposed overall payment impacts for radiation oncology and radiation therapy centers.

<table>
<thead>
<tr>
<th>(A) Specialty</th>
<th>(B) Allowed Charges (mil)</th>
<th>(C) Impact of Work RVU Changes</th>
<th>(D) Impact of PE RVU Changes</th>
<th>(E) Impact of MP RVU Changes</th>
<th>(F) Combined Impact**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncology</td>
<td>$1,769</td>
<td>0%</td>
<td>-3%</td>
<td>0%</td>
<td>-3%</td>
</tr>
<tr>
<td>Radiation Therapy Centers</td>
<td>$52</td>
<td>0%</td>
<td>-9%</td>
<td>0%</td>
<td>-9%</td>
</tr>
</tbody>
</table>

**Potentially Misvalued Codes**

CMS has again identified potentially misvalued codes for CY 2016. This list includes a few codes specific to radiation oncology and two which are indirectly or components of services provided to cancer patients. CPT® code 31626, (insertion of radiation therapy markers into lung airways using an endoscope) is used for the placement of fiducial markers into the thoracic area which may be used to assist in treatment delivery. This code was identified as potentially misvalued; however, after review the current Work RVUs assigned to the code were proposed to continue in CY 2016.
CMS also implement the high expenditure specialty screening tool, which was introduced last year and shelved based on stakeholder comments. This tool identifies potentially misvalued codes in the statutory category of “codes that account for the majority of spending under the PFS.” CMS believes current resources allow for proceeding with implementing the tool in screening for high expenditure codes. The tool was run excluding any codes with 10 and 90-day global periods, any codes reviewed since CY 2010, codes with fewer than $10 million in allowed charges and those that describe anesthesia or E/M services. The table below reflects services specific to radiation oncology and a few that are components of procedures performed on cancer patients, such as diagnostic laryngoscopies and eye exam with photos for eye plaque brachytherapy procedures.

### TABLE 8: Proposed Potentially Misvalued Codes Identified through High Expenditure by Specialty Screen

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>31575</td>
<td>Diagnostic laryngoscopy</td>
</tr>
<tr>
<td>77263</td>
<td>Radiation therapy planning</td>
</tr>
<tr>
<td>77334</td>
<td>Radiation treatment aid(s)</td>
</tr>
<tr>
<td>77470</td>
<td>Special radiation treatment</td>
</tr>
<tr>
<td>92250</td>
<td>Eye exam with photos</td>
</tr>
</tbody>
</table>

New codes for use under MPFS include CPT® code 77387 for IGRT and the new codes (yet to be released) for HDR brachytherapy treatments were also proposed to accept the RUC recommendations for value. The following table reflects the potentially misvalued codes with the RUC and CMS Work RVU recommendations for CY 2016, all were accepted without refinement. Code 7778A another new brachytherapy code was not included in the table by CMS.

### TABLE 11: CY 2016 Proposed Work RVUs for New, Revised and Potentially Misvalued Codes

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Descriptor</th>
<th>Current Work RVU</th>
<th>RUC Work RVU</th>
<th>CMS Work RVU</th>
<th>CMS Time Refinement</th>
</tr>
</thead>
<tbody>
<tr>
<td>31626</td>
<td>Insertion of radiation therapy markers into lung airways using an endoscope</td>
<td>4.16</td>
<td>4.16</td>
<td>4.16</td>
<td>No</td>
</tr>
<tr>
<td>77387</td>
<td>Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking when performed</td>
<td>N/A</td>
<td>0.58</td>
<td>0.58</td>
<td>No</td>
</tr>
<tr>
<td>7778B</td>
<td>Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions</td>
<td>N/A</td>
<td>1.4</td>
<td>1.4</td>
<td>No</td>
</tr>
<tr>
<td>7778C</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel</td>
<td>N/A</td>
<td>1.95</td>
<td>1.95</td>
<td>No</td>
</tr>
<tr>
<td>7778D</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels</td>
<td>N/A</td>
<td>3.8</td>
<td>3.8</td>
<td>No</td>
</tr>
<tr>
<td>7778E</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels</td>
<td>N/A</td>
<td>5.4</td>
<td>5.4</td>
<td>No</td>
</tr>
</tbody>
</table>
Several of the Direct PE Input values recommended by the RUC for the new codes in CY 2016 were not accepted by CMS. CMS made refinements to the recommendations and in each case these were lower than the RUC recommendations. Table 13: CY 2016 Proposed Codes with Direct PE Input Recommendations Accepted with Refinements, available in the proposed rule document, outlines the specific recommendations for the RUC values vs. those of the CMS. The radiation oncology codes which were not accepted without refinement and listed in the table are 77385 and 77386 for IMRT treatments and 77402, 77407 and 77412 for standard external beam treatments. CMS adjusted the equipment time recommended by the RUC for each code in CY 2016 by lowering it. More detail of the proposed changes regarding utilization of time related to treatment delivery is further along in this summary.

**Valuation and RVUs for New Codes in the Future**

The proposed rules for CY 2016 have a significant number of codes which do not have values assigned to them, but will have values at the time of the final rule. CMS has indicated in future proposed rule releases all code changes, except entirely new services, will have values assigned. Stakeholders will not have to wait until the final rule to see what the assigned values are for code changes.

CMS has indicated regardless of whether or not the AMA and the RUC release the codes to them prior to the February 10th deadline, all codes will have values assigned in the proposed rules going forward. In addition, new or revised codes are not subject to the phase-in over 2 years for changes in RVUs which are estimated to be >20%. The RVU changes for new and revised codes will be made for the year they are finalized.

**Radiation Treatment and Related Image Guidance Services**

The CY 2016 proposed rule contained a section under establishing Direct PE Inputs, Radiation Treatment and Related Image Guidance Services which had a significant amount of proposed changes and comments directly related to radiation oncology. The proposed changes were directly related to the treatment delivery and image guidance codes which were deleted in 2015 and changed to new or revised codes. The changes by the AMA and the RUC for CY 2015 were implemented by hospitals for these codes, but CMS delayed any changes for MPFS for one year until they could be addressed based on input and further review.

The result is there are substantial changes and revaluation of the new and revised codes that according to CMS it appears the RUC was not fully aware of the significance of how it would play out. The first area of proposed change is the RUC valuations of codes with regard to the equipment and time of use. In CY 2012 CMS identified services related to treatment delivery and specifically IMRT as potentially misvalued. The RUC recommended a 60 minute procedure time assumption for IMRT treatment delivery, but information available suggests treatment time is actually anywhere from 5 – 30 minutes per treatment. The changes by the CPT Editorial Panel which reduced the standard external beam codes down to just three revised codes and IGRT codes down to one new code, but expanded the IMRT treatment delivery to two new codes, resulted in MPFS indicating a more thorough review and re-valuation was necessary prior to implementation.

In the invoices provided to assist in the valuation of the codes it was noted that ‘on-board imaging” was already included in the price per minute associated with the capital equipment; therefore, it is not listed as a separate item in the proposed direct PE inputs for the new treatment codes. The PE worksheet included with the RUC recommendations included it as a separate item. In addition, to the refinements based on the time of equipment use...
there are three other areas in which CMS is seeking comments and/or making specific proposed rulings which are related to these services; image guidance, equipment utilization rate assumptions for linear accelerators and superficial radiation treatment services.

Image Guidance Services
In revising and assigning recommended values for the new IGRT code 77387, the RUC assumed the imaging code most widely reported in CY 2013 was cone beam CT, for this reason when values were assigned to CPT® code 77387 they were in line with CPT® code 77014. Unfortunately CMS indicated per CY 2013 claims, stereoscopic guidance represented with CPT® code 77421 was the most widely reported IGRT code and it’s assigned value was considerably lower than that of 77014. CMS is seeking comments on the appropriate work time associated with CPT® code 77387.

CPT® code 77014 will continue as a valid code. The RUC indicated without a treatment planning CT code for those scenarios where it would be appropriate to bill for the CT that took place, providers may have no alternative but to report higher valued diagnostic CT codes instead. With the utilization of code 77387 the RUC indicated the utilization of code 77014 is expected to drop to negligible levels, assuming that practitioners use the new IGRT code appropriately. CMS indicated once the new IGRT code is fully implemented they anticipate that CPT and/or the RUC will address the continued use of 77014 and if it continues to be part of the code set, they will provide recommendations as to appropriate values based on utilization.

The RUC recommendations for the values of all treatment delivery codes, 77402, 77407, 77412, 77385, 77386, 77372 and 77373 all incorporate the same capital cost of image guidance equipment, even though the IMRT and stereotactic treatment codes are the only ones which state the IGRT is part of the treatment and not separately billable. The RUC indicated that older lower-dose external beam radiation machines are no longer manufactured and IGRT is integrated in the single kind of linear accelerator used for all radiation treatment services. However, when the treatment codes were valued by the RUC a portion of the resource costs were already allocated to the PE RVUs for all of the treatment delivery codes, not just IMRT and stereotactic. CMS had considered valuing 77387 as a professional only service and not creating professional/technical components as envisioned by CPT. CMS is proposing to allow for professional and technical component billing for IGRT services as outlined by CPT guidance and using the RUC recommended direct PE inputs for these services. CMS is also seeking comments on the apparent contradiction between the technical component billing for IGRT in the context that is be included for all external beam treatment delivery codes.

Equipment Utilization Rate for Linear Accelerators
The cost of the capital equipment is the primary determining factor in the payment rates for treatment delivery codes. Each CPT code is estimated based on multiplying the assumed number of minutes the equipment is used for a procedure by per minute cost of the particular equipment item. Based on this there are a few assumptions applied by CMS when calculating the PE RVUs. Medicare has applied the default assumption that linear accelerators have a 50% utilization rate, meaning they are used 25 hours per week out of a 50-hour work week.

CMS no longer feels their assumptions on the equipment usage are correct. Per the RUC recommendations, the same type of linear accelerator is now typically used to furnish all levels and types of external beam treatments
because the previous machines used to furnish services are no longer manufactured. Based on this CMS indicated the same equipment item is used to furnish more services; therefore, the time utilization would be higher.

CMS is proposing to adjust the equipment utilization rate for linear accelerators from the default 50% to 70% based on the fact that linacs are now being typically used in a significantly broader range of services; therefore, supporting a higher time utilization rate. CMS also believes the rate is actually higher than 70% and more than 50 hours per week in which the treatment machines are used; this is based on other information reviewed.

CMS is proposing to use CY 2013 recommendations for the CY 2016 PFS payment rates and based on the information from the RUC in which the older machines are obsolete and phasing out. CMS is also assuming the initial transition of older machines to new machines by all centers had already begun to take place by CY 2013 and that in the years 2013 – 2016 the majority of the rest of obsolete machines will be replaced with a single linear accelerator.

Given that the transition from 50% utilization rate to 70% is a significant jump, CMS is proposing to phase this in over next two years. They are proposing to use the 60% equipment utilization rate for the linac in CY 2016 as displayed in the direct PE input database and implement the full 70% equipment utilization rate in CY 2017. CMS is seeking empirical data on the capital equipment costs, including equipment utilization rates, for the linac and other capital-intensive machines, and seeking comment on how to most accurately address issues surrounding these costs within the PE methodology.

### Superficial Radiation Treatment Delivery

Changes were made to CPT® code 77401 as outlined in the CPT Coding Manual by the AMA for CY 2015, based on those changes CMS sought comments from stakeholders regarding the changes which only allowed for a few services to be billed in addition to the superficial treatment delivery code. Comments were received and one commenter suggested the superficial treatments were rarely performed by radiation therapists, in fact superficial radiation treatments were typically performed by physicians. Due to this the commenter suggested the RVUs reflect physician work time and remove minutes of the radiation therapist from the valuation. CMS is seeking comments from other stakeholders and the RUC about this suggestion for changing the values assigned.

The stakeholder also suggested direct PE inputs include nursing time and update the price of the capital equipment used to treat superficial radiation lesions. Comments are being sought regarding the addition of nurse time as part of CPT® code 77401. After reviewing submitted invoices in order to update the capital equipment, CMS is proposing to update the equipment item ER045 “orthovoltage radiotherapy system” by renaming it “SRT-100 superficial radiation therapy system” and updating the price from $140,000 to $216,000, on the basis of the submitted invoices.

### Incident-to Changes

For the past several years CMS has addressed supervision expectations and guidelines in the hospital setting within the HOPPS proposed and finale rules, but had not addressed it for freestanding cancer centers and offices in the MPFS publications. CMS is proposing changes to incident-to in light of questions received from providers as to the appropriate physician to report services under on the claim form.
In response to commenters seeking clarification regarding which physician to bill under for an incident-to service, CMS states “Accordingly, the Medicare billing number of the ordering physician or other practitioner should not be used if that person did not directly supervise the auxiliary personnel.”

Per CMS incident-to services require direct supervision of the auxiliary personnel providing the service by the physician or other practitioner. CMS is proposing to revise regulations specifying the requirements for which physicians or other practitioners can bill for incident-to services. CMS is proposing to amend the previous statement that a service need not be supervised by the same physician upon whose professional service the incident to service is based and replace it with, “…the physician or other practitioner who bills for incident to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident to services.”

CMS has gone on to further state, “To be certain that the incident to services furnished to a beneficiary are in fact an integral, although incidental, part of the physician’s or other practitioner’s personal professional service that is billed to Medicare, we believe that the physician or other practitioner who bills for the incident to service must also be the physician or other practitioner who directly supervises the service. It has been our position that billing practitioners should have a personal role in, and responsibility for, furnishing services for which they are billing and receiving payment as an incident to their own professional services. This is consistent with the requirements that all physicians and billing practitioners attest on each Medicare claim that he or she “personally furnished” the services for which he or she is billing.”

Finally, CMS has gone on to add that under condition of Medicare payment, “auxiliary personnel who, under the direct supervision of a physician or other practitioner, provide incident to services to Medicare beneficiaries must comply with all applicable Federal and State laws.” This means auxiliary personnel cannot have been excluded from Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General (OIG). CMS is proposing to amend the regulation to explicitly prohibit any auxiliary personnel who have been excluded by Medicare, Medicaid and all other federally funded health care programs by the OIG from providing services to these beneficiaries even when incident-to the physician service.

**PQRS Measure Proposed for Removal**

CMS is proposing to remove PQRS measure 0386/194, Effective Clinical Care, Oncology: Cancer Care Stage Documented from the selection of PQRS measures. CMS indicated the clinical concept does not add clinical value to PQRS because documenting cancer stage is a basic standard of care documented early in patient’s care before treatment options are discussed.

**Submitting Comments**

Comments are encouraged and must be delivered no later than 5 pm, EST, September 8, 2015. When commenting please refer or list the file code CMS-1631-P for MPFS. No comments by fax can be accepted.

You may submit comments in one of four ways (no duplicates); however, it is recommended to submit them electronically at [http://www.regulations.gov](http://www.regulations.gov). Follow the instructions under the “submit a comment” tab.
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