If we established our own criteria in order to resolve the lack of standardization between the standards adopted by the various national accreditation organizations for PCMH, it is possible that the accrediting bodies would then be able to assist us in determining compliance with the CMS criteria. Depending on the nature of the criteria, the CMS criteria may cost less to implement but would likely require a practice to incur the cost for an accrediting body to review the practice's compliance. We invite public comment on the potential approaches we could use to identify advanced primary care practices for purposes of Medicare payment, including the possible use of one or more national accrediting organizations (and whether meaningful use of certified electronic health record technology should be required for such accreditation) as part of a Medicare approval process, as well as any other potential approaches to accrediting advanced primary care practices that we have not discussed here.

c. Beneficiary Attribution for Purposes of Payment

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. We would not expect that there would be more than one practice functioning as an advanced primary care practice for a beneficiary at any given time. However, in a fee-for-service environment we 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. We seek 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. We welcome 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. We are not considering proposals that would restrict a beneficiary's free choice of practitioners.

In summary, we believe that targeting primary care management payments to advanced primary care practices would have many merits including ensuring a basic level of care coordination and care management. We recognize that the advanced primary care model has demonstrated efficacy in improving the value of health care in several contexts, and we are exploring whether we can achieve these outcomes for the Medicare population through several demonstration projects. Careful analysis of the outcomes of these demonstration projects will inform our understanding of how this model of care affects the Medicare population and of potential PFS payment mechanisms for these services. At the same time, we also believe that there are many policy and operational issues to be considered when nationally implementing such a program within the PFS. Therefore, we generally invite broad public comment on the accreditation and attribution issues discussed above and any other aspect, including payment, of integrating an advanced primary care model in to the PFS.

I. Payment for Molecular Pathology Services

For CY 2012, the AMA CPT Editorial Panel began creating new CPT codes to replace the current codes used to bill for molecular pathology services. The new codes describe distinct molecular pathology tests and test methods. CPT divided these new molecular pathology codes into Tiers. Tier 1 codes describe common gene-specific and genomic procedures. Tier 2 codes capture reporting for less common tests and each Tier 2 code represents a group of tests that involve similar technical resources and interpretive work. For CY 2012, CPT created 101 new molecular pathology codes; 92 new Tier 1 codes for individual tests and nine Tier 2 codes for common groups of tests. These codes appear in Table 21. We anticipate that CPT will create additional molecular pathology codes for CY 2013.

We stated in our notice for the Clinical Laboratory Fee Schedule (CLFS) Annual Public Meeting (to be held July 16–17, 2012 at CMS headquarters in Baltimore, Maryland, more information at *https://www.cms.gov//Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Public_Meetings.html*) that we are following our process to determine the appropriate basis and payment amounts for new clinical diagnostic laboratory tests, including the molecular pathology tests, under the CLFS for CY 2013. However, we also stated that we understand stakeholders in the molecular pathology community continue to debate whether Medicare should pay for molecular pathology tests under the CLFS or the PFS. Medicare pays for clinical diagnostic laboratory tests through the CLFS and for services that ordinarily require physician work through the PFS. We stated that we believe we would benefit from additional public comments on whether these tests are clinical diagnostic laboratory tests that should be paid under the CLFS or whether they are physicians' services that should be paid under the PFS. Therefore, we said that we intend to solicit comment on this issue in this proposed rule, as well as public comment on pricing policies for these tests under the CLFS at the Annual Public Meeting. This section first discusses and requests comment on whether these molecular pathology CPT codes describe services that ordinarily require physician work, and then discusses our proposal to address payment for these CPT codes on the PFS, pending public comment on the first question. This proposal is parallel to the invitation to discuss at the CLFS Annual Public Meeting, the appropriate basis for establishing a payment amount for the molecular pathology CPT codes as clinical diagnostic laboratory tests under the CLFS.

As detailed in section II.B.1. of this proposed rule, Medicare establishes payment under the PFS by setting RVUs for physician work, practice expense (PE), and malpractice expense for services that ordinarily require physician work. To establish RVUs for physician work, we conduct a clinical review of the relative physician work (time by intensity) required for each PFS service. This clinical review includes the review of RVUs recommended by the American Medical Association Relative Value Scale Update Committee (AMA RUC) and others. The AMA RUC-recommended physician work RVUs typically are based in part on results of a survey conducted by the relevant specialty society for a service. CMS establishes RVUs for PE under a resource-based PE methodology that considers the cost of direct inputs, as well as indirect PE costs. The AMA RUC, through the Practice Expense Subcommittee, recommends direct PE inputs to CMS, and the relevant specialty societies provide pricing information for those direct inputs to CMS. After we determine the appropriate direct PE inputs, the PE methodology is used to develop proposed PE RVUs. Physician work and PE RVUs for each CPT code are constructed to reflect the typical case; that is, they reflect the service as it is furnished in greater than 50 percent of Medicare cases. CMS establishes resource-based malpractice expense RVUs using weighted specialty-specific malpractice insurance premium data collected from commercial and

physician-owned insurers in CY 2010 (74 FR 61758). For most services paid under the PFS, beneficiary cost-sharing is 20 percent of the payment amount.

CMS establishes a payment rate for new clinical diagnostic laboratory tests under the CLFS by either crosswalking or gap-filling. Crosswalking is used when a new test code is comparable to an existing test code, multiple existing test codes, or a portion of an existing test code on the CLFS. Under this methodology, the new test code is assigned the local fee schedule amounts and the national limitation amount (NLA) of the existing test, with payment made at the lesser of the local fee schedule amount or the NLA. Gap-filling is used when no comparable test exists on the CLFS. In the first year, carrier-specific amounts are established for the new test code using the following sources of information: Charges for the test and routine discounts to charges; resources required to perform the test; payment amounts determined by other payers; and charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant. For the second year, the NLA is calculated, which is the median of the carrier-specific amounts. See § 414.508. Services paid under the CLFS do not include any physician work, although tests paid under the CLFS can involve interpretation by a laboratory technician, a chemist, or a geneticist—none of which are occupations that meet the statutory definition of a physician. While payments can vary geographically due to contractor discretion across locality areas (which are the same localities used for the GPCIs under the PFS), payments cannot exceed a NLA nor can they be adjusted once rates are determined. In the CY 2008 PFS final rule with comment period, we adopted a prospective reconsideration process for new tests paid under the CLFS, allowing a single year for Medicare and stakeholders to review pricing for new tests after the payment is initially established (72 FR 66275 through 66279, 66401 through 66402). Finally, the statute waives beneficiary cost-sharing for clinical laboratory diagnostic tests paid on the CLFS.

For a handful of clinical laboratory services paid under the CLFS, we allow an additional payment under the PFS for the professional services of a pathologist when they meet the requirements for clinical consultation service as defined in § 415.130. The PFS pays for services that ordinarily require the work of a physician and, with regard to pathology services, explicitly pays for both the professional and technical component of the services of a pathologist as defined in § 415.130 including surgical pathology, cytopathology, hematology, certain blood banking services, clinical consultations, and interpretive clinical laboratory services.

Molecular pathology tests are currently billed using combinations of longstanding CPT codes that describe each of the various steps required to perform a given test. This billing method is called ''stacking'' because different ''stacks'' of codes are billed depending on the components of the furnished test. Currently, all of the stacking codes are paid through the CLFS. One stacking code, CPT code 83912 (molecular diagnostics; interpretation and report) is paid on both the CLFS and the PFS. Payment for the interpretation and report of a molecular pathology test when furnished and billed by a physician is made under the PFS using the professional component (PC, or 26) of CPT code 83912 (83912–26). Payment for the interpretation and report of a molecular pathology test when furnished by non-physician laboratory staff is made under the CLFS using CPT code 83912.

Since the creation of new molecular pathology CPT codes, there has been significant debate in the stakeholder community regarding whether these new molecular pathology codes describe physicians' services that ordinarily require physician work and would be paid under the PFS, or whether they describe clinical diagnostic laboratory tests that would be paid on the CLFS. The AMA RUC reviewed the 101 new molecular pathology CPT codes and concluded that 79 of 101 new molecular pathology codes include work furnished by a physician. The American Clinical Laboratory Association (ACLA) has indicated that 32 of the 101 new molecular pathology codes are interpreted by a physician and that a physician may perform the technical component associated with 2 of the 101 CPT codes. Only 15 of the 101 new codes appear on both the AMA RUC and ACLA list of codes that each believe include work furnished by a physician. Additionally, some stakeholders have suggested that all molecular pathology tests require physician interpretation and report. Other stakeholders have suggested that the interpretation and report of a molecular pathology test is not ordinarily required because the majority of the molecular pathology tests are clearly negative so interpretation and reporting generally are not necessary. In addition, some stakeholders have argued that molecular pathology tests are becoming more and more automated, and therefore generally do not require interpretation by a physician.

In the CY 2012 PFS final rule (76 FR 73190), we stated that for CY 2012, Medicare would continue to use the existing stacking codes for the reporting and payment of these molecular pathology services, and that the 101 new CPT codes would not be valid for payment for CY 2012. We did this because we were concerned that we did not have sufficient information to know whether these new molecular pathology CPT codes describe clinical diagnostic laboratory tests or services that ordinarily require physician work. For CY 2013, we continue to have many of the same concerns that led us not to recognize the 101 molecular pathology CPT codes for payment for CY 2012. Specifically, we acknowledge that we are lacking definitive answers to the following questions:

- Do each of the 101 molecular pathology CPT codes describe services that are ordinarily furnished by a physician?
- Do each of these molecular pathology CPT codes ordinarily require interpretation and report?
- What is the nature of that interpretation and does it typically require physician work?
- Who furnishes interpretation services and how frequently?

We are seeking public comment on these questions and the broader issue of whether the new molecular pathology codes describe physicians' services that should be paid under the PFS, or if they describe clinical diagnostic laboratory tests that should be paid under the CLFS.

As we continue to consider public comment on whether these molecular pathology CPT codes describe services that ordinarily require physician work, we want to ensure that there is a payment mechanism in place to pay for these CPT codes for CY 2013. We propose to price all of the 101 new molecular pathology codes through a single fee schedule, either the CLFS or the PFS. After meeting with stakeholders and reviewing each CPT code, we believe that there is little variation in the laboratory methodologies, as all of them employ gene sequencing processes. However, there are very different processes for establishing payment rates under the PFS and the CLFS. As discussed above, Medicare sets payment under the CLFS by either crosswalking or gap-filling and, after the prospective reconsideration process, currently cannot adjust the payment amount

further. In contrast, Medicare sets payment under the PFS through a set of resource-based methodologies for physician work, PE, and malpractice expense, and payment can be reviewed and adjusted as the resources required to furnish a service change. We are concerned that establishing different prices for comparable laboratory services across two different payment systems would create a financial incentive to choose one test over another simply because of its fee schedule placement. We are also concerned that the differences in prices would become more pronounced over time as the PFS continues to review the values for physician work and PE inputs relative to established CLFS prices. Therefore, because of the homogeneity of the laboratory methodologies behind these procedure test codes, we believe that it is appropriate for all 101 new molecular pathology CPT codes to be priced on the same fee schedule using the same methodology. We invite public comment on this proposal.

In our effort to determine the appropriate Medicare payment for these new molecular pathology codes, stakeholders will have the opportunity to discuss the CLFS payment basis for establishing payment amounts for the molecular pathology codes discussed above at the CLFS Annual Public Meeting in July 2012. Section 1833(h)(8)(A) of the Act, which discusses the CLFS, requires the Secretary to ''establish by regulation procedures for determining the basis for, and amount of, payment [under the CLFS] for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005.'' Clauses (i) and (ii) of section 1833(h)(8)(B) of the Act requires the Secretary to: 1) Make ''available to the public (through an Internet Web site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount * * * is being considered for a year;'' and, ''on the same day such list is made available, causes to have published in the **Federal Register** notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis * * * for establishing payment amounts for the tests on such list.'' Because we believe that these molecular pathology codes may be clinical diagnostic laboratory tests payable on the CLFS, comments and recommendations from the public on the appropriate basis for establishing payment amounts on the CLFS will be discussed at the CY 2013 CLFS Annual Public Meeting. More information on the CLFS Annual Public Meeting is available in the **Federal Register** at 77 FR 31620 through 31622 and on the CMS Web site at *http://www.cms.hhs.gov/ClinicalLabFeeSched*.

As a parallel to our invitation to discuss these molecular pathology codes as clinical diagnostic laboratory tests at the CLFS Annual Public Meeting in July 2012, we also propose payment amounts for these codes under the PFS for CY 2013. The AMA RUC provided CMS with recommendations for physician work RVUs and PE inputs for the 79 CPT codes it believes include physician work. At our request, CAP provided CMS with direct PE input recommendations for 15 of the remaining 22 CPT codes to the best of their ability. We do not have recommendations on physician work RVUs or direct PE inputs for 7 of 101 codes which represent tests that are patented, and therefore the methodology used to furnish the service is proprietary and has been unavailable to the AMA RUC or CMS to support developing appropriate direct PE inputs. For the 79 CPT codes, the AMA RUC-recommended physician work RVUs range from 0.13 to 2.35, with a median work RVU of 0.45. The AMA RUC-recommended physician intra-service times (which, for these codes, equals the total times) range from 7 minutes to 80 minutes, with a median intra-service time of 18 minutes. We would note that the physician work RVU for CPT code 83912–26 and all but one of the other clinical diagnostic laboratory services for which CMS recognizes payment for clinical interpretation is 0.37. Table 21 lists AMA RUC-recommended physician work RVUs and times for these services.

Molecular pathology tests can be furnished in laboratories of different types and sizes (for example a large commercial laboratory or a pathologist's office), and tests may be furnished in small or large batches. The methodologies used and resources involved in furnishing a specific test can vary from laboratory to laboratory. When developing direct PE input recommendations for CMS, CAP and the AMA RUC made assumptions about the typical laboratory setting and batch size to determine the typical direct PE inputs for each service. Given that many of these services are furnished by private laboratories, providing recommendations on the typical inputs was challenging for many services, and not possible for other services. The AMA RUC and CAP-recommended direct PE inputs are available on the CMS Web site in the files supporting this CY 2013 PFS proposed rule at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*. We appreciate all of the effort CAP has made to develop national pricing inputs. However, we agree with its view that, in many cases, there is no established protocol for executing many of these tests and that the potential means to execute these tests can vary considerably.

In addition to recommendations on physician work and direct PE inputs, the AMA RUC provided CMS with recommended utilization crosswalks for the 79 molecular pathology services it believes are typically furnished by a physician. When there are coding changes, the utilization crosswalk tracks Medicare utilization from an existing code to a new code. The existing code utilization figures are drawn from Medicare claims data. We use utilization crosswalk assumptions to ensure PFS BN and to create PE RVUs through the PE methodology. Currently, payment for the interpretation and report of a molecular pathology test when furnished and billed by a physician is made under the PFS using CPT code 83912–26. Because CPT created the new molecular pathology codes to replace the current stacking codes, when recommending utilization crosswalks, the AMA RUC started with the total utilization for CPT code 83912–26, and divided that utilization among the 79 CPT codes. CAP has indicated that it distributed the utilization based, in part, on ICD–9 diagnosis data. Table 22 lists the AMA RUC-recommended utilization crosswalks for these services.

We are concerned that the RUC-recommended utilization is too low because it is based on the utilization of CPT code 83912–26 only. Instead, we believe that the utilization assumptions for the technical component of the 101 new CPT codes should be based on the utilization of the corresponding CPT codes currently billed on the CLFS. Several laboratories provided us with a list of the molecular pathology tests that they perform, and identified the stacking codes that are currently used to bill for each test and the new CPT code that would be billed for each test. However, because the same molecular pathology test may be billed using different stacks, and the same stack may be billed for different tests, it is not possible to determine which stacks match which new CPT codes for all Medicare claims. Additionally, if a beneficiary has more than one test on the same date of service and both stacks

are billed on the same Medicare claim, it is not possible to determine which stacking codes on the claim make up each stack. Furthermore, some tests described by the new CPT codes are currently billed using general ''not otherwise classified'' (NOC) pathology CPT codes that capture a range of services and not just the molecular pathology tests described by the new CPT codes. Given these factors, it is difficult to estimate the utilization of the 101 new molecular pathology codes based on the Medicare billing of the current stacking and NOC codes.

If we were to finalize payment for molecular pathology services under the PFS, we do not believe that we could propose national payment rates at this time. Many outstanding questions remain including:

- If these services are furnished by a physician, what are the appropriate physician work RVUs and times relative to other similar services?
- Where and how are each of these services typically furnished—for example, what is the typical laboratory setting and batch size?
- What is the correct projected utilization for each of these services?

Given these major areas of uncertainty, if CMS determined that new molecular pathology CPT codes should be paid under the PFS for CY 2013, we are proposing to allow the Medicare contractors to price these codes because we do not believe we have sufficient information to engage in accurate national pricing and because the price of tests can vary locally. As previously discussed, this proposal is a parallel to the invitation to discuss at the CLFS Annual Public Meeting the appropriate basis for establishing a payment amount for these molecular pathology tests as clinical diagnostic laboratory tests under the CLFS. If we decide to finalize payment for these new codes under the PFS, we would consider modifying § 415.130 as appropriate to provide for payment to a pathologist for molecular pathology services.

After reviewing comments received on the proposals contained within this CY 2013 PFS proposed rule, and after hearing the discussion at the CLFS Annual Public Meeting, we will determine the appropriate basis for establishing payment amounts for the new molecular pathology codes. We intend to publish our final decision in the CY 2013 PFS final rule with comment period and, at the same time that rule is published, as stated in the CLFS Public Meeting Notice, to post final payment determinations, if any, for the molecular pathology tests that will be paid under the CLFS.

TABLE 21—AMA RUC–RECOMMENDED PHYSICIAN WORK RVUS AND TIMES FOR NEW MOLECULAR PATHOLOGY CPT CODES

CPT Code	Short descriptor	AMA RUC–Recommended physician work RVU	AMA RUC–Recommended physician intra-service time (minutes)
81206	Bcr/abl1 gene major bp	0.37	15
81207	Bcr/abl1 gene minor bp	0.15	11
81208	Bcr/abl1 gene other bp	0.46	18
81210	Braf gene	0.37	15
81220	Cftr gene com variants	0.15	10
81221	Cftr gene known fam variants	0.40	20
81222	Cftr gene dup/delet variants	0.22	13
81223	Cftr gene full sequence	0.40	20
81224	Cftr gene intron poly t	0.15	10
81225	Cyp2c19 gene com variants	0.37	13
81226	Cyp2d6 gene com variants	0.43	15
81227	Cyp2c9 gene com variants	0.38	14
81240	F2 gene	0.13	7
81241	F5 gene	0.13	8
81243	Fmr1 gene detection	0.37	15
81244	Fmr1 gene characterization	0.51	20
81245	Flt3 gene	0.37	15
81256	Hfe gene	0.13	7
81257	Hba1/hba2 gene	0.50	20
81261	Igh gene rearrange amp meth	0.52	21
81262	Igh gene rearrang dir probe	0.61	20
81263	Igh vari regional mutation	0.52	23
81264	Igk rearrangeabn clonal pop	0.58	22
81265	Str markers specimen anal	0.40	17
81266	Str markers spec anal addl	0.41	15
81267	Chimerism anal no cell selec	0.45	18
81268	Chimerism anal w/cell select	0.51	20
81270	Jak2 gene	0.15	10
81275	Kras gene	0.50	20
81291	Mthfr gene	0.15	10
81292	Mlh1 gene full seq	1.40	60
81293	Mlh1 gene known variants	0.52	28
81294	Mlh1 gene dup/delete variant	0.80	30
81295	Msh2 gene full seq	1.40	60
81296	Msh2 gene known variants	0.52	28
81297	Msh2 gene dup/delete variant	0.80	30
81298	Msh6 gene full seq	0.80	30
81299	Msh6 gene known variants	0.52	28
81300	Msh6 gene dup/delete variant	0.65	30
81301	Microsatellite instability	0.50	20

TABLE 21—AMA RUC–RECOMMENDED PHYSICIAN WORK RVUS AND TIMES FOR NEW MOLECULAR PATHOLOGY CPT CODES—Continued

CPT Code	Short descriptor	AMA RUC–Recommended physician work RVU	AMA RUC–Recommended physician intra-service time (minutes)
81302	Mecp2 gene full seq	0.65	30
81303	Mecp2 gene known variant	0.52	28
81304	Mecp2 gene dup/delet variant	0.52	28
81310	Npm1 gene	0.39	19
81315	Pml/raralpha com breakpoints	0.37	15
81316	Pml/raralpha 1 breakpoint	0.22	12
81317	Pms2 gene full seq analysis	1.40	60
81318	Pms2 known familial variants	0.52	28
81319	Pms2 gene dup/delet variants	0.80	30
81331	Snrpn/ube3a gene	0.39	15
81332	Serpina1 gene	0.40	15
81340	Trb@ gene rearrange amplify	0.63	25
81341	Trb@ gene rearrange dirprobe	0.45	19
81342	Trg gene rearrangement anal	0.57	25
81350	Ugt1a1 gene	0.37	15
81355	Vkorc1 gene	0.38	15
81370	Hla i & ii typing lr	0.54	15
81371	Hla i & ii type verify lr	0.60	30
81372	Hla i typing complete lr	0.52	15
81373	Hla i typing 1 locus lr	0.37	15
81374	Hla i typing 1 antigen lr	0.34	13
81375	Hla ii typing ag equiv lr	0.60	15
81376	Hla ii typing 1 locus lr	0.50	15
81377	Hla ii type 1 ag equiv lr	0.43	15
81378	Hla i & ii typing hr	0.45	20
81379	Hla i typing complete hr	0.45	15
81380	Hla i typing 1 locus hr	0.45	15
81381	Hla i typing 1 allele hr	0.45	12
81382	Hla ii typing 1 loc hr	0.45	15
81383	Hla ii typing 1 allele hr	0.45	15
81400	Mopath procedure level 1	0.32	10
81401	Mopath procedure level 2	0.40	15
81402	Mopath procedure level 3	0.50	20
81403	Mopath procedure level 4	0.52	28
81404	Mopath procedure level 5	0.65	30
81405	Mopath procedure level 6	0.80	30
81406	Mopath procedure level 7	1.40	60
81407	Mopath procedure level 8	1.85	60
81408	Mopath procedure level 9	2.35	80

TABLE 22—AMA RUC–RECOMMENDED UTILIZATION CROSSWALKS FOR NEW MOLECULAR PATHOLOGY CPT CODES

Source	Destination	Analytic ratio*
83912 26	81206	0.116
83912 26	81207	0.003
83912 26	81208	0.003
83912 26	81210	0.020
83912 26	81220	0.017
83912 26	81221	0.003
83912 26	81222	0.003
83912 26	81223	0.003
83912 26	81224	0.003
83912 26	81225	0.006
83912 26	81226	0.006
83912 26	81227	0.011
83912 26	81240	0.073
83912 26	81241	0.110
83912 26	81243	0.003
83912 26	81244	0.000
83912 26	81245	0.014
83912 26	81256	0.050

TABLE 22—AMA RUC–RECOMMENDED UTILIZATION CROSSWALKS FOR NEW MOLECULAR PATHOLOGY CPT CODES—Continued

Source	Destination	Analytic ratio*
83912 26	81257	0.014
83912 26	81261	0.014
83912 26	81262	0.002
83912 26	81263	0.001
83912 26	81264	0.011
83912 26	81265	0.043
83912 26	81266	0.001
83912 26	81267	0.006
83912 26	81268	0.001
83912 26	81270	0.050
83912 26	81275	0.050
83912 26	81291	0.017
83912 26	81292	0.003
83912 26	81293	0.001
83912 26	81294	0.002
83912 26	81295	0.003
83912 26	81296	0.001
83912 26	81297	0.002

TABLE 22—AMA RUC–RECOMMENDED UTILIZATION CROSSWALKS FOR NEW MOLECULAR PATHOLOGY CPT CODES—Continued

Source	Destination	Analytic ratio*
83912 26	81298	0.001
83912 26	81299	0.002
83912 26	81300	0.001
83912 26	81301	0.003
83912 26	81302	0.001
83912 26	81303	0.000
83912 26	81304	0.000
83912 26	81310	0.014
83912 26	81315	0.017
83912 26	81316	0.003
83912 26	81317	0.002
83912 26	81318	0.001
83912 26	81319	0.001
83912 26	81331	0.001
83912 26	81332	0.003
83912 26	81340	0.011
83912 26	81341	0.003
83912 26	81342	0.017

TABLE 22—AMA RUC–RECOMMENDED UTILIZATION CROSSWALKS FOR NEW MOLECULAR PATHOLOGY CPT CODES—Continued

Source	Destination	Analytic ratio*
83912 26	81350	0.002
83912 26	81355	0.011
83912 26	81370	0.043
83912 26	81371	0.029
83912 26	81372	0.011
83912 26	81373	0.011
83912 26	81374	0.029
83912 26	81375	0.006
83912 26	81376	0.006
83912 26	81377	0.006
83912 26	81378	0.006
83912 26	81379	0.003
83912 26	81380	0.003
83912 26	81381	0.003
83912 26	81382	0.003
83912 26	81383	0.003
83912 26	81400	0.007
83912 26	81401	0.007
83912 26	81402	0.007
83912 26	81403	0.007
83912 26	81404	0.007
83912 26	81405	0.007
83912 26	81406	0.003
83912 26	81407	0.003
83912 26	81408	0.003

*Percentage of source code utilization transferred to the destination code

J. Payment for New Preventive Service HCPCS G-Codes

Under section 1861(ddd) of the Act, as amended by Section 4105 of the Affordable Care Act, CMS is authorized to add coverage of ''additional preventive services'' if certain statutory criteria are met as determined through the national coverage determination (NCD) process, including that the service meets all of the following criteria: (1) They must be reasonable and necessary for the prevention or early detection of illness or disability, (2) they must be recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and (3) they must be appropriate for individuals entitled to benefits under Part A or enrolled under Part B. After reviewing the USPSTF recommendations for the preventive services, conducting evidence reviews, and considering public comments under the NCD process, we determined that the above criteria were met for the services listed in Table 23. Medicare now covers each of the following preventive services:

- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse, effective October 14, 2011;
- Screening for Depression in Adults, effective October 14, 2011;
- Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs, effective November 8, 2011;
- Intensive Behavioral Therapy for Cardiovascular Disease, effective November 8, 2011; and
- Intensive Behavioral Therapy for Obesity, effective November 29, 2011.

Table 23 lists the HCPCS G-codes created for reporting and payment of these services. The Medicare PFS payment rates for these services are discussed below. The NCD process establishing coverage of these preventive services was not complete at the time of publication of the CY 2012 PFS final rule in early November, so we could not indicate interim RVUs for these preventive services in our final rule addenda. However, we were able to include HCPCS G-codes and national payment amounts for these services in the CY 2012 PFS national relative value files, which became available at the end of the year and were effective January 1, 2012. From the effective date of each service to December 31, 2011, the payment amount for these codes was established by the Medicare Administrative Contractors.

TABLE 23—NEW PREVENTIVE SERVICE HCPCS G-CODES

HCPCS Code	HCPCS Code long descriptor	CMS National Coverage Determination (NCD)	CMS Change Request (CR)
G0442	Annual alcohol misuse screening, 15 minutes	Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (NCD 210.8).	CR7633
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes.	Screening Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (NCD 210.8).	CR7633
G0444	Annual Depression Screening, 15 minutes	Screening for Depression in Adults (NCD 210.9)	CR7637
G0445	High-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior; performed semi-annually, 30 minutes.	Screening for Sexually Transmitted infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent STIs (NCD 210.10).	CR7610
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes.	Intensive Behavioral Therapy for Cardiovascular Disease (NCD 210.11).	CR7636
G0447	Face-to-face behavioral counseling for obesity, 15 minutes.	Intensive Behavioral Therapy for Obesity (NCD 210.12).	CR7641

Two new HCPCS codes, G0442 (Annual alcohol misuse screening, 15 minutes), and G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), were created for the reporting and payment of screening and behavioral counseling interventions in primary care to reduce alcohol misuse.

We believe that the screening service described by HCPCS code G0442 requires similar physician work as CPT code 99211 (Level 1 office or other outpatient visit, established patient), that may not require the presence of a physician. CPT code 99211 has a work RVU of 0.18 and we believe HCPCS code G0442 should be valued similarly. As such, we are proposing a work RVU of 0.18 for HCPCS code G0442 for CY 2013. For physician time, we are proposing 15 minutes, which is the amount of time specified in the HCPCS code descriptor. For malpractice expense, we are proposing a malpractice expense crosswalk to CPT code 99211. The proposed direct PE inputs are reflected in the CY 2013 proposed direct PE input database, available on the CMS Web site under the downloads for the CY 2013 PFS proposed rule at *http://www.cms.gov/PhysicianFeeSched/*. We request public comment on these CY 2013 proposed values for HCPCS code G0442, which are the same as the current (CY 2012) values for this service.

We believe that the behavioral counseling service described by HCPCS