Abbott’s vascular division is pleased to provide you with this summary of the Medicare Physician Fee Schedule (PFS) Update for Calendar Year (CY) 2017. The information in this document is effective January 1, 2017 to December 31, 2017.

**PFS HIGHLIGHTS**

**CY 2017 Payment Update**

The Centers for Medicare & Medicaid Services (CMS) released the CY 2017 final rule for the Medicare Physician Fee Schedule (PFS) on November 2, 2016. The conversion factor for 2017 is $35.8887. The simple average changes from CY 2016 to CY 2017 for procedures that may use Abbott’s vascular products are as follows:

**Peripheral arterial interventional procedure payment rates:**

<table>
<thead>
<tr>
<th>Facility</th>
<th>-2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Facility</td>
<td>-2%</td>
</tr>
</tbody>
</table>

**Peripheral arterial diagnostic procedure payment rates:**

<table>
<thead>
<tr>
<th>Facility</th>
<th>+1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Facility</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Coronary arterial interventional procedure payment rates:**

<table>
<thead>
<tr>
<th>Facility</th>
<th>-2%</th>
</tr>
</thead>
</table>

**Coronary arterial diagnostic procedure payment rates:**

<table>
<thead>
<tr>
<th>Facility</th>
<th>-7%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Facility</td>
<td>-7%</td>
</tr>
</tbody>
</table>

**Transcatheter mitral valve repair procedure payment rates:**

| Facility   | +1% |

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New CPT Codes for Angioplasty

New CPT codes for angioplasty excluding the central nervous system, coronary, pulmonary, and lower extremities are effective January 1, 2017. The new codes combine the angioplasty procedure with radiological supervision and interpretation into a single comprehensive code. Codes for radiological supervision and interpretation 35450, 35452, 35458, 35460, 75962, 75964, 75966, and 75978 are deleted. New codes 37246-37249 are the bundled replacement codes. The reimbursement rates for CY 2017 provide payment for angioplasty in the physician office (non-facility) setting, in addition to the facility setting.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37246</td>
<td>Transluminal balloon angioplasty (except lower extremity artery(s) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery</td>
</tr>
<tr>
<td>37247</td>
<td>Transluminal balloon angioplasty (except lower extremity artery(s) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>37248</td>
<td>Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein</td>
</tr>
<tr>
<td>37249</td>
<td>Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (list separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>
Global Surgical Package

As required by Congress, CMS proposed a data-collection exercise related to pre- and post-procedure services for surgical procedures having a 10- or 90-day global period to better assess the work associated with these procedures. CMS proposed a set of eight new time-based, postoperative visit G-codes (GXXX1-GXXX8) for services related to and within 10- and 90-day global periods. However, widespread concerns about the burden and inability of physicians to track time persuaded CMS to pursue less burdensome ways of obtaining information. After considering the comments, CMS is finalizing a requirement to report postoperative visits furnished during 10- and 90-day global periods. However, rather than using the proposed set of G-codes for this reporting, CMS will require the use of CPT code 99024 – Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure. CMS will not, at this time, require time units or modifiers to distinguish levels of visits to be reported. Although providers are encouraged to begin reporting on January 1, 2017, there will be a delay in the requirement effective July 1, 2017. The final policy requires reporting of postoperative visits (CPT code 99024) for:

- Practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island
- Groups of 10 or more practitioners
- High-cost/high-volume procedures, as defined on the CMS website

All other practitioners are encouraged to report voluntarily.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

MACRA replaces the current Medicare physician reimbursement schedule with a new pay-for-performance program that's focused on quality and value. MACRA has two tracks: the Merit-Based Incentive Payment System (MIPS) and the advanced Alternative Payment Model (APM). MIPS combines parts of the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBM), and the Medicare Electronic Health Record (EHR) incentive program into one single program. Under MIPS, clinicians will be scored based on quality, resource use, clinical practice improvement, and EHR use and assigned a positive, negative, or neutral payment adjustment. To qualify for the Advanced APM track, clinicians must participate in value-based models including next-generation Accountable Care Organizations, Episode-Based Payment Models, and Medicare Shared Savings Program tracks 2 and 3. Advanced APM participants will be exempt from the MIPS payment adjustments.

Please find additional information on MACRA on the CMS Quality Payment Program website: qpp.cms.gov
Physician Quality Incentives

MACRA established new mandates that will have a direct effect on the physician quality reporting programs: the MIPS and the incentive payments for participation in eligible alternative payment models for EPs. These are scheduled to be implemented beginning in January 2019 with performance period starting January 1, 2017. Starting in 2019, adjustments to payment for quality reporting and other factors will be made under the MIPS.

Medicare Shared Savings Program (MSSP)

The MSSP was established to promote accountability, coordination of items and services under Parts A and B, and investment in infrastructure and care processes through an Accountable Care Organization. The following measures have been added to the care coordination/patient safety domain:

- ACO-12 Medication Reconciliation Post-Discharge
- ACO-44 Use of Imaging Studies for Low Back Pain
- ACO-43 Ambulatory Sensitive Condition Acute Composite

Physician Fee Schedule CY 2017 Payment Look-Up

To look up 2017 or prior year locality-specific physician payment rates, payment policy indicators, or relative value units, visit:

Unsure how to utilize CMS’ Web-based physician fee look-up tool?
Contact Abbott’s Vascular Reimbursement Hotline. A trained specialist can help you navigate the tool.

Please visit Abbott’s Vascular Reimbursement website at:

www.vascular.abbott/us/professional-resources/reimbursement.html

For questions regarding this Reimbursement Update and other questions regarding reimbursement for Abbott’s vascular products and related services, please contact:

**Abbott’s Vascular Reimbursement Hotline**

📞 800.354.9997
✉️ Questions@AskAbbottVascular.com

For questions regarding reimbursement for St. Jude Medical products and related services, please contact:

**St. Jude Medical Reimbursement Hotline**

📞 855.569.6430
✉️ hce@sjm.com

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