supporting the proposal due to the financial impact on certain services, stated that hospitals and ASCs do typically incur higher overhead costs in delivering services than physician offices.

The overwhelmingly majority of commenters objected to the proposed policy. Several commenters believed the services impacted by the policy were potentially misvalued, but still opposed our policy. Many commenters questioned whether facilities' costs for providing all services are necessarily higher than the costs of physicians or other practitioners. Commenters stated that the resources required to furnish services in nonfacility physician settings cannot be accurately measured using the OPPS methodology and that our proposal would result in rank order anomalies. Commenters indicated that it was inappropriate to base PFS payment on OPPS payment since a single APC contains multiple services that can involve a wide a range of costs that are averaged under the OPPS methodology. Many commenters also stated that since OPPS payment rates rely on the accuracy of APC payments, developed through hospitals accurately allocating their costs and charges to particular departments/APCs. These commenters stated that hospitals may have little incentive to accurately allocate their costs and charges to particular departments/APCs since they typically provide a broad range of services and therefore have the ability to make up for losses on one service with profits on another. The argument is that this ability makes the precise pricing of individual services less important in the OPPS system than it is in the physician setting. Also, the argument is that if physicians are going to be paid based upon the OPPS system it should be for all services so that like the hospitals they benefit from those overpaid in the hospital. Many commenters also questioned CMS' authority to use payment rates from other Medicare payment methodologies to cap PFS rates since they asserted the policy violated the statutory requirement that the PFS PE relative values be based on the resources used in furnishing the service. Some commenters also cited the financial impact of our proposed policy on the PFS rates as a further reason that the policy was inappropriate.

For all of these reasons, these commenters recommended that we not adopt the proposed policy. Many of these commenters also suggested modifications to the policy if CMS did decide to move forward. Commenters suggested that since the ASC rates reflect the OPPS relative weights to determine payment rates under the ASC payment system, and are not based on cost information collected from ASCs, the ASC rates should not be used in the proposed policy.

Commenters also stated a strong preference to use prospective year OPPS rates instead of current year OPPS rates as the point of comparison to prospective year PFS rates. The CY 2014 OPPS proposed rule proposed significant packaging that raised payment for many APCs, and therefore, raised the associated PFS cap rate.

Some commenters stated that they believed that CMS does not have authority to use any conversion factor in the policy other than the one calculated under existing law for CY 2014.

Commenters stated that the low-volume threshold (a minimum of 5 percent in the hospital outpatient setting) was proposed with insufficient rationale and recommended either a 50 percent threshold or an absolute volume threshold. Commenters also argued that there should be an ASC low-volume threshold for using ASC rates.

Commenters urged CMS to establish a means for stakeholders to demonstrate the validity of office costs relative to OPPS payments prior to implementing a cap for any particular code. Commenters also suggested that the AMA RUC should examine each code prior to the implementation of the policy for that code.

Commenters suggested excluding codes recently revalued, such as certain surgical pathology codes, from the cap as their resource inputs and costs are more accurate than those less recently revalued.

Commenters suggested that CMS should make the cap more transparent by identifying all affected codes and displaying the data used in establishing the capped values.

Several commenters suggested using the individual OPPS HCPCS code costs that are used to calculate the APC payment, rather than the APC payment rate itself, as a way of avoiding the problems caused by the averaging that goes on in calculating the APC rates. These commenters argued that individual code costs are a more appropriate comparison than APC payment rates.

Response: As we stated in the proposed rule, when services are furnished in the facility setting, such as an HOPD or ASC, the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We continue to believe that this payment difference generally reflects the greater costs that facilities incur compared to those incurred by practitioners furnishing services in offices and other non-facility settings. We also continue to believe that if the total Medicare payment when a service is furnished in the physician office setting exceeds the total Medicare payment when a service is furnished in an HOPD or an ASC, this is generally not the result of appropriate payment differentials between the services furnished in different settings. Rather, we continue to believe that it is primarily due to anomalies in the data we use under the PFS and in the application of our resource-based PE methodology to the particular services.

We greatly appreciate all of the comments that we received on our proposal. Given the many thoughtful and detailed technical comments that we received, we are not finalizing our proposed policy in this final rule with comment period. We will consider more fully all the comments received, including those suggesting technical improvements to our proposed methodology. After further consideration of the comments, we expect to develop a revised proposal for using OPPS and ASC rates in developing PE RVUs which we will propose through future notice and comment rulemaking.

At this time, we do not believe that our standard process for evaluating potentially misvalued codes, including the use of the AMA RUC is an effective means of addressing these codes. As we stated in the proposed rule, we do not believe that the direct practice expense information we currently use to value these codes is accurate or reflects typical resource costs. We have addressed these issues extensively in previous rulemaking (for example, 75 FR 73252) and again in section II.B.4. of this final rule with comment period. We believe the current review process for direct PE inputs only accommodates incomplete, small sample, and potentially biased or inaccurate resource input costs that may distort the resources used to develop nonfacility PE RVUs used in calculating PFS payment rates for individual services.

3. Ultrasound Equipment Recommendations

In the CY 2012 PFS proposed rule (76 FR 42796), we asked the AMA RUC to review the ultrasound equipment described in the direct PE input database. We specifically asked for review of the ultrasound equipment items described in the direct PE input database and whether the ultrasound