Medicare Physician Fee Schedule Proposed Rule for Calendar Year 2015

Summary of Key Provisions

On July 11, 2014, the Centers for Medicare and Medicaid Services (CMS) published in the *Federal Register* *Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models and Other Revisions to Part B for CY 2015; Proposed Rule*. Comments on the proposals found in the Physician Fee Schedule (PFS) can be submitted to CMS through September 2, 2014.

An overview of key proposals in the PFS follows in the paragraphs below. AMGA will continue to analyze the proposals, and develop comments after consultation with members.

Medicare Telehealth Services

The Medicare program covers certain telehealth services paid under the PFS, when the proper conditions are met. The services must be provided via an interactive telecommunications system and the patient receiving the services must be located at an eligible originating site. When these conditions are met, Medicare will pay both an originating site fee and a separate payment to the practitioner furnishing the service.

CMS has established an annual process by which new services can be considered for addition to the list of services that Medicare covers for telehealth. For CY 2015, CMS proposes to add the following services to the telehealth list:

- CPT codes 90845 (Psychoanalysis); 90846 (family psychotherapy-without patient present); and 90847 (family psychotherapy-conjoint psychotherapy-with patient present;
- CPT codes 99354 (prolonged service in the office or other outpatient setting requiring direct contact beyond the usual services; first hour); and 99355 (prolonged service in the office or other
- outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes)
- HCPCS codes G0438 (annual wellness visit; includes personalized prevention plan of service, initial visit); and G0439 (annual wellness visit, includes a personalized prevention plan of service, subsequent visit).

The proposed rule also lists services that stakeholders requested be added, but the agency felt did not meet the criteria for inclusion on the Medicare telehealth list.

Chronic Care Management (CCM)

CMS states that they are committed to supporting primary care and care management for their potential to improve the health of patients and reduce the growth of expenditures in the Medicare program. Accordingly, in the CY 2014 PFS, the agency finalized a policy to pay separately for care management services, non-face-to-face, for patients with two or more chronic conditions beginning in 2015. CMS proposes a payment rate of $41.92 for the CCM code, to be billed no more frequently than once a month. As finalized in the CY 2014 PFS, the CCM service must include:

- Access to CCM services 24/7, which means providing beneficiaries with a means to make timely contact with health care providers to address urgent chronic care needs;
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments;
- Care management for chronic conditions including systematic assessment of patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications;
- Creation of a patient-centered care plan document to assure that care is provided in a way that is congruent with patient choices and values;
- Management of care transitions between and among health care providers and settings;
- Coordination with home and community-based clinical service providers, as appropriate;
- Enhanced opportunities for a beneficiary and any relevant caregiver to communicate with the practitioner.

The billing requirements include:

- Informing the beneficiary about the availability of the CCM services and obtain written agreement to have the services provided;
- Documenting in the patient's medical record that all of the CCM services were explained and offered to the patient, noting the patient's decision;
- Providing the beneficiary a written or electronic copy of their care plan;
- Informing the beneficiary of the right to discontinue CCM services at any time;
- Informing the beneficiary that only one practitioner can furnish and be paid for these services during the 30-day period.

For CY 2015 CMS expands this list by proposing to require use of an electronic health record (EHR) to furnish these CCM services. The EHR platform must include an electronic care plan that is accessible to all providers within the practice, as well as exchanged with providers outside the practice.

CMS also proposes to remove the requirement that the clinical staff person furnishing CCM services must be a direct employee of the practitioner or the practitioner's practice in order to count toward the CCM time requirement. For services provided by clinical staff, CMS is proposing to modify the supervision requirement to general supervision, rather than direct supervision.

Medicare Shared Savings Program (MSSP)

Although additional rulemaking is expected in the near-term on the Medicare Shared Savings Program, the PFS proposed rule makes some changes to certain aspects of the program including a proposal to reward year-to-year improvements in quality performance scores on individual measures by adding a

quality improvement measure that adds bonus points to each of the four quality measure domains based on improvement, and CMS seeks on their proposed approach. Discussion on the approach begins on page 40475 of the proposed rule.

In response to feedback from stakeholders regarding "topped out" measures, CMS proposes to modify their benchmarking methodology to use flat percentages to establish the benchmark for a measure when the national fee-for-service data results in the 90th percentile being greater than or equal to 95 percent.

CMS is also proposing revisions to the quality measures to reflect up-to-date clinical guidelines and practice, reduce duplicative measures, increase focus on claims-based outcome measures, and reduce the reporting burden for Accountable Care Organizations (ACOs). The proposed changes would increase the number of measures calculated through claims, and decrease the number of measures reported by the ACO through the GPRO web interface. The total number would increase from 33 to 37. The new measures focus on avoidable admissions for patients with multiple chronic conditions; heart failure and diabetes; depression remission; all cause readmissions to a skilled nursing facility; and stewardship of patient resources (CAHPS measure).

CMS seeks public comment on future quality measures for consideration that address:

- Gaps in measures and additional specific measures
- Measures for retirement ("topped out" measures)
- Caregiver experience of care
- Alignment with the Value-Based Payment Modifier
- Assessment of care in the frail elderly population
- Utilization
- Health outcomes
- Public health

CMS is also seeking suggestions on ways that they might implement EHR-based reporting of quality measures in the MSSP for consideration in future rulemaking.

Valuing New, Revised, and Potentially Misvalued Codes

CMS proposes alternative processes for evaluating codes under the physician fee schedule. The provide three options and evaluates the pros and cons of the following approaches: 1) Propose work and malpractice (MP) RVUs and direct PE inputs for all new, revised and potentially misvalued codes in a proposed rule; 2) propose changes in work and MP RVUs and direct PE inputs in the proposed rule for new, revised, and potentially misvalued codes for which they receive RUC recommendations in time; continue to establish interim final values in the final rule for other new, revised, and potentially misvalued codes; or 3) increase CMS efforts to make available more information about the specific issues being considered in the course of developing values for new, revised and potentially misvalued codes to increase transparency, but without making changes to the existing process for establishing values.

CMS chooses the first option to make all changes in the work and MP RVUs and the direct PE inputs for new, revised and potentially misvalued services under the PFS by proposing the changes in the proposed rule, beginning with the PFS proposed rule for CY 2016. CMS proposes to include proposed values for all new, revised and potentially misvalued codes for which they have complete RUC recommendations by

January 15 of the preceding year. For the CY 2016 rulemaking process, CMS would include in the proposed rule proposed values for all services for which they have RUC recommendations by January 15, 2015. For those codes for which CMS does not receive the RUC recommendations by January 15th of a year, they would delay revaluing the code for one year and include proposed values in the following year's rule.

CMS is asking stakeholders the following questions on the proposal:

- Is this proposal preferable to the present process? Is another one of the alternatives better?
- If they were to implement this proposal, is it better to move forward with the changes, or is more time needed to make the transition such that implementation should be delayed beyond CY 2016? What factors should we consider in selecting an implementation date?
- Are there alternatives other than the use of G-codes that would allow us to address the annual CPT changes through notice and comment rather than interim final rulemaking?

CMS proposes to eliminate the refinement panel process because CMS believes "there would no longer be interim final values except for a very few codes that describe totally new services."

Physician Compare Website

A provision in the Affordable Care Act requires CMS to establish a Physician Compare website populated with information on Medicare-enrolled physicians and other eligible providers who participate in the Physician Quality Reporting System (PQRS). CMS is required to create a plan for making quality and patient experience data publicly available, with a report due to Congress by January 1, 2015 on their efforts.

For 2015, CMS proposes to expand public reporting of group-level measures by making all 2015 PQRS Group Practice Reporting Option (GPRO) web interface, registry, and EHR measures for group practices of two or more eligible professionals (EPs) and Accountable Care Organizations (ACOs) available for public reporting on Physician Compare in 2016. These data points must meet the minimum sample size of 20 patients and be deemed statistically valid and reliable.

As in 2014, CMS proposes to publicly report 20 PQRS individual measures reported in 2013 and collected through a registry, EHR, or claims in 2015. The agency proposes an expansion of measures for individual EPs by making all 2015 PQRS individual measures collected through a registry, EHR, or claims available for public reporting on Physician Compare in late 2016, if feasible.

The agency also plans to provide information on whether EPs are satisfactory reporters under PQRS, have adopted EHR, and participate in the PQRS cardiovascular prevention program measures group in support of the Million Hearts Campaign through notations on their profile.

CMS also proposes to publicly report 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data for PQRS and group practices of two or more EPs, as well as the CAHPS data for ACOs for those who meet the sample size requirements and collect their data through a CMS-specified CAHPS vendor, in 2016. For 2016, CMS also proposes to make available on Physician Compare the 2015 Qualified Clinical Data Registry (QCDR) measures data collected at the individual measure level or aggregated to a higher level, if technically feasible.

Tables 19 and 20 in the proposed rule summarize previously finalized policies for public reporting on the Physician Compare website and the Proposed Data for Public Reporting, respectively.

Electronic Health Record (EHR) Incentive Program

CMS states that they are seeking to avoid redundant or duplicative reporting otherwise required in other programs, and accordingly, are continuing to take steps to establish alignment among various quality reporting and payment programs that include the submission of clinical quality measures (CQMs). In 2014, the agency finalized their proposal to require EPs who seek to report CQMs electronically under the Medicare EHR Incentive Program to use the most recent version of the electronic specifications for the CQMs and have CEHRT that is tested and certified to the most recent version of the electronic specifications for the CQMs. Based on stakeholder feedback concerning the burden of recertification, CMS proposes for 2015 that EPs would not be required to ensure that their CEHRT products are recertified to the most recent version of the electronic specifications for the CQMs; however, EPs must still report the most recent version of the electronic specifications for the CQMs.

Physician Payment, Efficiency, and Quality Improvements—PQRS

PQRS is a pay-for-reporting program that uses a combination of incentive payments and downward payment adjustments to promote reporting of quality information by EPs. The program has provided payment incentives to individual EPs and group practices that have satisfactorily reported quality data, and will continue to do so through 2014. Significantly, in 2015, a downward payment adjustment will apply to EPs and groups that do not satisfactorily report data on quality measures or satisfactorily participate in a Qualified Clinical Data Registry. The CMS proposals in this rule apply primarily to the 2017 PQRS payment adjustment, which will be based on calendar year (CY) 2015 reporting.

For 2015, CMS is proposing to add 28 new individual measures and two measures groups to fill existing gaps in measurement. The agency is also proposing to remove 73 measures from PQRS. In sum, the proposed changes bring the number of PQRS measures to 240.

The PQRS program requires that EPs report measures from each of the National Quality Strategy (NQS) domains. NQS domains include patient safety, person and caregiver-centered experience and outcomes, communication and care coordination, effective clinical care, community/population health, and efficiency and cost reduction.

Reporting of PQRS Measures for Individual EPs

For 2015, which would affect the 2017 payment adjustment, CMS is proposing that individual EPs report on nine measures covering three NQS domains. Also, EPs who see at least one Medicare patient in a face-to-face encounter must report measures from a newly proposed cross-cutting measures set that focuses on preventive services, found in Table 21. CMS includes the rationale for each cross-cutting measure proposed, and invites public comment on what other measures should be included in the proposed cross-cutting measure set for 2015 and beyond. Individual EPs can report through the usual methods including claims (though CMS has expressed a desire to move away from this method in the future), a registry, measures groups, or an EHR.

Reporting of PQRS Measures through the Group Practice Reporting Option (GPRO)

The GPRO, which utilizes a web interface for reporting is available to medical groups with 25 or more EPs. For 2015, CMS is proposing to reduce the 411 sample size previously used to complete the interface, to 248. This reduction should reduce the administrative burden of completing the interface. Groups with 25-99 EPs that previously reported on a sample size of 218 records will also have to report on a sample size of 248 in 2015.

Group practices that have at least one eligible professional who sees at least one Medicare patient in a face-to-face encounter and chooses to report via registry would also be required to report on at least two measures in the newly proposed PQRS cross-cutting measures set. If these group practices report using both a certified survey vendor (for CAHPS survey responses), only one cross-cutting measure would need to be reported.

In addition, CMS reiterates the requirement that EPs report on the most recent version of electronically specified clinical quality measures (CQMs) and the agency proposes that EPs not be required to ensure that their Certified EHR Technology (CEHRT) products are recertified to the most recent version of the electronic specifications for the CQMs.

CMS is also seeking public comment on their proposal to change the deadline by which a group practice must register to participate in the GPRO to June 30 of the applicable 12-month reporting period (from the current September 30 date). CMS states that this proposed change will allow them to provide timelier feedback to groups, while still providing more than 6 months to determine whether they should participate in the PQRS GPRO, or elect to participate in the PQRS program as individual EPs.

Concerning the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures, in 2014, CMS required that all groups with 100 or more EPs participating in GPRO select a CMS-certified survey vendor to administer the CAHPS for PQRS survey on their behalf, with the agency administering and funding the data collection for that year. CMS proposes that in 2015, group practices bear the cost of administering the CAHPS for PQRS survey measures through a CMS-certified survey vendor (optional for groups of 25-99 EPs), and invites public comment on the proposal.

Physician Value-Based Payment Modifier

The Affordable Care Act (ACA) requires that CMS establish a value-based payment modifier (VBM) that provides differential payments under the PFS based upon the quality of care furnished, compared to its cost during a performance period. Performance along the continuum runs from high cost/low quality to low cost/high quality, with payment differentials determined by placement along the continuum based on quality and cost data. The law requires budget neutrality, and that the VBM will be applied to all physicians by January 1, 2017.

CMS proposes to increase the downward adjustment from -2.0 in the 2016 payment adjustment period (based on 2014 performance) to -4.0 percent for the 2017 payment adjustment period (based on 2015 performance). Accordingly, CMS is also proposing to increase the maximum upward adjustment in the 2017 payment adjustment period to +4.0 for groups and solo practitioners who fall into the high/quality, low cost category. An average payment adjustment would be +2.0.

CMS proposes a two-category approach as they classify groups and solo practitioners subject to the 2017 VBM. This approach is based on whether and how groups and solo practitioners participate in the PQRS. CMS proposes that Category 1 would include those groups with two or more EPs that meet the requirements for satisfactory reporting of data on PQRS quality measures via the PQRS GPRO web interface, EHR, or registry reporting options. CMS also includes in Category 1 groups that have not registered to participate in the PQRS GPRO in 2015, but at least 50 percent of the group's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individual EPs through the use of claims, EHR, or registry reporting. Groups in which 50 percent of EPs have satisfactorily participated in the PQRS QCDR would also be part of Category 1.

CMS proposes that Category 2 would include groups and solo practitioners that are subject to the 2017 VBM but do not fall within Category 1.

For the 2017 VBM, CMS is also proposing to apply the quality-tiering methodology to all groups and solo practitioners in Category 1; however, CMS also proposes that groups with between two and nine EPs and solo practitioners would only be subject to upward or neutral payment adjustments for the 2017 calculation.

In 2017, CMS also proposes to apply the VBM to EPs in groups with two or more EPs and to physicians and non-physician practitioners who are EPs that participate in ACOs, utilizing the PQRS GPRO web interface measures to determine the quality of care composite for groups and solo practitioners, in addition to those who are participating in Pioneer ACOs or the Comprehensive Primary Care initiative, or other Innovation Center models during the performance period.

CMS is also proposing to expand the informal inquiry process for the VBM beginning with the 2015 payment adjustment period that would establish a brief period for a group or solo practitioner to request correction of a suspected error in determining their VBM payment adjustment.

In a related matter, CMS states in the proposed rule that it will be providing Quality Resource Use Reports to all solo practitioners and groups of physicians in the late summer or early fall of 2014, reflecting data collection from 2013, so that those who are subject to the VBM will have some sense of how they will fare within the implementation framework outlined in the proposed rule.

Payment of Secondary Interpretation of Images

CMS is seeking comment to assess whether it should expand the number of circumstances under which it allows Medicare payments for second professional components for radiology services and if doing so would reduce duplicative advanced imaging studies. CMS is asking the following questions specifically:

- For which radiology services are physicians currently conducting secondary interpretations, and what, if any, institutional policies are in place to determine when existing images are utilized? To what extent are physicians seeking payment for these secondary interpretations from Medicare or other payers?
- Should routine payment for secondary interpretations be restricted to certain high-cost advanced diagnostic imaging services, such as those defined as such under section 1834(e)(1)(B) of the Act, for example, diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography)?
- How should the value of routine secondary interpretations be determined? Is it appropriate to apply a modifier to current codes or are new HCPCS codes for secondary interpretations necessary?
- CMS believes most secondary interpretations would be likely to take place in the hospital setting. Are there other settings in which claims for secondary interpretations would be likely to reduce duplicative imaging services?
- Is there a limited time period within which an existing image should be considered adequate to support a secondary interpretation?
- Would allowing for more routine payment for secondary interpretations be likely to generate cost savings to Medicare by avoiding potentially duplicative imaging studies?
- What operational steps could Medicare take to ensure that any routine payment for secondary interpretations is limited to cases where a new imaging study has been averted while minimizing

undue burden on providers or Part B contractors? For instance, steps might include restricting physicians' ability to refer multiple interpretations to another physician that is part of their network or group practice, requiring that physicians attach a physician's order for an averted imaging study to a claim for a secondary interpretation, or requiring physicians to identify the technical component of the existing image supporting the claim.

Removal of Employment Requirements for Services Furnished "Incident to" Rural Health Clinics (RHC) and Federally Qualified Health Center (FQHC) Visits

In an attempt to give RHCs and FQHCs additional flexibility without adversely affecting the quality or continuity of care, CMS is proposing to remove the requirement that services furnished "incident to" an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC and instead allow nurses, medical assistants, and other auxiliary personnel to furnish "incident to" services under contract in RHCs and FQHCs.

Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models

In the Affordable Care Act (ACA), the Secretary of Health and Human Services was tasked with evaluating each payment/delivery model established in the Center for Medicare and Medicaid Innovation (CMMI). Evaluations will consider such factors as outcomes, clinical quality, adverse effects, access, utilization, patient and provider satisfaction, sustainability, potential for the model to be applied on a broader scale, and total cost of care. CMS proposes to exercise the authority that it was awarded in the ACA to set requirements for states and other entities participating in CMMI models to collect and report information that it has deemed necessary for those evaluations. CMS proposes to require model participants and providers, and suppliers working under the models, to produce individually identifiable health information and other information deemed necessary to conduct the statutorily mandated research. That research will include the monitoring and evaluation of such models.

CMS views efforts to improve quality and reduce costs as being more likely to be successful if signals are aligned across payers. In selecting which models to choose for CMMI testing, the ACA allows the Secretary to consider "whether the model demonstrates effective linkage with other public sector or private sector payers." Multi-payer models will conduct quality measurement across all patients regardless of payer in order to maximize alignment and increase efficiency. Construction of multi-payer quality measures requires the ability to identify all individuals subject to the model test regardless of payer. The absence of identifiable data from private payers would result in considerable limitations on the level of evaluation conducted. Therefore, CMS proposes to require the submission of identifiable health and utilization information for patients of private payers treated by providers and suppliers participating in CMMI model testing when an explicit purpose of the model test is to engage private sector payers. If finalized, this regulation will provide clear legal authority for Health Insurance Portability and Accountability Act-Covered Entities to disclose any required protected health information.

Wherever possible, evaluations will make use of claims, assessment, and enrollment data available through CMS' existing administrative systems. However, evaluations will generally also need to include additional data not available through those systems.

As such, depending on the particular project, CMS or its contractor will require the production of the minimum data necessary to carry out the statutorily mandated research. Such data may include the identities of the patients served under the model, relevant clinical details about the services furnished and outcomes achieved, and any confounding factors that might influence the evaluation results

achieved through the delivery of such services. For illustrative purposes, below are examples of some of the types of information that could be required to carry out an evaluation, and for which the evaluator would need patient level identifiers.

- Utilization data not otherwise available through existing CMS systems
- Beneficiary, patient, participant, family, and provider experiences
- Beneficiary, patient, participant, and provider rosters with identifiers that allow linkages across time and datasets
- Beneficiary, patient, participant, and family socio-demographic and ethnic characteristics
- Care management details, such as details regarding the provision of services, payments or goods to beneficiaries, patients, participants, families, or other providers
- Beneficiary, patient, and participant functional status and assessment data
- Beneficiary, patient, and participant health behaviors
- Clinical data, such as, but not limited to lab values and information from EHRs
- Beneficiary, patient, participant quality data not otherwise available through claims
- Other data relevant to identified outcomes—for example, participant employment status, participant educational degrees pursued/achieved, and income

Reports of Payments or Other Transfers of Value to Covered Recipients

CMS proposes the following changes to reporting requirements and regulations under the Open Payments (Sunshine Act) program:

- Deleting the definition of "covered device" at §403.902.
- Deleting §403.904(g) and redesignating the remaining paragraphs in that section.
- Revising §403.904(c)(8) to require the reporting of the marketed name of the related covered and non-covered drugs, devices, biologicals, or medical supplies, unless the payment or other transfer of value is not related to a particular covered or non-covered drug, device, biological or medical supply.
- Revising §403.904(d) to require the reporting of the reporting of stock, stock options or any other options as distinct categories.

Data collection requirements would begin January 1, 2015 for applicable manufacturers and applicable group purchasing organizations.

Potentially Misvalued Services Under the Physician Fee Schedule

CMS proposes to add about 80 codes to the CMS list of potentially misvalued codes. CMS reviews high-expenditure services, by specialty, that have not been recently reviewed.

CMS also proposes to change the way they account for the infrastructure costs associated with radiation therapy equipment. CMS states this "proposal ensures that the way we account for infrastructure costs associated with medical equipment is the same across the PFS. This change would redistribute payment reduction to radiation therapy services to other physician fee schedule services." CMS also updates practice expense inputs for x-ray services to reflect that x-rays are currently done digitally.

Global Surgery

CMS proposes to transform all 10 and 90-day global codes to 0-day global codes beginning in 2017. CMS proposes to include all services provided on the day of surgery, and to pay separately for visits and

services actually furnished after the day of the procedure beginning in CY 2017. CMS cites the Office of the Inspector General to justify their decision, which has identified a number of surgical procedures that include more visits in the global period than are being furnished.

Definition of Colorectal Cancer Screening Tests

CMS proposes to eliminate cost sharing for anesthesia services provided during a colonoscopy by redefining "colorectal cancer screening test" to include anesthesia that is "separately furnished in conjunction with screening colonoscopies." Currently, anesthesia professionals bill Medicare separately for these services. Although Part B pays 100 percent for the colonoscopy service, beneficiaries currently pay co-insurance for the anesthesia service because that service is separately billed. If CMS adopts the proposal, they will provide a billing modifier to reflect the changed definition.

Payments for Physicians and Practitioners Managing Patients on Home Dialysis

The CMS proposal would make payment for home dialysis more consistent with dialysis provided at a center by allowing monthly capitation payment (MCP) physician or practitioner would bill for the age appropriate home dialysis MCP service (as described by HCPCS codes 90963 through 90966) for the home dialysis (less than a full month) scenario if the MCP physician or practitioner furnishes a complete monthly assessment of the End-Stage Renal Disease beneficiary and at least one face-to-face patient visit. CMS states "if a home dialysis patient was hospitalized during the month and at least one face to-face outpatient visit and complete monthly assessment was furnished, the MCP physician or practitioner should bill for the full home dialysis MCP service. We believe that this proposed change to home dialysis (less than a full month) provides consistency with our policy for partial-month scenarios pertaining to patients dialyzing in a dialysis center. If this proposal is adopted, we would modify the Medicare Claims Processing Manual to reflect the revised billing guidelines for home dialysis in the less than a full month scenario"

Clinical Laboratory Fee Schedule

As a result of the passage of section 216 of the Protecting Access to Medicare Act, CMS is not proposing any revisions to payment amounts for test codes on the Clinical Laboratory Fee Schedule based on technological changes. As a result CMS is required to implement a new Medicare payment system for clinical diagnostic laboratory tests based on private payor rates. Instead, CMS will establish through rulemaking the parameters for the collection of private payor rate information and other requirements to implement section 216.

Local Coverage Determination Process for Clinical Diagnostic Laboratory Tests

CMS is proposing a revised Local Coverage Determination (LCD) process for all new draft clinical diagnostic laboratory test LCDs published on or after January 1, 2015, as follows:

- Shortens the public comment period from 45 days to 30 days.
- Requires only an optional Carrier Advisory Committee meeting, no requirements for open stakeholder meeting.
- Publication of Comment/Response Document and final LCD within 45 calendar days of the close of the draft LCD comment period, instead of publication of Comment/Response Document and final LCD (no specified time of publication after the close of the comment period).
- Final LCD effective on the date of publication, instead of notice period of 45 calendar days with the final LCD effective the 46th calendar day.

Interested parties may still request reconsideration of an LCD, and an aggrieved party may further challenge an LCD, but overall, the proposals serve to limit the role of stakeholders in the LCD process.