furnished in conjunction with a screening colonoscopy.

We note that, in implementing these proposed revisions to the regulations, it will be necessary to establish a modifier for use when billing the relevant anesthesia codes for services that are furnished in conjunction with a screening colonoscopy and, thus, qualify for the waiver of the Part B deductible and coinsurance. If we adopt this proposal in the final rule, we will provide appropriate and timely information on this new modifier and its proper use so that physicians will be able to bill correctly for these services when the revised regulations become effective. We also note that the valuation of colonoscopy codes, which include moderate sedation, will be subject to the same proposed review as other codes that include moderate sedation, as discussed in section II.B.6 of this proposed rule.

I. Payment of Secondary Interpretation of Images

In general, Medicare makes one payment for the professional component of an imaging service for each technical component service that is furnished. Section 100.1, Chapter 13, of the Medicare Claims Processing Manual (Pub. 100–04) explains this policy in the context of EKGs and X-rays furnished in an Emergency Room. The manual section discusses the distinction between a "review" of an X-ray or EKG for which payment is included in the payment for the emergency department E/M payment, and the "interpretation and report" of an X-ray or EKG which can be billed separately and includes a written report addressing "the findings, relevant clinical issues, and comparative data (when available)." The section makes clear that a "professional component" interpretation service should only be billed for a full interpretation and report. The manual section goes on to explain that, in general, Medicare pays for only one interpretation of an EKG or X-ray service furnished to an emergency room patient. However, Medicare can pay for a second interpretation (which is billed using modifier −77) under "unusual circumstances (for which documentation is provided)." For instance, if an emergency room physician conducts an interpretation, identifies a questionable finding, and believes another physician's expertise is needed, then a second claim for an interpretation can be paid when furnished, for example, by a radiologist. The second interpretation must directly contribute to the diagnosis and treatment of the individual patient (rather than serving as a quality control measure), and the second interpretation must also be accompanied by a written report.

While a separate payment for the professional component for a radiology service is contingent upon meeting the conditions described in this section, practitioners bill Medicare and are paid for reviews of radiology images in other ways. For instance, review of a patient's previous radiology images is included and paid as part of the review of previous documentation in conjunction with E/M services. Reviews of extensive documentation and efforts to obtain previous documentation including existing imaging studies are considerations in deciding the appropriate level of complexity for evaluation and management services.[4]

In recent years, technological advances such as the integration of picture and archiving communications systems across health systems, growth in image sharing networks and health information exchange platforms through which providers can share images, and consumer-mediated exchange of images, have greatly increased physicians' access to existing diagnostic-quality radiology images. These advances offer new opportunities for physicians to reduce duplicative imaging, particularly with respect to high cost advanced diagnostic imaging modalities. For instance, a trauma patient transferred from a community hospital to a tertiary care center may arrive with high quality CT images sufficient to support an additional professional interpretation service. By accessing and utilizing these images to inform the diagnosis and record an interpretation in the medical record at the tertiary care facility, the provider and physicians may be able to avoid ordering substantially duplicative tests.

Questions have arisen as to whether and under what circumstances it would be appropriate for Medicare to permit payment under the PFS when physicians furnish subsequent interpretations of existing images, and whether uncertainty associated with payment for secondary interpretations inhibits physicians from seeking out, accessing, and utilizing existing images in cases where avoidance of a new study would result in savings to Medicare. We are seeking comment to assess whether there is an expanded set of circumstances under which it would be appropriate to allow more routine Medicare payment for a second professional component for radiology services, and whether such a policy would be likely to reduce the incidence of duplicative advanced imaging studies.

Specifically we are seeking comment on the following questions:

- For which radiology services are physicians currently conducting secondary interpretations, and what, if any, institutional policies are in place to determine when existing images are utilized? To what extent are physicians seeking payment for these secondary interpretations from Medicare or other payers?
- Should routine payment for secondary interpretations be restricted to certain high-cost advanced diagnostic imaging services, such as those defined as such under section 1834(e)(1)(B) of the Act, for example, diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography)?
- How should the value of routine secondary interpretations be determined? Is it appropriate to apply a modifier to current codes or are new HCPCS codes for secondary interpretations necessary?
- We believe most secondary interpretations would be likely to take place in the hospital setting. Are there other settings in which claims for secondary interpretations would be likely to reduce duplicative imaging services?
- Is there a limited time period within which an existing image should be considered adequate to support a secondary interpretation?
- Would allowing for more routine payment for secondary interpretations be likely to generate cost savings to Medicare by avoiding potentially duplicative imaging studies?
- What operational steps could Medicare take to ensure that any routine payment for secondary interpretations is limited to cases where a new imaging study has been averted while minimizing undue burden on providers or Part B contractors? For instance, steps might include restricting physicians' ability to refer multiple interpretations to another physician that is part of their network or group practice, requiring that physicians attach a physician's order for an averted imaging study to a claim for a secondary interpretation, or requiring physicians to identify the technical component of the existing image supporting the claim.

We seek comments on these questions, and welcome input on any additional considerations not mentioned here regarding the potential

[4] See, for example, 1997 Documentation Guidelines for Evaluation and Management Service, p. 45.

impact of allowing payment for secondary interpretation of images under other circumstances. Upon reviewing the comments received, we will consider whether any further action is appropriate, for instance, proposing under a future rulemaking to allow for payment of subsequent interpretations of advanced diagnostic images in lieu of duplicative studies.

J. Conditions Regarding Permissible Practice Types for Therapists in Private Practice

Section 1861(p) of the Act defines outpatient therapy services to include physical therapy, occupational therapy, and speech-language pathology services furnished by qualified occupational therapists, physical therapists, and speech-language pathologists in their offices and in the homes of beneficiaries. The regulations at §§ 410.59(c), 410.60(c), and 410.62(c) set forth special provisions for services furnished by therapists in private practice, including basic qualifications necessary to qualify as a supplier of occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP), respectively. As part of these basic qualifications, the current regulatory language includes descriptions of the various practice types for therapists' private practices. Based on our recent review of these three sections of our regulations, we are concerned that the language is not as clear as it could be—especially with regard to the relevance of whether a practice is incorporated. The regulations appear to make distinctions between unincorporated and incorporated practices, and some practice types are listed twice. Accordingly, we are proposing changes to the regulatory language to remove unnecessary distinctions and redundancies within the regulations for OT, PT, and SLP. We note that these proposed changes are for clarification only, and do not reflect any proposed change in our current policy.

To consistently specify the permissible practice types (a solo practice, partnership, or group practice; or as an employee of one of these) for suppliers of outpatient therapy services in private practice (for occupational therapists, physical therapists and speech-language pathologists), we propose to replace the regulatory text at § 410.59(c)(1)(ii)(A) through (E), § 410.60(c)(1)(ii)(A) though (E), and § 410.62(c)(1)(ii)(A) through (E).

K. Payments for Physicians and Practitioners Managing Patients on Home Dialysis

In the CY 2005 PFS final rule with comment period (69 FR 66357 through 66359), we established criteria for furnishing outpatient per diem ESRD-related services in partial month scenarios. We specified that use of per diem ESRD-related services is intended to accommodate unusual circumstances when the outpatient ESRD-related services would not be paid for under the monthly capitation payment (MCP), and that use of the per diem services are limited to the circumstances listed below.

- Transient patients—Patients traveling away from home (less than full month);
- Home dialysis patients (less than full month);
- Partial month where there were one or more face-to-face visits without the comprehensive visit and either the patient was hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient received a kidney transplant.
- Patients who have a permanent change in their MCP physician during the month.

Additionally, we provided billing guidelines for partial month scenarios in the Medicare claims processing manual, publication 100–04, chapter 8, section 140.2.1. For center-based patients, we specified that if the MCP physician or practitioner furnishes a complete assessment of the ESRD beneficiary, the MCP physician or practitioner should bill for the full MCP service that reflects the number of visits furnished during the month. However, we did not extend this policy to home dialysis (less than a full month) because the home dialysis MCP service did not include a specific frequency of required patient visits. In other words, unlike the ESRD MCP service for center-based patients, a visit was not required for the home dialysis MCP service as a condition of payment.

In the CY 2011 PFS final rule with comment period (75 FR 73295 through 73296), we changed our policy for the home dialysis MCP service to require the MCP physician or practitioner to furnish at least one face-to-face patient visit per month as a condition of payment. However, we inadvertently did not modify our billing guidelines for home dialysis (less than a full month) to be consistent with partial month scenarios for center-based dialysis patients. Stakeholders have recently brought this inconsistency to our attention. After reviewing this issue, we are proposing to allow the MCP physician or practitioner to bill for the age appropriate home dialysis MCP service (as described by HCPCS codes 90963 through 90966) for the home dialysis (less than a full month) scenario if the MCP physician or practitioner furnishes a complete monthly assessment of the ESRD beneficiary and at least one face-to-face patient visit. For example, if a home dialysis patient was hospitalized during the month and at least one face-to-face outpatient visit and complete monthly assessment was furnished, the MCP physician or practitioner should bill for the full home dialysis MCP service. We believe that this proposed change to home dialysis (less than a full month) provides consistency with our policy for partial month scenarios pertaining to patients dialyzing in a dialysis center. If this proposal is adopted, we would modify the Medicare Claims Processing Manual to reflect the revised billing guidelines for home dialysis in the less than a full month scenario.

III. Other Provisions of the Proposed Regulations

A. Ambulance Extender Provisions

1. Amendment to Section 1834(l)(13) of the Act

Section 146(a) of the MIPPA amended section 1834(l)(13)(A) of the Act to specify that, effective for ground ambulance services furnished on or after July 1, 2008 and before January 1, 2010, the ambulance fee schedule amounts for ground ambulance services shall be increased as follows:

- For covered ground ambulance transports that originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 3 percent.
- For covered ground ambulance transports that do not originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 2 percent.

The payment add-ons under section 1834(l)(13) of the Act have been extended several times. Recently, section 1104(a) of the Pathway for SGR Reform Act of 2013, enacted on December 26, 2013, as Division B (Medicare and Other Health Provisions) of Pub L. 113–67, amended section 1834(l)(13)(A) of the Act to extend the payment add-ons described above through March 31, 2014. Subsequently, section 104(a) of the Protecting Access to Medicare Act of 2014 (Pub. L. 113–93, enacted on April 1, 2014) amended section 1834(l)(13)(A) of the Act to extend the payment add-ons again