



## **Key Provisions in the CY 2015 Medicare Physician Fee Schedule Final Rule**

On October 31, the Centers for Medicare and Medicaid Services (CMS) released CMS-1612-FC, the [CY 2015 Medicare Physician Fee Schedule \(PFS\) Final Rule](#). The Rule was published in the Federal Register on November 13.

The American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE) have developed this summary of key provisions in the final rule to help GI practices prepare for these payment and policy changes that take effect January 1, 2015.

### **Major Provisions in the CY 2015 Medicare Physician Fee Schedule Final Rule**

1. Physician Payment Update
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3. CMS Efforts to Improve Transparency
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### **PHYSICIAN PAYMENT UPDATE**

Earlier this year, legislation was enacted that sets the Medicare physician payment update at zero for services furnished between January 1, 2015 and March 31, 2015. Without this congressional intervention, physician payments would be cut about 21 percent. CMS supports legislation to repeal the Medicare sustainable growth rate (SGR) formula and reform the physician payment system in a manner that provides more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

Not including the effect of the negative April 2015 conversion factor change under current law, the 2015 impact on total allowed charges for gastroenterology is as follows:

<i>Specialty</i>	<i>Allowed Charges (millions)</i>	<i>Impact of Work and malpractice RVU Changes</i>	<i>Impact of PE RVU Changes</i>	<i>Combined Impact</i>
<i>Gastroenterology</i>	<i>1,884</i>	<i>0%</i>	<i>0%</i>	<i>0%</i>

## **DELAY IN THE REVALUATION OF COLONOSCOPY**

The 2015 PFS final rule had significant changes, the most important of which for GI was the delay of the revaluation of colonoscopy and the lower GI endoscopy codes. The ACG, AGA and ASGE requested in written comments and in personal meetings with CMS that it delay the final review of the upper and lower endoscopy codes until the Agency adopted a more transparent rate-setting process and established a clear direction on valuing services where moderate sedation is inherent to the procedure. CMS agreed, stating in the final rule:

*“In light of the substantial nature of this code revision and its relationship to the policies on moderate sedation, CMS is delaying revaluation of the colonoscopy codes until CY 2016 when we will be able to include proposals in the proposed rule for their valuation, along with consideration of policies for moderate sedation. Accordingly for CY 2015, we are maintaining values for the lower gastrointestinal endoscopy codes at the CY 2014 levels.”*

**Member Note:** Due to budget neutrality adjustments and other system-wide physician payment changes in 2015, the PFS payment rates may change slightly from 2014.

### Moderate Sedation

At this time, CMS is not making changes to how the Agency currently values codes for which moderate sedation is an inherent part of the procedure. CMS intends to address this topic in future rulemaking, taking into account stakeholder comments and feedback.

### CMS’ Review of Colonoscopy Values

The GI societies worked with CMS during its initial review of the colonoscopy codes in 2014 and will continue to work with the Agency as it determines new valuations for lower GI endoscopy codes. Our societies are encouraged by and agree with CMS’ position from the 2015 PFS proposed rule that stated:

*“For many codes, the surveys conducted by specialty societies as part of the RUC [AMA/Specialty Society Relative Value Scale Update Committee] process are the best data that we have regarding the time and intensity of work. The RUC determines the criteria and the methodology for those surveys. It also reviews the survey results. This process allows for development of survey data that are more reliable and comparable across specialties and services than would be possible without having the RUC at the center of the survey vetting process. In addition, the debate and discussion of the services at the RUC meetings*

*in which CMS staff participate provides a good understanding of what the service entails and how it compares to other services in the family, and to services furnished by other specialties.”*

The GI societies’ recommendations to the RUC for colonoscopy were based on robust survey data from 165 practicing gastroenterologists in a variety of practice settings across the United States.

#### **CMS’ EFFORTS TO IMPROVE TRANSPARENCY**

Our societies applaud CMS for finalizing a new process by which stakeholders can review proposed reimbursement changes in the annual PFS proposed rule as opposed to the final rule, which typically occurs less than two months prior to significant reimbursement changes taking effect.

In the final rule, CMS finalized a new rate-setting process using CY 2015 as a transition year and then implementing a more transparent process by including most reimbursement changes in annual proposed rules beginning in CY 2017. The colonoscopy family and other lower GI endoscopy codes will be included in the CY 2016 proposed rule. Beginning with rulemaking for CY 2017, CMS will propose values for the vast majority of new, revised, and potentially misvalued codes and consider public comments before establishing final values for the codes.

#### **USE OF TEMPORARY MEDICARE G-CODES IN NEW RATE-SETTING PROCESS**

To implement this new initiative on transparency, CMS finalized the use of temporary G-codes to facilitate continued payment for new or modified CPT codes that do not have the benefit, due to timing of the AMA RUC process, of first being published in the proposed rule.

The GI societies acknowledge the use of G-codes as the temporary transitional bridge may be an administrative burden for medical practices because of the coding inconsistency it creates between Medicare and private payers.

However, like CMS, the GI societies believe stakeholders are better served by delaying the colonoscopy review for one year to afford the opportunity for public comment before values for services are finalized. CMS is also cognizant of the difficulties created by the use of G-codes and will seek to minimize their use moving forward. We agree that it is preferable to use CPT codes whenever possible.

#### Use of G Codes for Lower GI Endoscopy

Since the lower GI endoscopy CPT code set is changing for CY 2015, including the deletion of some of the CY 2014 codes, CMS is creating G-codes for 10 services that had CPT codes in 2014 that changed in 2015 to allow practitioners to report services to CMS in CY 2015 the same way they did in CY 2014 and at CY 2014 valuations.

CMS will require physicians to report the G-code instead of the corresponding 2015 CPT code for existing procedures that have new CPT code assignments in CPT 2015.

#### Lower Gastrointestinal Endoscopy G-Codes Replacing CY 2015 CPT Codes

CY 2014 CPT Code <sup>1</sup>	CY 2015 HCPCS Code	Long Descriptor
44383	G6018	Ileoscopy,through stoma;with transendoscopic stent placement (includes predilation )
44393	G6019	Colonoscopy through stoma;with ablation of tumor(s),polp(s),or other lesion(s)not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44397	G6020	Colonoscopy through stoma;with transendoscopic stent placement (includes predilation)
44799	G6021	Unlisted procedure,intestine
45339	G6022	Sigmoidoscopy, flexible; with ablation of tumor(s),polyp(s),or other lesions(s)not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45345	G6023	Sigmoidoscopy, flexible; with transenoscopic stent placement (includes predilation)
45383	G6024	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45387	G6025	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)
0226T	G6027	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed
0227T	G6028	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)

#### New CPT Codes Not Recognized in CY 2015 by Medicare

In addition, CMS set the value of all other new 2015 CPT codes at 0.00 RVUs. We have received guidance from CMS as to how gastroenterologists should report these new procedures that have been assigned 0.00 RVUs to CMS. CMS's intent is for physicians to continue to bill as they would have in CY 2014. Therefore, new procedures that have new CPT codes in 2015 but do not have G code crosswalks should be reported as they were in 2014 for Medicare beneficiaries.

CPT 2015 Code	Description	CMS CY 2015 Crosswalk
44381	S bowel endoscopy w/dilation	44380, 44799
44403	C-stoma w/EMR resection	44388, 44799
44404	C-stoma w/injection	44388, 44799
44405	C-stoma w/dilation	44388, 44799
44406	C-stoma w/ultrasound	44388, 44799
44407	C-stoma w/ndl aspir/bx	44388, 44799
44408	C-stoma w/decompression	44388, 44799
45349	Sigmoidoscopy w/EMR resection	45330, 44799
45350	Sgmdsc w/band ligation	45330, 44799
45390	Colonoscopy w/EMR resection	45378, 44799
45393	Colonoscopy w/decompression	45378, 44799
45398	Colonoscopy w/band ligation	45378, 44799

**Physicians are encouraged to reach out to their payers regarding guidance on how to report the new 2015 CPT codes for non-Medicare commercial lines of service.** Reporting lower GI endoscopy codes in

2015 will depend on status of the patient (e.g., commercial, Medicare Advantage, traditional fee for service Medicare).

The following may be helpful in determining when to report CPT and G-codes for 2015.

- If the patient is Medicare (fee for service , Medicare Advantage), and:
  - If the code has not changed from 2014 to 2015
    - Physicians report the CPT code and CMS fees are based on 2014 values
  - If the code has changed from 2014 to 2015
    - Physicians report the G code and CMS fees are based on 2014 values
  - If the code is new for 2015
    - Physicians report the CY 2014 CPT code(s)
    - Do not report the CPT 2015 codes; they are not valued by CMS

When reaching out to payers regarding use of new 2015 CPT codes for commercial lines of service, we note that not all payers have decided whether they will recognize the new CPT codes and, if so, what the value of the codes should be. It might be helpful to look at the 2014 RVU values for the base codes and the 2015 value of the increment from the upper GI endoscopy for the procedure when beginning a dialogue with payers. For example, the increment for stent over the upper GI endoscopy base codes for stent is 1.98. This increment can be added to a lower GI endoscopy base code to calculate an RVU for the new stent codes as a point of reference for reimbursement discussions.

<b>Procedure</b>	<b>Increment over base code</b>
Submucosal injection	0.30
Balloon dilation	0.58
Endoscopic Ultrasound	1.38
Stent placement	1.98
Ablation	2.07
Endoscopic Ultrasound/FNA	2.07
Endomucosal resection	2.78

### **GI CODE-SPECIFIC ISSUES**

In the 2014 Final Rule, CMS assigned interim final values to all upper GI endoscopy codes. In the 2015 final rule, CMS finalized the value and increased the physician work values of some of the codes. The table below lists the CY 2014 interim final work RVU and the CY 2015 final work RVU. While almost half of all codes received an increase in RVUs, most increases were nominal at between 0.02 and 0.16 of an RVU higher than the 2014 interim RVU values. While the GI societies were pleased to see that CMS increased the valuation for stent procedures, we remain disappointed that the physician work RVU for

highly complex procedures including endoscopic ultrasound, and injection and banding of esophageal varices, was finalized at a low value.

For 2015, CMS established an interim value for a new code 91200, liver elastography. The GI societies are concerned that CMS did not accurately capture the cost of the equipment needed to perform this procedure, and will address this in their comments to the Final Rule.

**Member Note:** There are numerous errors to the physician work values for upper GI endoscopy codes in the 2015 Addendum B files posted by CMS. The values in Addendum B are used in determining final 2015 Medicare reimbursement rates. CMS staff responded to GI's inquiry and confirmed that there are errors. CMS is working to investigate the errors and post a corrected addendum as soon as possible. The table below contains the correct 2015 physician work values, based on the preamble to the Final Rule.

### 2015 Physician Work Values for Upper GI Endoscopy Code Families

CPT	Description	2014 Interim Final Work RVUs	2015 Final Work RVUs
43197	Esophagoscopy flex dx brush	1.48	1.52
43198	Esophagosc flex trnsn biopsy	1.78	1.82
43200	Esophagoscopy flexible brush	1.50	1.52
43201	Esoph scope w/submucous inj	1.80	1.82
43202	Esophagoscopy flex biopsy	1.80	1.82
43204	Esoph scope w/sclerosis inj	2.40	2.43
43205	Esophagus endoscopy/ligation	2.51	2.54
43206	Esoph optical endomicroscopy	2.39	2.39
43211	Esophagoscop mucosal resect	4.21	4.30
43212	Esophagoscop stent placement	3.38	3.50
43213	Esophagoscopy retro balloon	4.73	4.73
43214	Esophagosc dilate balloon 30	3.38	3.50
43215	Esophagoscopy flex remove fb	2.51	2.54
43216	Esophagoscopy lesion removal	2.40	2.40
43217	Esophagoscopy snare les remv	2.90	2.90
43220	Esophagoscopy balloon <30mm	2.10	2.10
43226	Esoph endoscopy dilation	2.34	2.34
43227	Esophagoscopy control bleed	2.99	2.99
43229	Esophagoscopy lesion ablate	3.54	3.59
43231	Esophagoscop ultrasound exam	2.90	2.90
43232	Esophagoscopy w/us needle bx	3.54	3.59
43233	Egd balloon dil esoph30 mm/>	4.05	4.17
43235	Egd diagnostic brush wash	2.17	2.19

43236	Uppr gi scope w/submuc inj	2.47	2.49
43237	Endoscopic us exam esoph	3.57	3.57
43238	Egd us fine needle bx/aspir	4.11	4.26
43239	Egd biopsy single/multiple	2.47	2.47
43240	Egd w/transmural drain cyst	7.25	7.25
43241	Egd tube/cath insertion	2.59	2.59
43242	Egd us fine needle bx/aspir	4.68	4.83
43243	Egd injection varices	4.37	4.37
43244	Egd varices ligation	4.50	4.50
43245	Egd dilate stricture	3.18	3.18
43246	Egd place gastrostomy tube	3.66	3.66
43247	Egd remove foreign body	3.18	3.21
43248	Egd guide wire insertion	3.01	3.01
43249	Esoph egd dilation <30 mm	2.77	2.77
43250	Egd cautery tumor polyp	3.07	3.07
43251	Egd remove lesion snare	3.57	3.57
43252	Egd optical endomicroscopy	3.06	3.06
43253	Egd us transmural injxn/mark	4.68	4.83
43254	Egd endo mucosal resection	4.88	4.97
43255	Egd control bleeding any	3.66	3.66
43257	Egd w/thrml txmnt gerd	4.11	4.25
43259	Egd us exam duodenum/jejunum	4.14	4.14
43260	Ercp w/specimen collection	5.95	5.95
43261	Endo cholangiopancreatograph	6.25	6.25
43262	Endo cholangiopancreatograph	6.60	6.60
43263	Ercp sphincter pressure meas	6.60	6.60
43264	Ercp remove duct calculi	6.73	6.73
43265	Ercp lithotripsy calculi	8.03	8.03
43266	Egd endoscopic stent place	4.05	4.17
43270	Egd lesion ablation	4.21	4.26
43273	Endoscopic pancreatoscopy	2.24	2.24
43274	Ercp duct stent placement	8.48	8.48
43275	Ercp remove forgn body duct	6.96	6.96
43276	Ercp stent exchange w/dilate	8.84	8.94
43277	Ercp ea duct/ampulla dilate	7.00	7.00
43278	Ercp lesion ablate w/dilate	7.99	8.02
43450	Dilate esophagus 1/mult pass	1.38	1.38
43453	Dilate esophagus	1.51	1.51

Review of High Expenditure Services across Specialties with Medicare Allowed Charges of \$10,000,000 or More

In the 2015 PFS proposed rule, code 91110 (GI tract capsule endoscopy) was identified by CMS as a high expenditure service with Medicare allowed charges of \$10,000 or more that could be potentially misvalued. The GI societies agreed to survey the code, along with code 91111 (esophageal capsule endoscopy) identified as part of its family. However, CMS is allowing the RUC to delay survey of procedures from the “high expenditure” screen so that the RUC can focus on the CMS request to survey and revalue codes with 010 and 090 day global periods. The GI societies will take advantage of the delay; there are no plans to survey these codes until CMS indicates that they must be surveyed.

**CMS CHANGES DEFINITION OF COLORECTAL CANCER SCREENING TESTS**

Effective January 1, 2015, CMS has modified the definition of “colorectal cancer screening tests” to include anesthesia that is furnished in conjunction with screening colonoscopies. The effect of changing the definition is an extension of the waiver of beneficiary coinsurance and deductible for anesthesia furnished in conjunction with a screening colonoscopy. CMS has justified this modification on the increasing number of colonoscopies during which anesthesia is separately furnished using an anesthesia professional.

In the rule, CMS maintains its position that it lacks the authority to modify the definition of colorectal cancer screening tests to include a screening colonoscopy with polyp removal. Consequently, Medicare beneficiaries will be liable for coinsurance for a screening colonoscopy and separately billed anesthesia services when a polyp or growth is removed during the screening encounter; the deductible will continue to be waived.

<b>Cost Sharing</b>	<b>Screening Colonoscopy</b>	<b>Separately Billed Anesthesia with Screening Colonoscopy</b>	<b>Screening Colonoscopy with Polyp Removal</b>	<b>Separately Billed Anesthesia Screening Colonoscopy with Polyp Removal</b>
<b>Final 2015 MPFS - Effective 1/1/15</b>				
Coinsurance	Waived	Waived	Applies	Applies
Deductible	Waived	Waived	Waived	Waived

Anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a colorectal cancer screening test should include the 33 modifier on the claim line with the anesthesia service. In situations that begin as a colorectal cancer screening test, but for which another service such as colonoscopy with polyp removal or biopsy is furnished, the anesthesia professional should report a PT modifier on the claim line rather than the 33 modifier.

**REPORTS OF PAYMENTS OR OTHER TRANSFERS OF VALUE TO COVERED RECIPIENTS**

Amongst the provisions of the final rule are changes that will have a significant impact on the way continuing medical education (CME) is treated within the Open Payments program (or Sunshine Act). The program, mandated by Congress, is designed to create greater transparency in relationships between physicians and drug and device manufacturers. In the proposed rule, CMS put forth a policy that would eliminate an existing exclusion from reporting requirements for certified and accredited CME, which exempts indirect transfers from industry supporters to CME faculty due to the clear firewall that already exists. In its place, CMS proposed a more general exclusion that relied on a subjective standard of whether an industry supporter knew the identity of speakers or other recipients.

Despite efforts across the physician community to maintain the existing exclusion for certified CME activities, the final rule moves forward with the original CMS proposal. However, in the rule's clarifying discussion, CMS makes clear that many CME transfers will still maintain protection from the reporting requirements. Specifically, transfers from an industry donor or manufacturer will not trigger the reporting requirement so long as the manufacturer or donor does not require, instruct, direct, or otherwise cause the CME provider to direct the payment or transfer of value to a physician. In these cases, the transfer is not reportable even if the manufacturer or donor learns the identity of the recipient.

The changes included in the final rule do not completely satisfy the concerns of many CME stakeholders, but the guidance provided by CMS minimizes the overall impact of the changes by continuing the exempt many instances even in the absence of the deleted exclusion.

## **PHYSICIAN QUALITY REPORTING SYSTEM**

In 2017, all physicians are at risk of a -2% penalty under the Physician Quality Reporting Program (PQRS) for failure to successfully submit quality data for the 2015 performance year. Because the Value-Based Payment (VBP) Modifier program is tied to PQRS, all groups of physicians and solo practitioners are also at risk of a negative modifier (-2% to -4%) in 2017 if they do not meet PQRS quality reporting requirements.

For the 2015 performance year, CMS has changed the requirements for PQRS participation. Most notably:

- to avoid the payment penalty, eligible professionals and group practices must report 9 measures covering 3 National Quality Strategy (NQS) domains and report each measure for at least 50% of the eligible professional's Medicare Part B fee-for-service patients seen during the reporting period to which the measure applies;
- if an eligible professional or group practice sees at least one Medicare patient in a face-to-face encounter, at least 1 of the 9 measures will need to be a cross-cutting measure. CMS has finalized a list of 19 cross-cutting measures; and

- group practices (2+ eligible professionals) will have until June 30, 2015, to register to participate in the PQRS Group Practice Reporting Option (GPRO).

PQRS will continue to allow eligible professionals and group practices to participate in PQRS using all currently available reporting mechanisms: claims, qualified registry, electronic health record (EHR), GPRO Web Interface, Qualified Clinical Data Registry (QCDR), and certified survey vendors for the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) measures.

**2015 PQRS Reporting Mechanisms and Requirements\***

Reporting Mechanism	Requirements to Avoid 2015 PQRS Adjustment (-2%)
<u>Medicare Claims:</u>  Individual Eligible Professionals	Report at least 9 measures for 50% of applicable Medicare FFS patients covering at least 3 NQS domains. One measure must be a cross-cutting measure.
<u>Qualified Registry for Reporting Individual Measures:</u>  Individual Eligible Professionals and Group Practices (2+ eligible professionals)	Report at least 9 measures for 50% of applicable Medicare FFS patients covering at least 3 NQS domains. One measure must be a cross-cutting measure.
<u>Qualified Registry for Reporting Measures Groups:</u>  Individual Eligible Professionals	Report at least 1 measures group for at least 20 patients, a majority (11) of which must be Medicare Part B FFS patients.
<u>Certified EHR Product:</u>  Individual Eligible Professionals and Group Practices (2+ eligible professionals)	Report 9 measures covering at least 3 NQS domains. If the Certified Electronic Health Record Technology does not contain patient data for at least 9 measures across 3 domains, then the eligible professional/group is required to report all of the measures for which there is Medicare data. At least one measure must have Medicare patient data.

<p><u>Qualified Clinical Data Registry:</u></p> <p>Individual Eligible Professionals</p>	<p>Report at least 9 measures, covering at least 3 NQS domains. Report each measure for at least 50% of applicable patients (Medicare and non-Medicare). At least 2 measures must be outcome measures. Or, if 2 outcome measures are not available, report on at least 1 outcome measure and at least one of the following types of measures: resource use, patient experience of care, efficiency/appropriate use, or patient safety.</p> <p>Measures are selected by the Qualified Clinical Data Registry</p>
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*\* Please refer to the final rule for additional reporting requirements, including information about the Web Interface reporting mechanism for group practices under the GPRO.*

### VALUE-BASED PAYMENT MODIFIER

CMS is required by law to apply the VBP modifier to all physicians in 2017. The final rule implements this mandate. CMS will continue to assign group practices and solo practitioners into one of two categories based on their PQRS participation. Those who are successful PQRS participants will be assigned to Category 1 and will have a modifier calculated from their quality and cost scores. Physicians in groups of 2-9 eligible professionals and solo practitioners in Category 1 will be held harmless from downward adjustments in 2017.

Group practices and solo practitioners who are not successful PQRS participants will be placed in Category 2. Group practices with 10 or more eligible professionals in Category 2 will automatically have their modifier set at -4%. Groups of 2-9 eligible professionals and solo practitioners in this category will have a modifier of -2%.

### Payment Adjustments under Quality Tiering for Category 1 (Successful PQRS Participants)

<b>Group Practices 10+ Eligible Professionals</b>				
	<b>Quality/Cost</b>	<b>Low Cost</b>	<b>Average Cost</b>	<b>High Cost</b>
	<b>High Quality</b>	+4.0(x)	+2.0(x)	0.0%
	<b>Average Quality</b>	+2.0(x)	0.0%	-2.0%
	<b>Low Quality</b>	0.0%	-2.0%	-4.0%
<b>Group Practices 2-9 Eligible Professionals and Solo Practitioners</b>				
	<b>Quality/Cost</b>	<b>Low Cost</b>	<b>Average Cost</b>	<b>High Cost</b>
	<b>High Quality</b>	+2.0(x)	+1.0(x)	0.0%

	<b>Medium Quality</b>	+1.0(x)	0.0%	0.0%
	<b>Low Quality</b>	0.0%	0.0%	0.0%

(x) = the upward payment adjustment factor which will be established after the performance period has ended. Because the VBP modifier is budget neutral, (x) is based on the aggregate amount of downward payment adjustments.

### PHYSICIAN COMPARE WEBSITE

Our societies remain encouraged with CMS' improvements to the Physician Compare website to ensure that the information contained in each provider's profile is accurate and current. We are also encouraged by CMS' decision to only publish on Physician Compare those measures that are statistically valid and reliable, and, therefore, most likely to help consumers make informed decisions about the Medicare professionals they choose to oversee their health care needs.

CMS finalized it will only include on Physician Compare those measures deemed valid, reliable, and for which the physician has a minimum sample size of 20 patients. Also, if a measure is not considered helpful and/or if consumers do not understand the relevance of the measure to their health care decision making process, CMS will not include these measures on the Physician Compare profile page. CMS also will not publicly post measures (PQRS, QCDR, other) that are in their first year of reporting, given concerns raised about their validity, reliability, accuracy, and comparability. After a measure's first year in the program, CMS will evaluate the measure to see if and when the measure is suitable for public reporting.

#### Physician Compare Finalized Policies

<b>Data Collection Year</b>	<b>Physician Compare Publication Year</b>	<b>Type of Data</b>	<b>Reporting Mechanism</b>	<b>Finalized Policies Regarding Quality Data on Physician Compare</b>
2015	2016	PQRS, PQRS GPRO Meaningful Use	PQRS: Web Registry, and Claims  EHR data	Will include and indicate satisfactory reporters in PQRS and Meaningful Use programs
2015	2016	PQRS	Registry, EHR, or claims	Include all 2015 PQRS measures for individuals collected through a registry, EHR, or claims.
2015	2016	PQRS	QCDR	Include all 2015 QCDR individual level data

2015	2016	PQRS, PQRS GPRO, ACO GPRO	Web, EHR,, registry, and administrative claims	<p>Include all 2015 PQRS GPRO measures reported via the web, EHR, and registry for group practices of 2 or more.</p> <p>All measures reported by ACOs (20 patient minimum sample size)</p>
2015	2016	CAHPS for PQRS, CAHPS for ACOs	CMS-certified CAHPS vendor	2015 CAHPS for PQRS for group practices of 2 or more and CAHPS data for ACOs

### **ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM**

CMS finalized that beginning in CY 2015, eligible professionals will not be required to ensure that their health IT products are recertified to the most recent version of the electronic specifications for clinical quality measures. This proposal changes CMS’ policy as outlined in the 2014 PFS final rule, where eligible professionals are currently required to use the most recent version of electronic specifications for quality measures, as well as, the health IT certified for these specifications. Eligible professionals must still report the most recent version of the electronic specifications for the clinical quality measures.

### **MORE INFORMATION**

Additional information on the final rule will be posted on our websites. In the meantime, questions should be directed to Brad Conway, Vice President of Public Policy, ACG, at 301-263-9000 or [bconway@gi.org](mailto:bconway@gi.org); Joshua Keepes, Director of Regulatory Affairs, AGA, at 240-482-3223 or [jkeepes@gastro.org](mailto:jkeepes@gastro.org); Lakitia Mayo, ASGE, Director of Health Policy and Quality, at 630-570-5641 or [lmayo@asge.org](mailto:lmayo@asge.org).