Final 2018 Medicare Physician Fee Schedule Summary

General Payment Updates

Conversion Factor and RVU Changes

The overall update to payments under the Physician Fee Schedule (PFS) based on the finalized Calendar Year (CY) 2018 rates will be +0.41 percent compared to 2017. This update reflects the positive 0.50 percent update established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). However, CMS must also meet statutory requirements for annual reductions in PFS expenditures resulting from adjustments to relative values of misvalued codes. CMS fell short of the required misvalued code target, and as a result the conversion factor is reduced by 0.09 percent. After applying these adjustments, and the budget neutrality adjustment to account for changes in Relative Value Units (RVUs), as required by law, the final 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor (CF) of $35.89. The 2018 Anesthesia CF is $22.19, which is a slight increase from the 2017 CF of $22.05. As a result of CMS's collective proposals in this rule, most specialties would receive neutral or very minor payment adjustments. For more detail on specialty specific payments, refer to Table 50: CY 2018 PFS Estimated Impact on Total Allowed Charges by Specialty (p. 1152).

As with every year, CMS finalized a myriad of minor modifications to the inputs and RVUs of particular codes. CMS did not finalize its proposal to use the most recent data for the CY 2018 malpractice RVUs and to align the update of malpractice premium data and malpractice Geographic Practice Cost Indices to once every three years. Additionally, for 2018, CMS is finalizing the values for individual services that generally reflect the expert recommendations from the RUC without as many refinements as CMS made in recent years. CMS has faced scrutiny over placing such emphasis on the RVS Update Committee (RUC) recommendations and CMS notes it will continue engage with numerous stakeholders with regard to its approach for accurately valuing codes.

Hospital Outpatient Department Payment Rates

The Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the Outpatient Prospective Payment System (OPPS) beginning January 1, 2017. For CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services. However, for CY 2018 CMS is finalizing a reduction to the current PFS payment rates for these items and services by 20 percent. CMS currently pays for these services under the PFS based on a percentage of the OPPS payment rate. Specifically, the final policy will change the PFS payment rates for these services from 50 percent of the OPPS payment rate to 40 percent of the OPPS rate. CMS believes that this adjustment will provide a more level playing field for competition between hospitals and physician practices by promoting greater payment alignment. This has been a controversial topic and hospitals are responding with harsh criticism.

Changes to the Medicare Shared Savings Program (MSSP)

Three-day SNF Waiver Application Changes

CMS finalized two policies designed to ease burdens associated with the application for the three-day Skilled Nursing Facility (SNF) waiver. CMS will no longer require the narrative describing any financial relationships that exist between the ACO, SNF affiliates, and acute care hospitals. The waiver does not protect or require such a relationship, nor does it permit any relationship that would otherwise be liable under current fraud and abuse laws; and, therefore, the narrative is not useful for the purposes of whether to grant a waiver. Second, CMS believes requiring the applying ACO to demonstrate that each of their intended SNF affiliates has a three or higher star rating under the CMS five-star Quality Rating System with documentation is unnecessary because CMS checks that itself when the application is reviewed. Therefore, the agency is removing this requirement as part of the SNF waiver application. However, CMS clarifies that the agency retains the requirement for SNF affiliates to have and maintain a three star or higher rating.

Initial MSSP Application Changes

CMS finalized a policy to remove the requirement to submit supporting documents or narratives as part of the application process, and alternatively CMS would request these materials if additional information is needed. This includes narratives corresponding to required processes and patient centeredness criteria, the ACO's organization and management structure, how the ACO would distribute shared savings, and how the ACO's proposed plan would achieve the specific goals of shared savings. CMS intends to retain all requirements related to ACO eligibility and public reporting.

New Primary Care Codes for MSSP Assignment

MSSP assignment is based on where beneficiaries receive the plurality of their primary care, which is defined by a specific set of billing codes identified and periodically updated by CMS. The agency finalized a policy to modify the list of primary care codes used for MSSP assignment to include new primary care codes that were added to Medicare in recent years. Specifically, beginning in 2018 for the performance year 2019 and subsequent years the agency added the following codes to the list of primary care codes used for MSSP assignment:

- Complex CCM codes 99487 and 99489, CCM add on-code G0506
- Behavioral health integration codes G0502, G0503, G0504, G0507

CMS states it will consider whether additional codes, including Advance Care Planning codes 99497 and 99498, should be added to the definition of primary care services in future rulemaking for purposes of assignment of beneficiaries to ACOs under the Shared Savings Program.

Assignment Modifications for ACOs with RHC and FQHC Participants

The 21st Century Cures Act requires the Secretary of Health and Human Services to assign beneficiaries to MSSP ACOs based on their utilization of primary care services furnished by physicians and also increasingly on their utilization of services furnished by Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs), effective beginning with the 2019 performance year. As such, CMS finalized the following modifications to the MSSP assignment process, which are effective beginning with the 2019 performance year. Specifically, CMS will:

- Eliminate the requirement for ACOs that include an RHC or FQHC as an ACO participant to provide an attestation identifying physicians who directly provide primary care services in each RHC or FQHC that is an ACO participant and/or ACO provider/supplier in the ACO. Therefore, submission of National Provider Identifiers (NPIs) or other identifying information will no longer be necessary.
- Treat a service reported on an RHC or FQHC claim as if it were a primary care service performed by a primary care physician under the assignment methodology in §425.402
- Include all RHC and FQHC claims in step one of assignment.
- Remove revenue center codes from the definition of primary care services.

By removing the attestation requirement, CMS treats a service reported on an RHC or FQHC institutional claim as a primary care service furnished by a primary care physician. CMS notes that in considering all services billed under the Tax Identification Number (TIN) of the ACO participant RHC or FQHC, the agency will include services that do not meet the definition of primary care services, and such services would not be limited to those provided by a primary care physician, as defined under current program rules. Therefore, a beneficiary could be furnished services in an RHC and FQHC only by a nurse practitioner, physician assistant, clinical nurse specialist, or any other practitioner in an RHC and FQHC and still be eligible for assignment to the ACO. CMS notes that the agency may assess non-physician practitioner (NPP) claims and may consider whether services provided in RHCs/FQHCs by NPPs who provide primary care should be treated differently for purposes of beneficiary assignment than those provided by NPPs who supplement or support specialty practices. CMS will adjust all ACO benchmarks at the start of 2019 so that the ACO benchmarks reflect the use of the same assignment rules as will apply during that performance year.

Compliance with MSSP ACO TIN Exclusivity Requirement

MSSP guidelines require an ACO participant TIN that submits claims for primary care services used to determine an ACO's assigned beneficiary population to be exclusive to one ACO. A participant TIN that does not bill for those services does not have to be exclusive to one ACO. As part of the MSSP application and annual update process, CMS checks TINs that are being added to an ACO to determine if the TIN may participate with multiple ACOs or if it needs to be exclusive to one ACO. During the performance year, CMS also monitors TIN/ACO overlap as part of its assignment algorithm process. Through CMS monitoring, the agency has discovered instances where an ACO participant TIN that had been approved to participate in multiple ACOs subsequently began billing for primary care services used in assignment during a benchmark or performance year.

Rather than the current policy under which an ACO may be required to remove an overlapping ACO participant and recertify its ACO participant list for the performance year (thus necessitating redetermination of beneficiary assignment and delays in or revisions to benchmark or performance year calculations), CMS believes it would be less disruptive for ACOs if the agency permitted more flexibility to ensure stability during the performance year. Therefore, CMS finalized its proposal and the new TIN exclusivity policy stipulates that overlapping TINs that begin billing for services used in assignment during a benchmark or performance year (including claims for services furnished during the benchmark of performance year but submitted during the three-month claims runout) will remain on the ACO participant lists for all affected ACOs for the remainder of the performance year in which CMS determines that an overlap exists. This avoids the TIN to have to select one ACO during the performance year and obviates the need for CMS to recalculate program methodologies including assignment and benchmarks for affected ACOs.

To ensure that the TIN overlap does not inadvertently result in assignment of the same beneficiaries to multiple ACOs, CMS finalized a policy where the agency will exclude any claims for services used in assignment which are furnished by the overlapping TIN. Therefore, CMS would not consider any service billed through that TIN when performing beneficiary assignment for the applicable benchmark or performance year, including final assignment. ACOs with overlapping TINs could be subject to compliance actions from CMS, such as having to submit a corrective action plan for how the ACO intends to address the overlap issue. Finally, the affected ACOs will be required to resolve the overlap prior to recertification of their ACO participant lists for the subsequent performance year.

Quality Provisions

CMS finalizes a conforming change to the regulation text to clarify that going forward CMS has the authority to re-designate a measure as pay for reporting when significant changes to the CMS Web Interface measure set are made in the Quality Payment Program (QPP). Specifically, CMS is modifying

§425.502(a)(5) to include the right for the agency to re-designate a measure as pay-for-reporting when a substantive change to a CMS Web Interface measure that is used to assess quality performance for the Shared Savings Program is made under the QPP.

CMS also finalized needed adjustments to the quality reporting data validation process for ACOs, acknowledging that the changes CMS finalized in 2017 resulted in standards that may inappropriately penalize ACOs that make quality data reporting errors, which are unrelated to care quality and instead are due to misunderstandings in the measure reporting requirements. Specifically, CMS finalizes a policy to set the audit match rate threshold based on the median match rate (80 percent) for ACOs audited in calendar year 2016. If an ACO has a match rate below 80 percent, absent unusual circumstances, CMS would adjust the ACO's overall quality score proportional to the ACO's audit performance. For each percentage point difference between the ACO's match rate and the match rate considered passing the audit, the ACO's overall quality score would be adjusted downward by 1 percent. CMS continues the policy that if after the audit process CMS determines there is an audit match rate of less than 80 percent, the ACO may be required to submit a Corrective Action Plan (CAP).

Excluding Interim-Payments Made Under Demonstrations, Pilots or Time Limited Programs

CMS believes that use of interim payments made under a demonstration, pilot or time limited program could have an increasingly large effect on ACO benchmarks and performance year expenditure calculations in the future given widespread stakeholder interest in participating in alternative payment models and CMS interest in testing and expanding additional payment models that may lead to higher quality and more coordinated care at a lower cost to Medicare. CMS conducted a preliminary analysis that suggests interim non-claims based payments (i.e., payments that are subject to reconciliation at a later date) made under a demonstration, pilot, or time limited program can fluctuate significantly from quarter to quarter and may not reflect the actual final reconciled payment amount. Therefore, CMS is finalizing a policy that going forward only final non-claims based payments made under a demonstration, pilot or time limited program will be included in financial calculations related to benchmarks and performance year expenditures under the Shared Savings Program.

Therefore, CMS is revising the applicable regulations to make clear that CMS would include only final individually beneficiary identifiable payments made under a demonstration, pilot or time limited program in financial calculations related to establishing and updating benchmarks and determining performance year expenditures under the Shared Savings Program. This policy would be applied to calculations that are necessary to determine ACO performance for the 2018 performance year and subsequent performance years. For ACOs that are in the middle of an agreement period when this revised policy takes effect, CMS will adjust the benchmarks for these ACOs at the start of the 2018 performance year and each subsequent performance year so that the benchmark for the ACO reflects the use of the same payment information that would apply in expenditure calculations for the performance year.

Therefore, when calculating expenditures for performance years before 2018, CMS includes all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot, or time limited program. When calculating expenditures for performance year 2018 and subsequent performance years, CMS would only include individually beneficiary identifiable payments made under a demonstration, pilot or time limited program that are final and not subject to further reconciliation. To be consistent with treatment of claims-based payments, such final payments would have to be available in the separate CMS system by the end of the three-month claims run out period.

Notably and in response to NAACOS comments, CMS states they are exploring improvements to feedback reports and data files provided to ACOs to increase program transparency. "We appreciate the suggestions regarding including payments under a demonstration, pilot, or time limited program in the financial reports, and we will take them under advisement as we work to further refine the reports."

E/M and Care Management Services
CMS acknowledges the need to revise guidelines and documentation requirements for billing evaluation and management (E/M) services. The agency sought feedback on ways to reform the guidelines, reduce associated burdens, and better align E/M coding and documentation with the current practice of medicine. CMS states it will consider the best approaches for such collaboration, and it will take the public comments received into account as the agency considers developing proposals for future rulemaking. The agency notes that a comprehensive reform of E/M documentation guidelines would likely require a multi-year, collaborative effort among stakeholders.

For CY 2018, the CPT Editorial Panel is creating CPT codes 99492, 99493, 99494 and 99484 to describe payment for psychiatric collaborative care services currently covered by Medicare using G-codes (G0502, G0503, G0504) and behavioral health integration service G0507, respectively. CMS finalized its proposal to adopt the CPT codes and no longer use the G-codes, effective for claims with dates of service beginning January 1, 2018.

Care Management in RHCs and FQHCs
CMS finalized revisions to care management service payments for RHCs and FQHCs. Effective January 1, 2018, RHCs and FQHCs will use two new codes to bill for Chronic Care Management (CCM), behavioral health integration (BHI) and the Psychiatric Collaborative Care Model (CoCM). The CCM code 99490 will be denied for RHCs and FQHCs for claims with dates of service on or after January 1, 2018. This new policy is in part a response to concerns that RHCs/FQHCs cannot bill for complex CCM, a policy which CMS finalized last year and is not changing. The agency establishes two new G-codes for use by RHCs and FQHCs:

- **G0511** a General Care Management code with the payment set at the average of the national non-facility PFS payment rates for CCM codes 99490 and 99487 and general BHI code 99484.
- **G0512** a Psychiatric CoCM code with the payment set at the average of the national non-facility PFS payment rates for psychiatric CoCM codes 99492 and 99493.

CMS will not apply a geographic adjustment to these codes. RHCs and FQHCs are required to submit claims for care management services on an institutional claim (electronically per the HIPAA compliant ANSI X12 837I or the Form CMS 1450, also known as the UB-04,) and are not authorized to bill care management services separately to the PFS. These services can be furnished under general, rather than direct, supervision of a physician, nurse practitioner, physician assistant, or certified nurse-midwife when they are furnished by auxiliary personnel, as defined in §410.26(a)(1). Certified Electronic Health Record (her) technology is a requirement for CCM, but it is not a requirement for general BHI or psychiatric CoCM services. To bill the new G0511 code, an RHC or FQHC must meet the requirements for either CCM (CPT 99490 or CPT 99487) or general BHI (CPT 99484). If the requirements for CPT code 99484 are met, the code can be billed and certified EHR technology is not required. Additional information on the new care management codes for RHCs and FQHCs is available on this CMS website for RHCs, and on this CMS website for FQHCs.

Patients Over Paperwork Initiative: Retroactive Changes to PQRS and Value Modifier Requirements
CMS recently launched the "Patients Over Paperwork" Initiative, a cross-cutting, collaborative process that evaluates and streamlines regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. This effort emphasizes a commitment to removing regulatory obstacles that get in the way of providers spending time with patients. The Medicare PFS final rule includes the following as part of this initiative:

- Reducing reporting requirements
- Removing downward payment adjustments based on performance for practices that meet minimum quality reporting requirements

This comes mainly from the reduced requirements for the Physician Quality Reporting System (PQRS) and the Value-Based Payment Modifier penalties, which CMS changes retroactively to reduce burden

particularly on small practices by reducing requirements, effectively allowing more providers the opportunity to avoid penalties under these programs for 2018.

Physician Quality Reporting System

CMS finalizes a policy to retroactively modify the satisfactory reporting criteria for the CY 2016 reporting period for purposes of the 2018 PQRS payment adjustment. Specifically, CMS lowers the requirement from nine measures across three National Quality Strategy (NQS) domains to six measures with no domain or cross-cutting measure requirement. For group practices, this applies to the following reporting mechanisms: qualified registry; Qualified Clinical Data Registry (QCDR); direct EHR product; and EHR data submissions vendor product. CMS also removes the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS survey requirement for group practices comprised of 100 or more eligible professionals (EPs). It is important to note that no changes are made for the Web Interface criteria in this rule.

These changes will allow more clinicians to avoid the 2018 PQRS penalty, and they align reporting requirements (retroactively to the 2016 reporting year) with the MACRA Merit-Based Incentive Payment System (MIPS) quality reporting requirements. Tables 21 and 22 summarize the modifications to the requirements for avoiding the 2018 PQRS penalty for individual and group reporting (page 641, page 645). CMS clarifies that these changes also apply to individual EPs and group practices using the secondary reporting period available to clinicians if an ACO fails to report quality measures on behalf of such individual EPs or group practices for the applicable reporting period, during the CY 2016 reporting period for purposes of the 2017 and 2018 PQRS payment adjustments, as applicable. For more information on this policy, please refer to our 2017 Medicare PFS rule Summary.

Meaningful Use Clinical Quality Measurement for Eligible Professionals Participating in the EHR Incentive Program for 2016

Similar to the modifications made to PQRS requirements, CMS finalized a policy to change the reporting criteria for eligible professionals and groups who chose to electronically report clinical quality measures (CQMs) through the PQRS Portal for purposes of the Medicare EHR Incentive Program (Meaningful Use). Specifically, CMS lowers the requirement from nine CQMs covering at least three NQS domains to six CQMs with no domain requirement to better align criteria with the transition year requirements of theQPP. An eligible professional or group who satisfies the reporting criteria may qualify for the 2016 incentive payment and may avoid the downward payment adjustment in 2017 and/or 2018, depending on the eligible professional or group's applicable EHR reporting period for the payment adjustment year.

CMS does not make changes to the Medicaid EHR Incentive Program criteria in this rule, however the agency makes corresponding changes in the 2018 Hospital Inpatient Prospective Payment System rule. For 2017, Medicaid eligible professionals are required to report on any six CQMs that are relevant to the EP's scope of practice.

Value-Based Payment Modifier

Finally, CMS makes similar changes to the Value-Based Payment Modifier (Value Modifier) requirements for the 2018 payment year, applicable retroactively to the 2016 reporting year:

- Reduces the automatic downward adjustment for groups and solo practitioners in Category 2 (those who do not meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50 percent of the group's EPs meet the criteria as individuals) to negative 2 percent for groups with 10 or more EPs and at least one physician, and negative 1 percent for groups with between two and nine EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs.
- Holds all groups and solo practitioners who are in Category 1 (those who meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups

that have at least 50 percent of the group's EPs meet the criteria as individuals) harmless from downward payment adjustments under quality tiering for the last year of the program (the 2018 payment year).

- To provide a smoother transition to the MIPS and to align incentives across all groups and solo practitioners, reduces the maximum upward adjustment under the quality-tiering methodology to two times an adjustment factor (+2.0x) for groups with 10 or more EPs. This is the same maximum upward adjustment under the quality-tiering methodology CMS finalized and will maintain for groups with between two and nine EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs.
- CMS states it will not report 2018 Value Modifier data in the Physician Compare downloadable database as this would be the first and only year such data would have been reported. However, to promote transparency they will continue to make the Value Modifier public use and research identifiable files available.

See Tables 23-26 (pages 736-737) for a summary of these final policies and comparisons to previous requirements finalized by CMS. As a reminder, CMS waives Value Modifier participation for those in the Pioneer and Next Generation ACO Models, as well as the Comprehensive ESRD Care Initiative, and the Oncology Care Model. In general, on behalf of its ACO participant TINs, an ACO submits PQRS quality data using the Group Practice Reporting Option (GPRO) Web Interface. Successful reporting allows the ACO, and its participant TINs, to avoid penalties and potentially earn bonuses under PQRS and the Value Modifier. For more information on how Value Modifier policies apply to ACOs, please visit our Value Modifier resource page including our Value Modifier resource, which provides an overview of the 2018 Value Modifier requirements for ACOs.

Medicare Telehealth and Remote Patient Monitoring Services

For 2018, CMS is finalizing the addition of several codes to the list of approved telehealth services, including:

- HCPCS code G0296 (visit to determine low dose computed tomography [LDCT] eligibility)
- CPT code 90785 (Interactive Complexity)
- CPT codes 96160 and 96161 (Health Risk Assessment)
- HCPCS code G0506 (Care Planning for Chronic Care Management)
- CPT codes 90839 and 90840 (Psychotherapy for Crisis)

CMS is also finalizing a policy to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners. Finally, CMS is also finalizing separate payment for CPT code 99091, which describes certain remote patient monitoring. Starting in 2018 this code can be billed separately allowing a physician or other qualified professional to bill and receive payment for monitoring biometric patient data transmitted digitally by a patient or caregiver. The code allows for $57 per month per patient for a cumulative 30 minutes of monitoring.

- CPT code 99091: Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time.

MACRA Patient Relationship Codes

MACRA requires CMS to develop care episode and patient condition groups, and classification codes for such groups for use in MIPS cost analysis. To facilitate the attribution of patients and episodes to one or more clinicians, section 1848(r)(3) of the Act requires the development of patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. The categories are required to include different relationships of the clinician to the patient and reflect various types of responsibility for and frequency of furnishing care. CMS posted the operational list of patient relationship categories on May 17, 2017 and they are as follows:

- Continuous/Broad Services
- Continuous/Focused Services
- Episodic/Broad services
- Episodic/Focused Services
- Only as Ordered by Another Clinician

In the proposed rule, CMS sought comment on these categories in preparation for potential subsequent revisions. In this rule, CMS finalizes the Level II HCPCS Modifiers listed in Table 27 as the patient relationship codes for use on a voluntary basis starting in 2018. Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, would include the applicable HCPCS modifiers listed in Table 27, as well as the National Provider Identifier (NPI) of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner), again on a voluntary basis. CMS plans to provide more clinician education on use of the modifiers during this time. CMS also clarifies the modifiers would also not be tied or related to intensity of services (E/M services).

Medicare Diabetes Prevention Program (MDPP)

The MDPP expanded model is an expansion of CMS' Center for Medicare and Medicaid Innovation's (Innovation Center) Diabetes Prevention Program (DPP) model test under the authority of section 1115A of the Act. The Secretary expanded the DPP model test under the authority of section 1115A(c) of the Act. For further information on the DPP model test, and the associated National DPP administered by the Centers for Disease Control and Prevention (CDC), please review our 2017 MPFS final rule summary and the Innovation Center and CDC websites. The aim of the MDPP expanded model is to continue to test a method of prevention of the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes as defined by the MDPP beneficiary eligibility criteria which was finalized in the 2017 Medicare PFS rule. Services available through the MDPP expanded model are MDPP services furnished in community and health care settings by coaches, such as trained community health workers or health professionals. The MDPP services are covered as preventive services under Medicare.

In the 2017 PFS final rule, CMS established a January 1, 2018 start date for the MDPP. In this final rule, CMS makes MDPP services available on April 1, 2018 to provide more time for the agency to ensure MDPP suppliers have sufficient time to enroll in Medicare after the effective date of the final rule. CMS also finalizes policies regarding eligibility criteria, payment for MDPP services, and MDPP supplier enrollment and compliance requirements.

Appropriate Use Criteria for Advanced Diagnostic Imaging

Section 218(b) of the Protecting Access to Medicare Act (PAMA) directs CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. The 2016 Medicare PFS final rule with comment period addressed the initial component of the new Medicare AUC program, specifying applicable AUC and established the process by which provider-led entities (PLEs) may become qualified to develop, modify or endorse AUC. The first list of qualified PLEs was posted on the CMS

website at the end of June 2016. The 2017 Medicare PFS final rule established specifications of qualified clinical decision support mechanisms (CDSMs) for use in the AUC program and specified the first list of priority clinical areas for the program. The first list of qualified CDSMs are available on the CMS website here. For more information on these proposals, please see our 2017 Final Medicare PFS Rule Summary. In this rule, CMS establishes the start date of the Medicare AUC program for advanced diagnostic imaging services. Specifically, CMS finalizes a start date for the Medicare AUC Program for Advanced Diagnostic Imaging. The Medicare AUC program will begin with an educational and operations testing year in 2020, requiring physicians to start using AUCs and reporting this information on their claims at that time. During this first year of the AUC program, CMS will pay claims for advanced diagnostic imaging services regardless of whether they correctly contain information on the required AUC consultation. This allows both clinicians and the agency to prepare for this new program. More information on the AUC program is available on the CMS website.