Key Provisions of the Medicare Physician Fee Schedule Proposed Rule for CY 2014

Summary prepared by the American Medical Association

Background: A more than 600-page proposed rule to govern Medicare physician payment policy in 2014 was released by CMS on July 8 and published in the Federal Register on July 19. Comments are due September 6; a final rule will be issued on or around November 1. AMA will circulate draft comments to states and specialties prior to the deadline. A summary of key provisions and a CMS-prepared impact table follow.

Potentially Misvalued Services/Relative Value Issues: Since 2006, the AMA/Specialty Society RVS Update Committee (RUC) has identified over 1,500 potentially misvalued services through objective screening criteria and has completed review of approximately 1,300 of these services. The RUC's efforts for 2009-2013 have resulted in $2.5 billion in redistribution within the Medicare Physician Payment Schedule. The proposed rule recognizes this significant work and indicates that CMS will continue to examine potentially misvalued codes with the RUC and other individuals and stakeholder groups. As part of this effort, CMS is asking the RUC to review about a dozen services that its contractor medical directors suggested may be misvalued. The agency also accepted 48 RUC-recommended practice expense refinements and has asked for RUC input on a number of other practice expense issues to be addressed in future rulemaking.

In direct contrast to the RUC's use of objective screens and cross-specialty review, CMS has also proposed an arbitrary new policy calling for large payment reductions for over 200 services it assumes are "misvalued" simply because Medicare payment is greater in the physician's office than in a hospital outpatient department (HOPD) or ambulatory surgical center (ASC). The agency proposes, with a few exceptions, to cap physician payments for these services at the HOPD or ASC level. An example of the consequences of this proposal is CPT code 88367 *Insitu Hybridization Auto*, which is most commonly performed in an independent laboratory or pathology office. The service, which requires a $150 kit, is currently paid at $258.23 in this setting. In contrast, code 88367 is rarely performed in the HOPD and its associated costs have been averaged together with other services with significantly less practice costs to produce a payment of only $54.92 in this setting. Thus, CPT code 88367 will see a 79% cut in payment due to this capitation proposal. For hospitals, payments above and below the cost of the service are assumed to average out over time. But physicians (who are not paid the hospital rate for other services within the group where the $54.92 average more than covers costs) cannot offset their losses this way. The AMA will aggressively oppose this proposal and seek to delay implementation until the RUC can review these codes.

Payment for Care Coordination: As a result of the ongoing efforts of the AMA CPT Editorial Panel and the RUC to identify non face-to-face physician services and advocate for recognition of the physician work and resource costs involved, CMS has proposed to expand its coverage of care coordination services. Historically, CMS has declined to cover non face-to-face services (e.g. telephone calls, team conferences) on grounds that they are already covered as a component of Evaluation and Management (E/M) services. An extensive effort by a CPT Editorial Panel and RUC Chronic Care Coordination Workgroup (C3W), convinced CMS that the current E/M codes do not adequately capture the costs of providing care to all Medicare patients. As a result, CMS agreed to cover transitional care management in 2013 and is now proposing to also pay for complex chronic care coordination as of 2015.

The CMS proposal mimics language adopted for CPT 2014 to allow reporting for patients who have two or more chronic conditions, are at risk for death or significant decline, and are expected to require care management for at least 12 months or until the patient's death. While the CPT language does include some instruction related to practice capabilities (e.g., 24 hour/7 day per week communication access), CMS is proposing more significant requirements. CMS has also added several requirements intended to ensure that beneficiaries have consented to the arrangement and would require reporting in 90-day increments rather than the monthly basis called for by CPT. The agency has not yet proposed relative values or offered any payment information related to the services. Over the next year, CPT and the RUC will work with CMS and stakeholders to discourage overly burdensome requirements and to ensure that all the necessary resources are captured in the payment.

Revisions to the Medicare Economic Index (MEI): In response to AMA advocacy, CMS in 2012 convened a technical expert panel to conduct a comprehensive review of the MEI. The panel made 13 recommendations to improve the accuracy of the MEI, ten of which are included in the proposed rule. Major revisions are: moving payroll for non-physician personnel who can bill independently from the practice expense portion to the physician compensation (work) portion of the index; changing the price proxy for physician compensation to wages of professionals instead of all private non-farm workers; creating new categories for clinical labor costs and for other professional services like billing; and changing the price proxy for fixed capital to business office space costs instead of residential costs. Review of historical values shows that in some years the revised MEI would have led to somewhat higher values and in others it would lead to somewhat lower values; for 2014, the current estimate for the revised MEI is 0.7 and unrevised is 0.8, but the value may change in the final rule. The change in payroll costs for non-physicians who can bill independently would increase the physician compensation share of the MEI from 48.3% to 50.9% and reduce the non-physician compensation share by the same amount. The proposed change will increase the "work" and decrease the "practice expense" shares of the relative value units and geographic indexes by the same amount.

Geographic Practice Cost Indexes (GPCIs): As it is required to do every three years, CMS proposes to update the GPCIs to use more recent data (see downloads at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-P.html) but no major changes are proposed in the GPCI methods or payment locality definitions. New professional liability premium data for Puerto Rico boosts that area's malpractice GPCI by 17%. There is a modest impact on the GPCIs due to the MEI-related change in the shares of work vs. practice expense, particularly notable because 100% of practice expense geographic changes are reflected in the practice expense GPCI but only 25% of physician work geographic differences are reflected in the work GPCI. The GPCI update is phased in over two years. An AMA analysis (http://www.ama-assn.org/resources/doc/washington/gpci-changes-table.pdf) looking at the impacts of the GPCI update shows that the changes range from minus 4% to plus 3% with most localities seeing changes of less than one percent over the two-year period. CMS is seeking comments on whether it should use a proprietary source it has identified for commercial rent data instead of continuing to use residential rent data.

Physician Compare: CMS continues to implement modifications in the Physician Compare web site and is proposing to expand public reporting for both group practices and individual eligible practitioners (EPs) starting in 2015, based on 2014 data. The AMA has been very involved with CMS as the agency moves forward on this initiative. Physician input is critical to ensuring the site provides information that is accurate and useful for patients and physicians. While the AMA was pleased with several changes CMS recently made to the web site, including using claims data to verify physicians' information and modifying the search function related to how physicians and specialties are listed, additional improvements are necessary to ensure both the search function and underlying demographics of the data are accurate.

For 2014, CMS proposes to expand the quality measures posted on Physician Compare by publicly reporting performance on *all* measures collected through the GPRO web interface for groups of all sizes participating in 2014 under the PQRS GPRO and for ACOs participating in the Medicare Shared Savings Program (MSSP). The agency will provide a 30 day preview period prior to publication of quality data on Physician Compare so that group practices and ACOs can view their data as it will appear on Physician Compare before it is publicly reported. The AMA's comments will express disappointment that CMS is proposing to expand the web site, prior to ensuring the accuracy of the underlying database.

PQRS

2014 PQRS Participation, Incentives, and Penalties: 2014 is the last year a physician can qualify for an incentive payment of 0.5% under PQRS. 2014 will also serve as the performance year for the 2016 penalty adjustment of 2%. For individual participation, CMS proposes to increase the

number of measures that must be reported from three to nine measures. (The measures must cover at least three of the National Quality Strategy domains).

CMS will no longer recognize the reporting of one measure or one measures group, or the election of Administration Claims reporting conducted by CMS as viable reporting options for *avoiding* a PQRS penalty. However, physicians may report on three measures on 50% of their applicable patients to *avoid* the 2016 PQRS penalty. CMS also proposes to lower the percentage of applicable patients a physician must report on from 80% to 50% in order to be considered a satisfactory reporter. PQRS measures groups in 2014 will only be reportable through a registry. In addition, the agency will eliminate the six-month registry reporting period for 2014. CMS proposes to allow only groups with 100 or more EPs to report via the GPRO web interface. Moreover, CMS proposes a new reporting mechanism that would allow groups of 25 or more EPs to count reporting of CG CAHPS survey measures towards meeting the criteria for satisfactory reporting for the 2014 PQRS incentive and avoiding the 2016 PQRS penalty. Finally, for group practices reporting individual measures via registry, CMS proposes to increase the number of measures that must be reported from three to nine and proposes a 50% threshold instead of an 80% threshold, which is also proposed for the individual satisfactory reporting criteria for the 2014 PQRS incentive.

PQRS Qualified Clinical Data Registries: CMS proposes to add a new clinical data registry option permitting physicians and other PQRS-eligible professionals to report quality measures used by clinical data registry instead of those on the PQRS measures list. Clinical data registries would need to be able to at least capture nine measures covering at least three of the National Quality Strategy domains. The rule proposes a very high bar for qualifying clinical registries in 2014. AMA will advocate for a more phased approach to allow flexibility in how clinical registries meet PQRS qualification criteria over time.

PQRS Measures and Measures Groups: For 2014, CMS proposes to add 47 new individual measures and three measures groups to fill existing measure gaps, and to retire a number of claims-based measures to encourage reporting via registry and EHR-based reporting mechanisms. CMS proposes to modify the definition of a measures group for 2014, requiring a measures group to consist of six measures, rather than four. The proposed rule also maintains that while CMS still has the statutory authority to use non-NQF (National Quality Forum) endorsed measures, the agency believes that each PQRS quality measure must be endorsed by NQF. Also, in response to requests from certain hospital-based physician groups, CMS is proposing to include measures available under the Hospital inpatient quality reporting program (that have been retooled to be reported via the registry based reporting mechanism) for the 2014 PQRS.

Potential Future Changes: CMS is exploring ways to merge the feedback reports provided to participants in PQRS and for calculation of the Value-Based Modifier so that an EP would receive one, merged feedback report showing reporting data for PQRS and performance data for the VBM. In addition, the agency seeks comment as to whether to eliminate the claims-based reporting mechanism beginning with 2017. The AMA opposes elimination of the claims based reporting option until more physicians are participating in the PQRS program using alternative reporting modalities.

Electronic Health Record (EHR) Incentive Program: CMS proposes to permit PQRS-eligible professionals to submit clinical quality measure (CQM) information using qualified clinical registries (as defined above for the PQRS program) for purposes of meeting the CQM reporting component of meaningful use for the Medicare EHR Incentive program beginning in 2014.

Value-Based Payment Modifier (VBM):
Despite serious unresolved methodological issues, the proposed rule would more than double the number of physicians who are subject to the VBM and would also increase penalties under the program from a maximum of 1% to a maximum of 2%. The law requires the VBM to be phased in over a three-year period beginning in 2015 and ending in 2017, when it would apply to ***all*** physicians. However, CMS, over the protests of the AMA, is basing adjustments in any given year on a "performance year" two years earlier, which means that any requirements attached to the 2016 payment adjustment essentially take effect in 2014. Last year, the AMA convinced CMS to limit the application of VBM to groups of 100 (rather than 25) or more physicians and other PQRS-eligible professionals. Now, the agency is proposing to apply VBM to physicians in groups of ten or larger in 2016, thereby extending the payment adjustment to an estimated 58% of physicians. Payments for affected physicians would be cut by 2% in 2016 unless they successfully participated in one of the PQRS group options or unless 70% of the physicians and other eligible professionals in the group participated in PQRS as individuals. Successful PQRS participants would then be subject to a second "quality tiering" step where groups are compared nationally on quality and cost and have the potential to earn an unspecified bonus or a penalty of up to 2%. In 2014, however, only the groups of 100 or more would be subject to penalties. The AMA has repeatedly argued that the Value-Based Modifier is a flawed concept that cannot be equitably applied across the board to all physicians. Efforts to repeal the proposal, slow its expansion, limit potential penalties, and eliminate the two-year lag between performance and adjustment years will continue.

Physician Feedback Reports: For a preview of the impact of the VBM on physicians' payments, in September of this year, physicians in groups of 25 or more PQRS-eligible professionals will have access to a confidential feedback report that is based on 2012 data for their Medicare patients. Officially known as Quality and Resource Use Reports (QRURs), these reports will compare quality and resource use among physicians and will provide a preview of

how affected groups might fare under the VBM. QRURs have now been tested in nine states and with 54 large physician groups. The goal is to provide feedback reports to physicians in all groups and solo practices by fall of 2014 and to provide the ability to drill down to additional data, including patient identity, as recommended by the AMA and its state and specialty society work group on the QRURs.

Telehealth Services: CMS proposes an expansion of geographic locations where telehealth services may be covered by Medicare. Currently, CMS is permitted to cover Medicare telehealth services in a county that is not a Metropolitan Statistical Area (MSA), in designated rural health professional shortage areas (HPSAs); or sites participating in a federal telemedicine demonstration project. The proposed rule would expand permissible sites located in rural census tracts as determined by the Office of Rural Health Policy. CMS also proposes to expand telehealth service codes that will be reimbursed by Medicare to include transitional care management services.

Investigational Devices Exemption(IDE): CMS proposes, based on the broad grant of authority to administer the Medicare program, to establish new criteria governing coverage of the costs and routine items and services in Category A and B IDE studies and trials. In addition to establishing new uniform scientific and ethical standards, CMS would make all IDE coverage decisions centrally rather than leaving decisions to its contractors because it believes this change will eliminate coverage variations that impact national clinical trials. While the various proposals establish uniformity and centralization, the new standards could prove a significant barrier.

Chiropractors Billing for Evaluation & Management (E/M) Services: In response to questions that have arisen as to "whether it would be appropriate to allow chiropractors to furnish and bill Medicare for E/M services," CMS is seeking public comment on whether Medicare should allow chiropractors to use E/M codes for services beyond the "pre-manipulative patient assessment" included in CPT codes 98940-98942, *Chiropractic Manipulation Treatment.* CMS poses detailed questions on appropriate clinical situations, services, and current E/M codes; potential patient benefits; whether new "chiropractic E/M" codes would be needed; projected volume; and whether these services are "already being furnished by another physician or other practitioner." CMS will consider possible modifications in future rulemaking but is not proposing to pay chiropractors for E/M services in CY 2014.

Colorectal Cancer Screening/Fecal Occult Blood Tests: Current Medicare coverage rules require an attending physician to write an order for a screening fecal occult blood test (FOBT). CMS proposes, starting in 2014, to also allow physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) to order a screening FOBT. The rule notes that PAs, NPs and CNSs can now order diagnostic tests and conduct wellness visits, and says a physician order is no longer needed to ensure that beneficiaries receive counseling on the implications of

the test results. CMS invites public comment, including on whether "a practitioner permitted to order a screening FOBT must be the beneficiary's attending practitioner."

Clinical Laboratory Fee Schedule: In a marked departure from current practice, CMS proposes to establish a process to reexamine the payment amounts established under the Clinical Laboratory Fee Schedule (CLFS) to determine if changes in technology for the delivery of that service warrant an adjustment to the payment amount. It is widely expected that this would generally lead to reductions in payment. CMS points to the substantial reduction in cost over the past decade of sequencing the human genome to support the proposal that adjustments are warranted in light of the rate of technological change and often dramatic decrease in costs. This proposal will impact payment for independent and hospital laboratories, as well as diagnostic tests furnished in a physician's office.

Liability for Overpayments: CMS waives recovery of overpayments in certain "without fault" situations where the overpayment is not identified within a specific time period. Previously, the law allowed a three-year look-back period. The proposed rule implements changes enacted by the American Taxpayer Relief Act of 2012 that give Medicare more time to recover overpayments – extending the three-year time limit to five years. CMS still retains its authority to reopen claims at any time in cases of fraud. It is important to note that CMS has previously proposed a ten year look back period for overpayments in a proposed rule issued in 2012, still pending. The AMA strongly opposed the ten-year look-back period and suggested it be aligned with other program integrity look backs of three years. Congress authorized the extension to five years, which we will oppose in our comments on the fee schedule.

Other provisions:

- Stipulate that outpatient therapy caps do apply to critical access hospitals.
- Add language to ensure that "incident to" services are provided only by practitioners permitted under state law to do so.
- Eliminate a provision that made coverage for abdominal aortic aneurysm screening contingent on a referral stemming from an initial preventive visit within the past year.

Impact Estimates of the CY 2014 PFS on Total Allowed Charges by Specialty*

The following is an explanation of the information represented in Table 71:
• Column A (Specialty): The Medicare specialty code as reflected in our physician/supplier enrollment files.
• Column B (Allowed Charges): The aggregate estimated PFS allowed charges for the specialty based on CY 2012 utilization and CY 2013 rates. That is, allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty.
• Column C (Impact of Work and Malpractice (MP) RVU Changes): This column shows the estimated CY 2014 impact on total allowed charges of the changes in the work and malpractice RVUs, including the impact of changes due to potentially misvalued codes.
• Column D (Impact of PE RVU Changes): This column shows the estimated CY 2014 impact on total allowed charges of the changes in the PE RVUs.
• Column E (Combined Impact): This column shows the estimated CY 2014 combined impact on total allowed charges of all the changes in the previous columns.

TABLE 71—CY 2014 PFS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY *

Specialty	Allowed charges (mil)	Impact of work and MP RVU changes (percent)	Impact of PE RVU changes (percent)	Combined impact (percent)
(A)	(B)	(C)	(D)	(E)
TOTAL	$86,995	2	−2	0
01—ALLERGY/IMMUNOLOGY	213	1	−4	−3
02—ANESTHESIOLOGY	1,862	4	−1	3
03—CARDIAC SURGERY	355	3	−1	2
04—CARDIOLOGY	6,425	2	0	2
05—COLON AND RECTAL SURGERY	158	2	−2	0
06—CRITICAL CARE	273	3	−1	2
07—DERMATOLOGY	3,113	2	−4	−2
08—EMERGENCY MEDICINE	2,929	3	0	3
09—ENDOCRINOLOGY	447	2	−2	0
10—FAMILY PRACTICE	6,358	2	−1	1
11—GASTROENTEROLOGY	1,901	3	−2	1
12—GENERAL PRACTICE	528	2	−2	0
13—GENERAL SURGERY	2,236	3	−2	1
14—GERIATRICS	231	3	−1	2
15—HAND SURGERY	151	2	−2	0
16—HEMATOLOGY/ONCOLOGY	1,890	2	−3	−1
17—INFECTIOUS DISEASE	635	3	−1	2
18—INTERNAL MEDICINE	11,416	3	−2	1
19—INTERVENTIONAL PAIN MGMT	640	2	−3	−1
20—INTERVENTIONAL RADIOLOGY	219	2	−6	−4
21—MULTISPECIALTY CLINIC/OTHER PHY	79	2	−2	0
22—NEPHROLOGY	2,123	3	−2	1
23—NEUROLOGY	1,498	2	−4	−2
24—NEUROSURGERY	712	2	−1	1
25—NUCLEAR MEDICINE	51	2	−1	1
27—OBSTETRICS/GYNECOLOGY	688	2	−2	0
28—OPHTHALMOLOGY	5,592	2	−2	0
29—ORTHOPEDIC SURGERY	3,683	2	−2	0
30—OTOLARNGOLOGY	1,128	2	−4	−2
31—PATHOLOGY	1,134	3	−8	−5
32—PEDIATRICS	63	3	−3	0
33—PHYSICAL MEDICINE	999	3	−3	0
34—PLASTIC SURGERY	367	2	−2	0
35—PSYCHIATRY	1,165	3	−1	2
36—PULMONARY DISEASE	1,775	3	−2	1
37—RADIATION ONCOLOGY	1,783	1	−6	−5
38—RADIOLOGY	4,635	2	−3	−1
39—RHEUMATOLOGY	551	2	−5	−3
40—THORACIC SURGERY	332	3	−1	2
41—UROLOGY	1,858	2	−4	−2
42—VASCULAR SURGERY	925	2	−4	−2
43—AUDIOLOGIST	56	2	−1	1
44—CHIROPRACTOR	722	3	−1	2
45—CLINICAL PSYCHOLOGIST	579	4	−1	3
46—CLINICAL SOCIAL WORKER	408	4	−1	3
47—DIAGNOSTIC TESTING FACILITY	779	0	−7	−7
48—INDEPENDENT LABORATORY **	812	1	−27	−26
49—NURSE ANES/ANES ASST	1,055	4	0	4
50—NURSE PRACTITIONER	1,937	3	−2	1
51—OPTOMETRY	1,106	2	−2	0
52—ORAL/MAXILLOFACIAL SURGERY	44	2	−4	−2
53—PHYSICAL/OCCUPATIONAL THERAPY	2,797	2	−1	1
54—PHYSICIAN ASSISTANT	1,405	3	−2	1
55—PODIATRY	1,975	2	−2	0
56—PORTABLE X-RAY SUPPLIER	110	1	−2	−1

TABLE 71—CY 2014 PFS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY*—Continued

Specialty	Allowed charges (mil)	Impact of work and MP RVU changes (percent)	Impact of PE RVU changes (percent)	Combined impact (percent)
(A)	(B)	(C)	(D)	(E)
57—RADIATION THERAPY CENTERS	62	0	−13	−13
98—OTHER	25	3	−2	1

*Table 71 shows only the payment impact on PFS services. These impacts use a constant conversion factor and thus do not include the effects of the January 2014 conversion factor change required under current law.
**PFS Payments only, which account for ~17% of Independent Laboratory payments from Medicare.

Table 72 shows the estimated impact of selected policy proposals on total allowed charges, by specialty. The following is an explanation of the information represented in Table 72:

• Column A (Specialty): The Medicare specialty code as reflected in our physician/supplier enrollment files.

• Column B (Allowed Charges): The aggregate estimated PFS allowed charges for the specialty based on CY 2012 utilization and CY 2013 rates. That is, allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty.

• Column C (Impact of 2012 Claims data, 90 Percent Equipment Utilization Assumption, Ultrasound Changes, and Other Minor Changes): This column shows the estimated CY 2014 impact on total allowed charges of the changes in the RVUs due to the 90 percent equipment utilization assumption discussed in section II.A.2.f. of this proposed rule, ultrasound changes discussed in section II.A.5, the use of CY 2012 claims data to model payment rates, and all other proposals that result in minimal redistribution of payments under the PFS.

• Column D (Impact of OPPS/ASC cap): This column shows the estimated CY 2014 impact on total allowed charges of the changes in the RVUs resulting from our proposed policy discussed in section II.A.4. of this proposed rule.

• Column E (Impact of MEI Revision): This column shows the estimated CY 2014 combined impact on total allowed charges of the changes in the RVUs resulting from our proposed policy to adjust the RVUs to match the proposed revised MEI weights.

• Column F (Cumulative Impact): This column shows the estimated CY 2014 combined impact on total allowed charges of all the proposed changes in the previous columns.

TABLE 72—CY 2014 PFS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY BY SELECTED PROPOSAL*

Specialty	Allowed charges (mil)	Impact of 2012 claims data, 90% utilization assumption, ultrasound changes, and other minor changes (percent)	Impact of OPD/ASC cap (percent)	Impact of MEI revision (percent)	Total (cumulative) impact (percent)
(A)	(B)	(C)	(D)	(E)	(F)
TOTAL	$86,995	0%	0%	0%	0%
01—ALLERGY/IMMUNOLOGY	213	−1	0	−2	−3
02—ANESTHESIOLOGY	1,862	0	0	3	3
03—CARDIAC SURGERY	355	0	0	2	2
04—CARDIOLOGY	6,425	2	0	0	2
05—COLON AND RECTAL SURGERY	158	0	0	0	0
06—CRITICAL CARE	273	0	0	2	2
07—DERMATOLOGY	3,113	0	0	−2	−2
08—EMERGENCY MEDICINE	2,929	0	0	3	3
09—ENDOCRINOLOGY	447	−1	1	0	0
10—FAMILY PRACTICE	6,358	0	1	0	1
11—GASTROENTEROLOGY	1,901	0	0	1	1
12—GENERAL PRACTICE	528	0	0	0	0
13—GENERAL SURGERY	2,236	0	0	1	1
14—GERIATRICS	231	0	1	1	2
15—HAND SURGERY	151	−1	1	0	0
16—HEMATOLOGY/ONCOLOGY	1,890	−1	1	−1	−1
17—INFECTIOUS DISEASE	635	0	0	2	2
18—INTERNAL MEDICINE	11,416	0	1	0	1
19—INTERVENTIONAL PAIN MGMT	640	−1	0	0	−1
20—INTERVENTIONAL RADIOLOGY	219	−1	−2	−1	−4
21—MULTISPECIALTY CLINIC/OTHER PHY	79	−1	0	1	0

TABLE 72—CY 2014 PFS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY BY SELECTED PROPOSAL*—Continued

Specialty	Allowed charges (mil)	Impact of 2012 claims data, 90% utilization assumption, ultrasound changes, and other minor changes (percent)	Impact of OPD/ASC cap (percent)	Impact of MEI revision (percent)	Total (cumulative) impact (percent)
(A)	(B)	(C)	(D)	(E)	(F)
22—NEPHROLOGY	2,123	0	0	1	1
23—NEUROLOGY	1,498	0	−1	−1	−2
24—NEUROSURGERY	712	0	0	1	1
25—NUCLEAR MEDICINE	51	0	1	0	1
27—OBSTETRICS/GYNECOLOGY	688	0	0	0	0
28—OPHTHALMOLOGY	5,592	0	1	−1	0
29—ORTHOPEDIC SURGERY	3,683	−1	1	0	0
30—OTOLARNGOLOGY	1,128	−1	0	−1	−2
31—PATHOLOGY	1,134	1	−6	0	−5
32—PEDIATRICS	63	0	0	0	0
33—PHYSICAL MEDICINE	999	−1	1	0	0
34—PLASTIC SURGERY	367	0	1	−1	0
35—PSYCHIATRY	1,165	0	0	2	2
36—PULMONARY DISEASE	1,775	0	1	0	1
37—RADIATION ONCOLOGY	1,783	1	−4	−2	−5
38—RADIOLOGY	4,635	−1	0	0	−1
39—RHEUMATOLOGY	551	−3	1	−1	−3
40—THORACIC SURGERY	332	0	0	2	2
41—UROLOGY	1,858	−1	0	−1	−2
42—VASCULAR SURGERY	925	1	−3	0	−2
43—AUDIOLOGIST	56	0	1	0	1
44—CHIROPRACTOR	722	1	1	0	2
45—CLINICAL PSYCHOLOGIST	579	0	0	3	3
46—CLINICAL SOCIAL WORKER	408	0	0	3	3
47—DIAGNOSTIC TESTING FACILITY	779	−4	0	−3	−7
48—INDEPENDENT LABORATORY**	812	1	−25	−2	−26
49—NURSE ANES/ANES ASST	1,055	0	0	4	4
50—NURSE PRACTITIONER	1,937	0	1	0	1
51—OPTOMETRY	1,106	0	1	−1	0
52—ORAL/MAXILLOFACIAL SURGERY	44	0	−1	−1	−2
53—PHYSICAL/OCCUPATIONAL THERAPY	2,797	0	1	0	1
54—PHYSICIAN ASSISTANT	1,405	0	1	0	1
55—PODIATRY	1,975	−1	1	0	0
56—PORTABLE X-RAY SUPPLIER	110	1	1	−3	−1
57—RADIATION THERAPY CENTERS	62	0	−8	−5	−13
98—OTHER	25	0	1	0	1

*Table 72 shows only the payment impact on PFS services. These impacts use a constant conversion factor and thus do not include the effects of the January 2014 conversion factor change required under current law.

**PFS Payments only, which account for ~17% of Independent Laboratory payments.