

## **2013 Medicare Physician Fee Schedule Proposed Rule Summary**

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On Friday July 6, 2012, the Centers for Medicare and Medicaid Services (CMS) posted a display copy of the proposed Medicare Physician Fee Schedule (PFS) for 2013. The proposed rule updates payment policies and payment rates for services furnished under the PFS and includes changes to the quality reporting initiatives associated with the PFS – the Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, the Shared Savings Program, and the physician value-based payment modifier.

The rule in its entirety can be found [here](#). (Please note: The rule is scheduled to be published in the Federal Register on July 30, 2012 and the link will change). The addenda to the rule, including Addendum B, which lists the proposed RVUs for each CPT code, can be found [here](#). The provisions of the rule will be effective January 1, 2013 unless stated otherwise. Comments on the rule are due by COB September 4, 2012.

A chart listing the proposed PFS payment rates can be found [here](#).

The following summarizes the major provisions of the proposed rule.

### **SGR and Conversion Factor (CF) Impact**

The current CF, which expires on December 31, 2013, is \$34.0376. Without congressional action, the CF will be reduced by 27.4 % to \$24.7124 due to the SGR formula. Congress has prevented reductions in the CF due to the SGR formula for numerous years and it is anticipated that it will once again take similar action. Assuming that the SGR reductions are prevented by legislation, a 2013 CF of \$34.0376 was utilized for purposes of the payment projections in the prepared charts.

### **Specialty Impact**

Table 84 (see Attachment 1), extracted from the rule, provides a summary of the impact of the proposed changes in the rule by specialty. All of these changes are budget neutral in the aggregate which explains why the impact for all physicians (i.e., total row) is shown as zero. For most specialties, the most significant changes are those reflected in Columns C and E, Column C primarily reflects the final year of the 4-year transition to the revised practice expense methodology. Column E reflects the impact of the proposal to increase payment to community physicians and other practitioners for managing a patient following a discharge from a hospital or skilled nursing facility. Under the budget neutrality requirement, the increase in payments for this new service is “paid for” by reductions in payments for all other specialties. The data shown in the attached specialty charts does not include the effect of the January 2013 conversion factor change due to the SGR formula.

The overall impact of the 2013 proposed rule on hematology services is shown below.

**TABLE 84: CY 2013 PFS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty by Selected Proposal\***

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges (mil)	Baseline (PPIS transition, new utilization and other factors)	Updated Equipment Interest Rate Assumption	Discharge Transition Care Management	Input Charges for Certain Radiation Therapy Procedures	Combined Impact
TOTAL	\$85,485	0%	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	\$1,891	0%	1%	-2%	0%	-1%

Attached to this summary are several charts comparing payment for evaluation and management services (E/M) and hematology/oncology procedural services in 2012 to 2013. Overall, E/M services will increase, with office-based E/M services increasing by 1 – 2 percent and hospital care services increasing by approximately 1 percent. Most procedural codes, including infusion and injection codes and apheresis services in the hospital will see reductions of 1 – 2 percent. Most chemotherapy codes are seeing reductions of about 3 percent, which are largely due to the phase-in of the practice expense changes begun in 2010.

CMS did not respond to ASH and ASCO’s comments seeking increases in the values of two of the chemotherapy codes (96413 and 96416) in this proposed rule. We expect to hear CMS’ decision on these codes in the final rule. While anti-coagulant management services—CPT Codes 99363 and 99364—are not recognized by Medicare for payment, CMS has published values for these codes in the proposed rule as they may be reimbursed by other payers. Both codes are proposed for substantial reductions as indicated in the attached charts. We suspect this might be in error (the PE RVUs are being reduced to 0) and have brought this to the attention of CMS and they are looking into the issue.

**RUC Review of Potentially Mis-valued Codes**

At the direction of CMS, the AMA’s Relative Value Update Committee (RUC) has reviewed the relative values assigned to various categories of services. CMS has typically identified for review, codes with substantial growth in utilization, codes billed in multiple units, and codes for which the site of service had changed. In this rule, CMS is proposing two new categories of potentially mis-valued codes for review: CPT codes that have not been valued since the implementation of the fee schedule, (known as “Harvard-valued” codes) with Medicare annual allowed charges of \$10 million or more; and CPT codes without physician work values with stand-alone practice expense procedure times.

In reviewing the list of “Harvard-valued” codes that CMS is directing the RUC to review next year, we have not identified any of interest to ASH. Under the second new category of potentially mis-valued codes, CMS is proposing to significantly reduce the procedure time assumptions used in developing the RVUs for two radiation therapy services: intensity modulated radiation treatment (IMRT) and stereotactic body radiation therapy (SBRT).

**Geographic Practice Expense Index (GPCI)**

The GPCI is an adjustment CMS calculates and applies to both the work and practice expense relative value units for each code to reflect differences in labor, rent and other cost elements based on geographic areas. CMS is not proposing any changes to its GPCI policies for 2013. However, CMS is evaluating the recommendations contained in a recent report of the Institute of Medicine (IOM) for improving the technical accuracy of the methodology for calculating the GPCI which likely will lead to some proposals in the future. The discussion of the IOM report can be found on pages 116-132 of the proposed rule.

**Primary Care and Care Coordination**

***Post-Discharge Transitional Care Management Services.*** For several years, CMS has been actively exploring ways to improve payment for evaluation and management services generally and primary care

services in particular. In the CY 2012 PFS proposed rule, CMS initiated a discussion to gather information about how primary care services have evolved to focus on preventing and managing chronic disease. CMS also proposed a review of evaluation and management (E/M) services as potentially mis-valued services and suggested that the AMA Relative (Value) Update Committee (AMA RUC) might consider changes in the practice of chronic disease management and care coordination as a key reason for undertaking this review. However, CMS chose not to finalize the proposal to review E/M codes due to consensus from an overwhelming majority of commenters that a review of E/M services using the current RUC processes could not appropriately value the evolving practice of chronic care coordination.

Over the past year, the American Medical Association (AMA) and the American Academy of Family Physicians (AAFP) created workgroups to consider new options for coding and payment for primary care services. The AAFP Task Force recommended that CMS create new primary care E/M codes and pay separately for non-face-to-face E/M CPT Codes. In addition, the AMA's Chronic Care Coordination Workgroup (C3W) is in the process of developing codes to describe care transition and care coordination activities. CMS states it is continuing to monitor the progress of this workgroup and look forward to receiving its final recommendations.

In the CY 2013 PFS proposed rule, CMS decided to proceed with a proposal to refine PFS payment for post discharge care management services. While CMS has always argued that pre and post services including coordination of care is generally included in the total work of evaluation and management services, CMS is now agreeing that the evaluation and management codes may not reflect all of the services and resources required to provide comprehensive, coordinated care management for certain types of beneficiaries.

CMS is proposing to create a new code (a G-code) to describe the care management associated with the transition of a patient from care provided by a treating physician during a hospital, skilled nursing facility (SNF), or community mental health center stay to the care of the patient's primary physician in the community. The new code will describe all non-face-to-face services related to the transitional care management furnished to patients whose problems require moderate or high complexity medical decision making; the code must be billed within 30 days following the discharge date. The code will be paid once during this 30 day period to a single provider. CMS expects this code will be billed most frequently by primary care physicians and practitioners, but it can be billed by any physician managing the patient's care in the post-discharge period.

The discharging physician would not be eligible to bill this new code, as CMS believes that the existing discharge codes adequately capture the resources of the discharging physician. In addition, surgeons performing 10-day or 90-day global services would not be eligible to use the new code since the global payment presumably would cover the post care management services.

The service would include the following:

- Assuming responsibility for the patient's care including, obtaining and reviewing the discharge summary, reviewing diagnostic tests and treatments and updating the patient's medical record within 14 days of discharge;
- Establishing or adjusting a care plan to reflect an assessment of the patient's health status, medical needs, functional status, pain control and psychosocial needs following discharge;
- Communication with the patient and/or caregiver within 2 business days of discharge: an assessment of understanding of the medication regimen and education to reconcile the differences between pre- and post-stay regimens, education on the on-going care plan and potential complications, etc.

- Communication with other health care professionals who will assume care of the patient when necessary;
- Assessment of the need for and assistance in coordinating follow up visits with providers and community services;
- Establishment or reestablishment of needed community resources;
- Assistance in scheduling any required follow-up with community providers and services.

Because CMS expects the billing physician to have an existing relationship with the patient or to establish one shortly after discharge, CMS is requiring the billing practitioner to bill separately for an evaluation and management service within 30 days prior to the discharge or within the first 14 days of the 30 day post-discharge period. CMS would like comments on whether a face-to-face visit should be required when billing for the post-discharge transitional care management service and how to incorporate a required visit on the same day into payment for the proposed code. Comments are also requested on whether billing should occur when the patient's plan of care is established.

CMS is proposing a work value for the new G-code of 1.28 RVUs, which is equivalent to the value assigned to the hospital discharge day management code, 99238. The practice and malpractice expenses would be crosswalked to CPT code 99214.

CMS is establishing the values for this new service in a budget neutral manner. As indicated in Attachment 1, this is expected to add 5 percent to the payments for family practice, 3 percent for internal medicine and nurse practitioners and slightly less for geriatricians and physician assistants. However, all other specialties will see some net reductions in payment in the -1 to -2 percent ranges to offset this added cost.

**ASH will need to consider this proposal carefully. Clearly the intent of this proposal is to benefit primary care physicians. However, CMS has not defined the term community physician nor restricted the payment to only physicians and practitioners with a primary care specialty designation. Thus, internal medicine subspecialties, including hematology-oncology, who are not the admitting/discharging physician, may be able to bill this service if they are actively treating the patient.**

*Primary Care Services Furnished in Advanced Primary Care Practices.* CMS believes that targeting primary care management payments to advanced primary care practices (i.e., a medical home) would have many merits including ensuring a basic level of care coordination and care management and in improving the value of health care. Several demonstration projects are being conducted to see if these outcomes can be achieved in the Medicare population. CMS has identified a number of policy and operational issues that would need to be resolved before such a program could be implemented nationally and they invite public comments on the following:

- Definition of an Advanced Primary Care Practice – If CMS were to establish an enhanced payment for these services, the agency would need to establish criteria to determine whether or not a practice could be considered an advanced primary care practice. One method being considered would be to determine whether the practice's services mirror those of practices in the Innovation Center's Comprehensive Primary Care initiative. Another alternative would be to look to whether the practice is recognized as an advanced primary care practice by a national accreditation program, like that of the National Committee for Quality Assurance (NCQA), but CMS recognizes that this is costly and a lengthy process. CMS is soliciting comments on what processes should be considered for application and confirmation that accreditation standards have been met.

- Determining if a Practice is Serving as the Advanced Primary Care Practice for a Beneficiary – One potential issue surrounding comprehensive primary care services delivered in an advanced primary care practice is attribution of a beneficiary to an advanced primary care practice. In a fee-for-service environment CMS would need to determine which practice is currently serving as the advanced primary care practice for the beneficiary in order to ensure appropriate payment. One method of attribution could be that each beneficiary prospectively chooses an advanced primary care practice. CMS seeks comment on how such a choice might be documented and incorporated into the fee-for-service environment. Other attribution methodologies might examine the quantity and type of E/M or other designated services furnished to that beneficiary by the practice. CMS welcomes input on the most appropriate approach to the issue of how to best determine the practice that is functioning as the advanced primary care practice for each beneficiary. CMS is not considering proposals that would restrict a beneficiary’s free choice of practitioners.

**Payment for New Preventive Service HCPCS G-Codes**

As authorized by the Affordable Care Act (ACA), CMS has added coverage for a number of preventive services. Prior to December 31, 2011, these services were valued by the Medicare contractors, but effective January 1, 2012, CMS established the payment rates for these services. The rates were not developed in time to be published in the final 2012 MPFS rule; therefore CMS is announcing them in this year’s proposed rule. The services in question are:

- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse  
Brief Face-to-Face Behavioral Counseling for Alcohol Misuse
- Screening for Depression in Adults
- Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity

The practice expenses for all of these preventive services are in the CY 2013 proposed direct input database available on the CMS website.

**Payment for Part B Drugs**

Currently, Medicare pays for drugs provided by a physician based on 106 percent of Average Sales Price (ASP). While the authority has never been used, current law permits CMS to substitute the average manufacturer’s price (AMP) in determining payment if it is lower than ASP. In the 2012 final rule, CMS specified that the substitution of AMP for ASP will be made only if ASP exceeds the AMP by 5 percent or more for several quarters (to eliminate a short term anomaly) and payment would be based on 103 percent of AMP rather than 106 percent of ASP. CMS did not implement this policy in 2012 due to concerns related to drug shortages. In this rule, CMS is proposing to add language to prevent the AMP price substitution policy from taking effect if the drug and dosage form are reported by the FDA on their Current Drug Shortage list (or other FDA reporting tool identifying shortages of drugs).

**Durable Medical Equipment (DME) Face-to-Face Requirement**

In an effort to combat fraud and abuse and reduce improper payments for DME items, CMS is proposing to implement a requirement for a face to face (or telehealth) encounter as a condition of payment for certain high cost DME. The physician will need to document and communicate to the DME supplier that he/she or a physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a fact-to-face encounter with the patient no more than 90 days before the order for the DME is written or within 30 days after the order is written. During this encounter an assessment of the need for the covered item of DME must have occurred. CMS specifies what must be included in the written order for the DME to be reimbursed.

CMS is also proposing to compensate physicians who document that a PA, NP, or CNS has performed a face-to-face encounter for the list of covered DME items. Only physicians who do not bill an E/M code for the face to face encounter can bill the new G-code estimated at \$15. If multiple written orders for DME originate from one visit the physician can receive the G code payment only once.

Table 24 of the rule includes the list of DME requiring a written order and face-to-face encounter. The list includes DME items that meet at least one of the following criteria: 1) items that currently require a written order, 2) items that cost more than \$1000, 3) items the DME MACs believe are susceptible to fraud, waste, and abuse, 4) items determined by CMS, the HHS Office of the Inspector General and the GAO believe are susceptible to fraud, waste and abuse. The DME items on the list mainly fall in the following categories: TENS units, oxygen and respiratory equipment, cervical traction devices, hospital beds and accessories, external infusion pumps, wheelchairs and accessories.

### **Multiple Procedure Payment Reductions Expanded to Cardiovascular and Ophthalmology Codes**

Currently a 50% multiple procedure payment reduction (MPPR) is applied to the professional and technical components of advanced imaging codes provided in the same session. This policy is based on the assumption that there are efficiencies in physician work as well as labor, supplies and equipment when more than one imaging procedure is performed. The policy was extended to the Practice Expense (PE) of therapy services (PT, speech therapy and occupational therapy). A 20 percent reduction is applied to the PE of the second and additional therapy codes billed the same day. Addendum F of the rule lists the diagnostic imaging codes subject to the MPPR and Addendum H lists the therapy codes subject to MPPR.

In this rule, CMS is proposing to apply the MPPR to the technical component (TC) of certain cardiovascular and ophthalmology diagnostic services. CMS would provide full payment for the highest paid service and reduce the TC for subsequent cardiovascular or ophthalmology services furnished by the same physician or group practice to the same patient on the same day by 25 percent.

### **Telehealth Services**

CMS is proposing to add alcohol and/or substance abuse assessment and intervention services as well as several preventive services to the list of approved telehealth services for 2013. The preventive services include: annual alcohol misuse screening, brief behavioral counseling for alcohol misuse, annual face-to-face intensive behavioral therapy for cardiovascular disease, annual depression screening, behavioral counseling for obesity, and semi-annual high intensity behavioral counseling to prevent sexually transmitted infections.

### **Payment for Molecular Pathology Services**

CMS is inviting comments on whether newly created molecular pathology CPT codes should be paid under the MPFS or the Clinical Laboratory Fee Schedule (CLFS). CMS remains uncertain as to whether these services ordinarily require physician work and thus should be paid under the MPFS, or are clinical diagnostic laboratory tests that should be paid under the CLFS. If CMS determines that new molecular pathology CPT codes should be paid under the MPFS for CY 2013, CMS proposes that Medicare contractors would price these codes because the price of tests can vary locally and because this would allow more time for CMS to gather information on these codes to price them nationally. CMS is also inviting discussion at the CLFS Annual Public Meeting of the appropriate payment amounts for these new codes as clinical diagnostic laboratory tests under the CLFS.

### **Therapy Data Collection**

As required by a law passed earlier this year, CMS is proposing to implement a claims-based data collection process for therapy services to gather data about patient function and condition. Under the proposal, physical, occupational and speech therapists will be required to include new codes and

modifiers on claims for therapy services that will not affect payment, but will convey information about patients' functional limitations at the outset of therapy, periodically throughout therapy, and at discharge from therapy. Information on therapist-established patient goals will also be collected under this proposal. This system is proposed to be implemented on January 1, 2013. After a six-month testing period, CMS proposes not to process any claims that do not contain the required information for dates of service beginning July 1, 2013. The data collected will be used primarily to design a new payment system for therapy services.

### **Removing Barriers to Midlevel Providers**

CMS proposes to revise the conditions of coverage and payment regulations to allow non-physician practitioners (NPPs) and limited-license physicians to order portable x-ray services within the scope of their Medicare benefit and state scope of practice laws. Currently, CMS regulations limit ordering of portable x-ray services to a doctor of medicine or osteopathy. In addition, CMS proposes to clarify that "anesthesia and related care" for purposes of the CRNA benefit means services related to anesthesia that are within the state scope of practice for CRNAs in the state in which the services are furnished.

### **Physician Quality Reporting System (PQRS)**

Since its initial implementation in 2007, PQRS has continued to evolve largely as a result of statutory updates enacted by Congress and is moving into a new phase with the CY 2013 program. Those who successfully report quality measures in 2013 and 2014 will receive a bonus payment of 0.5 percent of total allowed charges for services provided during the reporting period. Like last year, an additional 0.5 percent will be available for those who participate in a maintenance of certification (MOC) program required for board certification by a recognized physician specialty organization. Providers who do not report quality measures in 2013 will be subject to a payment adjustment in 2015 of -1.5 percent and -2.0 percent in 2016. To avoid the payment adjustment, CMS is proposing that providers successfully report 1 PQRS measure or measure group.

CMS proposes to include 264 individual measures and 26 measure groups for individuals and group practices to report in CY 2013 and 2014. There are no changes being proposed to the current hematology measures on MDS, multiple myeloma, and CLL. The rule includes proposals to align PQRS measures for EHR-based reporting with measures reported under the EHR Incentive Program. In addition, CMS is proposing changes to the Group Practice Reporting Option and the measures required under Medicare's Shared Saving Program.

CMS is proposing to expand the definition of group practice to include 2- 24 eligible professionals and expand the use of claims, registry, and EHR reporting to groups of 2-99 eligible professionals.

More information on PQRS can be found [here](#).

### **Electronic Prescribing (eRx) Incentive Program**

CMS uses a combination of incentive payments and penalties to encourage electronic prescribing. Through 2013, successful e-prescribers are provided incentive payments of 0.5%. In 2013, CMS will apply a payment adjustment of -1.5% for non-successful e-prescribers, which will increase to -2% in 2014. Eligible professionals are identified by NPI or TIN. In the proposed rule, CMS is proposing new criteria for groups of 2 – 24 to participate in eRx and is proposing two additional hardship exemptions for eligible professionals participating in the EHR Incentive Program.

To successfully participate in the eRx program, eligible professionals must submit e-prescribing measures for at least 25 unique electronic prescribing events in 2013. Group practices with 2-24 professionals must report 225 measures; group practices of 25-99 must report 625 measures; and groups of 100 or more must

report 2,500 unique measures. Eligible professionals can report via claims, qualified registry or qualified EHR; however, the requirement must be met by reporting through a single mechanism.

More information on the eRx incentive program can be found [here](#).

### **Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program**

The establishment of a value-based payment modifier (VBM) was mandated by the ACA in order to provide differential payment to physicians and group practices based upon the quality of care furnished to Medicare beneficiaries compared to the cost of that care during a specific performing period. The statute requires the VBM be implemented in a budget neutral manner. Beginning in CY 2015, groups of physicians with 25 or more eligible professionals will be subject to the VBM; in CY 2017, the VBM will apply to all physicians.

In CY 2015, CMS is proposing to separate groups of physicians into two categories: those who have met the criteria to qualify for an incentive payment under the PQRS group practice reporting option and those who have not met the criteria to qualify for an incentive or did not participate in the PQRS. CMS is proposing to set the VBM for the first group at 0.0, meaning if the group successfully participated in PQRS their payments would not be affected. This group would have the option to have their VBM calculated using a quality tiering approach, which would allow the group to earn a positive payment adjustment for high performance and be at risk for a negative payment adjustment for poor performance. For the second category of group practices – those that did not qualify for a PQRS incentive payment or did not participate in PQRS, CMS is proposing to set the VBM at -1.0 percent.

CY 2013 is the performance period for the CY 2015 VBM. CMS is proposing to apply the VBM at the TIN level for the group practice, meaning if a physician moves from one group to another between 2013 and 2015 his payment will be adjusted based on the 2013 TIN.

Since 2010, CMS has provided confidential physician feedback reports to certain physicians and group practices. The reports compare quality of care and costs among the physicians and groups. Starting in 2013, CMS proposes to include the value-based modifier score in these reports.

More information on the value-based modifier program can be found [here](#).

### **Physician Compare Website**

Physician Compare is a website with information on physicians and other providers who bill Medicare. The website was launched in 2010 and more information on participating providers has been added each year. CY 2013 is the first year for which CMS is required to publish information on physician performance on quality and patient experience measures.

For 2013, CMS is proposing to use data reported under existing CMS reporting systems, such as the Physician Quality Reporting System (PQRS), PQRS Group Practice Reporting Option (GPRO), Medicare EHR Incentive Program and Shared Savings Program, for those providers who participate in these programs. For the Medicare EHR Incentive Program and the PQRS Cardiovascular Prevention measures group, CMS will just report the names of providers who participate, while CMS will report data on specific quality measures for the other programs. For all data sources, CMS will only post data that is technically feasible, available, that meet a minimum sample size and that are statistically valid and reliable. CMS is also proposing to change the minimum patient sample size from 25 to 20 patients.

In future years, CMS proposes to expand the website to include measures from other sources, if possible. One proposal for the future is to include quality measures that have been developed and collected by

specialty societies. Another is to develop composite measures at the disease module level, initially with 2013 GPRO data and possibly expanded in future years. CMS invites comment on these proposals.

More information on the Physician Compare initiative is available [here](#).

### **Medicare Shared Savings Program- Accountable Care Organizations**

In the rule, CMS lays out how the PQRS payment adjustment would be implemented for those participating in the Medicare Shared Savings Programs beginning in 2015. CMS proposes to use the final GPRO quality measures for 2015. Accountable Care Organizations (ACOs) would only need to report 22 GPRO quality measures but would not need to report the other 11 Shared Savings Program quality performance measures to satisfactorily report for the PQRS payment adjustment – the performance standards would count toward the shared savings adjustment, however.

Consistent with PQRS, the reporting of measures would occur two years prior to the payment adjustment, so data will be collected in 2013 for the 2015 adjustment payment. CMS also proposes that if an ACO satisfactorily reports the ACO GPRO web interface measures during the reporting period its participant TINs with ACO provider/suppliers who are EPs would not be subject to the PQRS payment adjustment – if they do not satisfactorily report the ACO GPRO web interface measures during the reporting period they would be subject to the adjustment starting in 2015.

CMS goes on to clarify that no registration or self-nomination is required for ACO providers/suppliers that are EPs to participate in PQRS under the Shared Savings Program. EPs within an ACO must participate under the ACO participant TIN as a group practice under the Shared Savings Program for the PQRS payment adjustment – therefore they cannot avoid the payment adjustment by filing as an individual under traditional PQRS.

More information on the Shared Savings Program is available [here](#).

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(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges (mil)	Baseline (PPIS transition, new utilization and other factors)	Updated Equipment Interest Rate Assumption	Discharge Transition Care Management	Input Charges for Certain Radiation Therapy Procedures	Combined Impact
TOTAL	\$85,485	0%	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	\$198	0%	1%	-2%	1%	0%
ANESTHESIOLOGY	\$1,969	-2%	0%	-1%	0%	-3%
CARDIAC SURGERY	\$366	-1%	0%	-1%	0%	-2%
CARDIOLOGY	\$6,565	-1%	0%	-1%	0%	-3%
COLON AND RECTAL SURGERY	\$153	1%	0%	-1%	0%	1%
CRITICAL CARE	\$261	1%	0%	-1%	0%	0%
DERMATOLOGY	\$3,008	0%	1%	-2%	0%	-1%
EMERGENCY MEDICINE	\$2,819	0%	0%	-1%	0%	-1%
ENDOCRINOLOGY	\$434	1%	0%	-1%	0%	0%
FAMILY PRACTICE	\$5,872	2%	0%	5%	0%	7%
GASTROENTEROLOGY	\$1,885	1%	0%	-1%	0%	0%
GENERAL PRACTICE	\$577	1%	0%	-1%	0%	0%
GENERAL SURGERY	\$2,261	1%	0%	-1%	0%	0%
GERIATRICS	\$217	2%	0%	2%	0%	4%
HAND SURGERY	\$134	1%	0%	-1%	0%	0%
HEMATOLOGY/ONCOLOGY	\$1,891	0%	1%	-2%	0%	-1%
INFECTIOUS DISEASE	\$623	2%	0%	-1%	0%	1%
INTERNAL MEDICINE	\$11,049	1%	0%	3%	0%	5%
INTERVENTIONAL PAIN MGMT	\$533	0%	0%	-1%	0%	-1%
INTERVENTIONAL RADIOLOGY	\$202	-2%	0%	-1%	0%	-3%
MULTISPECIALTY CLINIC/OTHER PHY	\$201	-1%	0%	-1%	0%	-2%
NEPHROLOGY	\$2,064	0%	0%	-1%	0%	-1%
NEUROLOGY	\$1,596	2%	0%	-1%	0%	1%
NEUROSURGERY	\$680	0%	0%	-1%	0%	-1%
NUCLEAR MEDICINE	\$48	-2%	-1%	-1%	0%	-4%
OBSTETRICS/GYNECOLOGY	\$698	1%	0%	-1%	0%	0%
OPHTHALMOLOGY	\$5,621	2%	0%	-1%	0%	1%
ORTHOPEDIC SURGERY	\$3,609	0%	0%	-1%	0%	-1%
OTOLARNGOLOGY	\$1,069	1%	1%	-1%	0%	0%
PATHOLOGY	\$1,185	-1%	0%	-1%	0%	-2%
PEDIATRICS	\$64	1%	0%	3%	0%	5%
PHYSICAL MEDICINE	\$980	2%	0%	-1%	0%	1%
PLASTIC SURGERY	\$351	1%	0%	-1%	0%	0%
PSYCHIATRY	\$1,149	1%	0%	-1%	0%	0%
PULMONARY DISEASE	\$1,691	1%	0%	-1%	0%	0%
RADIATION ONCOLOGY	\$1,982	-3%	-3%	-2%	-7%	-15%
RADIOLOGY	\$4,724	-2%	-1%	-1%	0%	-4%
RHEUMATOLOGY	\$544	0%	1%	-2%	0%	0%
THORACIC SURGERY	\$340	-1%	0%	-1%	0%	-2%
UROLOGY	\$1,905	-1%	0%	-1%	0%	-2%
VASCULAR SURGERY	\$881	-2%	0%	-1%	0%	-3%
AUDIOLOGIST	\$57	-3%	0%	-1%	0%	-5%
CHIROPRACTOR	\$738	2%	0%	-1%	0%	0%

CLINICAL PSYCHOLOGIST	\$567	-2%	0%	-1%	0%	-3%
CLINICAL SOCIAL WORKER	\$400	-2%	0%	-1%	0%	-3%
DIAGNOSTIC TESTING FACILITY	\$848	-5%	-2%	-2%	1%	-8%
INDEPENDENT LABORATORY	\$1,064	-2%	1%	-2%	1%	-2%
NURSE ANES / ANES ASST	\$1,142	-3%	0%	-1%	0%	-4%
NURSE PRACTITIONER	\$1,606	2%	0%	3%	0%	5%
OPTOMETRY	\$1,048	2%	0%	-1%	0%	0%
ORAL/MAXILLOFACIAL SURGERY	\$44	1%	1%	-1%	0%	0%
PHYSICAL/OCC THERAPY	\$2,263	3%	0%	-1%	0%	3%
PHYSICIAN ASSISTANT	\$1,219	1%	0%	2%	0%	3%
PODIATRY	\$1,897	2%	1%	-2%	0%	1%
PORTABLE X-RAY SUPPLIER	\$104	2%	1%	-2%	1%	2%
RADIATION THERAPY CENTERS	\$71	-4%	-5%	-2%	-8%	-19%
OTHER	\$19	1%	0%	-1%	0%	0%

\* Table 84 shows only the proposed payment policy impact on PFS services. We note that these impacts do not include the effects of the negative January 2013 conversion factor change under current law.