C. Medicare Telehealth Services

1. Billing and Payment for Telehealth Services

Several conditions must be met for Medicare to make payments for telehealth services under the PFS. The service must be on the list of Medicare telehealth services and meet all of the following additional requirements:

- The service must be furnished via an interactive telecommunications system.
- The service must be furnished by a physician or other authorized practitioner.
- The service must be furnished to an eligible telehealth individual.
- The individual receiving the service must be located in a telehealth originating site.

When all of these conditions are met, Medicare pays a facility fee to the originating site and makes a separate payment to the distant site practitioner furnishing the service.

Section 1834(m)(4)(F)(i) of the Act defines Medicare telehealth services to include professional consultations, office visits, office psychiatry services, and any additional service specified by the Secretary, when furnished via a telecommunications system. We first implemented this statutory provision, which was effective October 1, 2001, in the CY 2002 PFS final rule with comment period (66 FR 55246). We established a process for annual updates to the list of Medicare telehealth services as required by section 1834(m)(4)(F)(ii) of the Act in the CY 2003 PFS final rule with comment period (67 FR 79988).

As specified at §410.78(b), we generally require that a telehealth service be furnished via an interactive telecommunications system. Under §410.78(a)(3), an interactive telecommunications system is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

Telephones, facsimile machines, and stand-alone electronic mail systems do not meet the definition of an interactive telecommunications system. An interactive telecommunications system is generally required as a condition of payment; however, section 1834(m)(1) of the Act allows the use of asynchronous "store-and-forward" technology when the originating site is part of a federal telemedicine demonstration program in Alaska or Hawaii. As specified in §410.78(a)(1), asynchronous store-and-forward is the transmission of medical information from an originating site for review by the distant site physician or practitioner at a later time.

Medicare telehealth services may be furnished to an eligible telehealth individual notwithstanding the fact that the practitioner furnishing the telehealth service is not at the same location as the beneficiary. An eligible telehealth individual is an individual enrolled under Part B who receives a telehealth service furnished at a telehealth originating site.

Practitioners furnishing Medicare telehealth services are reminded that these services are subject to the same non-discrimination laws as other services, including the effective communication requirements for persons with disabilities of section 504 of the Rehabilitation Act and language access for persons with limited English proficiency, as required under Title VI of the Civil Rights Act of 1964. For more information, see http://www.hhs.gov/ocr/civilrights/resources/specialtopics/hospitalcommunication.

Practitioners furnishing Medicare telehealth services submit claims for telehealth services to the MACs that process claims for the service area where their distant site is located. Section 1834(m)(2)(A) of the Act requires that a practitioner who furnishes a telehealth service to an eligible telehealth individual be paid an amount equal to the amount that the practitioner would have been paid if the service had been furnished without the use of a telecommunications system.

Originating sites, which can be one of several types of sites specified in the statute where an eligible telehealth individual is located at the time the service is being furnished via a telecommunications system, are paid a facility fee under the PFS for each Medicare telehealth service. The statute specifies both the types of entities that can serve as originating sites and the geographic qualifications for originating sites. With regard to geographic qualifications, §410.78(b)(4) limits originating sites to those located in rural health professional shortage areas (HPSAs) or in a county that is not included in a metropolitan statistical area (MSA).

Historically, we have defined rural HPSAs to be those located outside of MSAs. Effective January 1, 2014, we modified the regulations regarding originating sites to define rural HPSAs as those located in rural census tracts as determined by the Federal Office of Rural Health Policy of the Health Resources and Services Administration (HRSA) (78 FR 74811). Defining "rural" to include geographic areas located in rural census tracts within MSAs allows for broader inclusion of sites within HPSAs as telehealth originating sites. Adopting the more precise definition of "rural" for this purpose expands access to health care services for Medicare beneficiaries located in rural areas. HRSA has developed a website tool to provide assistance to potential originating sites to determine their geographic status. To access this tool, see the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

An entity participating in a federal telemedicine demonstration project that has been approved by, or received funding from, the Secretary as of December 31, 2000 is eligible to be an originating site regardless of its geographic location.

Effective January 1, 2014, we also changed our policy so that geographic status for an originating site would be established and maintained on an annual basis, consistent with other telehealth payment policies (78 FR 74400). Geographic status for Medicare telehealth

originating sites for each calendar year is now based upon the status of the area as of December 31 of the prior calendar year.

For a detailed history of telehealth payment policy, see 78 FR 74399.

2. Adding Services to the List of Medicare Telehealth Services

As noted previously, in the CY 2003 PFS final rule (67 FR 79988), we established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public with an ongoing opportunity to submit requests for adding services. Under this process, we assign any qualifying request to make additions to the list of telehealth services to one of two categories. Revisions to criteria that we use to review requests in the second category were finalized in the CY 2012 PFS final rule (76 FR 73102). The two categories are:

- Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter, a practitioner who is present with the beneficiary in the originating site. We also look for similarities in the telecommunications system used to deliver the service; for example, the use of interactive audio and video equipment.

- Category 2: Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the service is accurately described by the corresponding code when furnished via telehealth and whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient. Submitted evidence should include both a description of relevant clinical studies that

demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. Our evidentiary standard of clinical benefit does not include minor or incidental benefits.

Some examples of clinical benefit include the following:

- Ability to diagnose a medical condition in a patient population without access to clinically appropriate in-person diagnostic services.
- Treatment option for a patient population without access to clinically appropriate in-person treatment options.
- Reduced rate of complications.
- Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
- Decreased number of future hospitalizations or physician visits.
- More rapid beneficial resolution of the disease process treatment.
- Decreased pain, bleeding, or other quantifiable symptom.
- Reduced recovery time.

For the list of telehealth services, see the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html. Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, qualifying requests submitted before the end of CY 2016 will be considered for the CY 2018 proposed rule. Each request to add a service to the list of Medicare

telehealth services must include any supporting documentation the requester wishes us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requesters should be advised that any information submitted is subject to public disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, see the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

3. Submitted Requests to Add Services to the List of Telehealth Services for CY 2017

Under our existing policy, we add services to the telehealth list on a category 1 basis when we determine that they are similar to services on the existing telehealth list for the roles of, and interactions among, the beneficiary, physician (or other practitioner) at the distant site and, if necessary, the telepresenter. As we stated in the CY 2012 final rule with comment period (76 FR 73098), we believe that the category 1 criteria not only streamline our review process for publicly requested services that fall into this category, but also expedite our ability to identify codes for the telehealth list that resemble those services already on this list.

We received several requests in CY 2015 to add various services as Medicare telehealth services effective for CY 2017. The following presents a discussion of these requests, and our decisions regarding additions to the CY 2017 telehealth list. Of the requests received, we found that four services were sufficiently similar to ESRD-related services currently on the telehealth list to qualify on a category 1 basis. Therefore, we proposed to add the following services to the telehealth list on a category 1 basis for CY 2017:

- CPT codes 90967 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age; 90968 (End-stage

renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age; 90969 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age); and 90970 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older).

As we indicated in the CY 2015 final rule with comment period (80 FR 41783), for the ESRD-related services (CPT codes 90963-90966) added to the telehealth list for CY 2016, the required clinical examination of the catheter access site must be furnished face-to-face "hands on" (without the use of an interactive telecommunications system) by a physician, CNS, NP, or PA. This requirement also applies to CPT codes 90967-90970.

While we did not receive a specific request, we also proposed to add two advance care planning services to the telehealth list. We have determined that these services are similar to the annual wellness visits (HCPCS codes G0438 & G0439) currently on the telehealth list:

- CPT codes 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), or surrogate); and 99498 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)).

We also received requests to add services to the telehealth list that do not meet our criteria for Medicare telehealth services. We did not propose to add the following procedures for observation care, emergency department visits, critical care E/M, psychological testing, and

physical, occupational and speech therapy, for the reasons noted:

a. Observation Care: CPT codes--

- 99217 (observation care discharge day management (this code is to be utilized to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for observation or inpatient care services [including admission and discharge services, 99234-99236 as appropriate.]));

- 99218 (initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit);

- 99219 (initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit);

- 99220 (initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit);

- 99224 (subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: problem focused interval history; problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit);

- 99225 (subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit);

- 99226 (subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit);

- 99234 (observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit);

- 99235 (observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually the presenting problem(s) requiring

admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit);

- 99236 (observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit);

The request to add these observation services referenced various studies supporting the use of observation units. The studies indicated that observation units provide safe, cost effective care to patients that need ongoing evaluation and treatment beyond the emergency department visit by having reduced hospital admissions, shorter lengths of stay, increased safety and reduced cost. Additional studies cited indicated that observation units reduce the work load on emergency department physicians, and reduce emergency department overcrowding.

In the CY 2005 PFS proposed rule (69 FR 47510), we considered a request but did not propose to add the observation CPT codes 99217-99220 to the list of Medicare telehealth services on a category two basis for the reasons described in that rule. The most recent request did not include any information that would cause us to question the previous evaluation under the category one criterion, which has not changed, regarding the significant differences in patient acuity between these services and services on the telehealth list. While the request included evidence of the general benefits of observation units, it did not include specific information

demonstrating that the services described by these codes provided clinical benefit when furnished via telehealth, which is necessary for us to consider these codes on a category two basis. Therefore, we did not propose to add these services to the list of approved telehealth services.

b. Emergency Department Visits: CPT codes--

- 99281 (emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the presenting problem(s) are self-limited or minor);

- 99282 (emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the presenting problem(s) are of low to moderate severity);

- 99283 (emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the presenting problem(s) are of moderate severity);

• 99284 (emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function); and

• 99285 (emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and mental status: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function).

In the CY 2005 PFS proposed rule (69 FR 47510), we considered a request but did not propose to add the emergency department visit CPT codes 99281-99285 to the list of Medicare telehealth services for the reasons described in that rule.

The current request to add the emergency department E/M services stated that the codes are similar to outpatient visit codes (CPT codes 99201-99215) that have been on the telehealth list since CY 2002. As we noted in the CY 2005 PFS final rule, while the acuity of some patients in the emergency department might be the same as in a physician's office; we believe

that, in general, more acutely ill patients are more likely to be seen in the emergency department, and that difference is part of the reason there are separate codes describing evaluation and management visits in the Emergency Department setting. The practice of emergency medicine often requires frequent and fast-paced patient reassessments, rapid physician interventions, and sometimes the continuous physician interaction with ancillary staff and consultants. This work is distinctly different from the pace, intensity, and acuity associated with visits that occur in the office or outpatient setting. Therefore, we did not propose to add these services to the list of approved telehealth services on a category one basis.

The requester did not provide any studies supporting the clinical benefit of managing emergency department patients with telehealth which is necessary for us to consider these codes on a category two basis. Therefore, we did not propose to add these services to the list of approved telehealth services on a category two basis.

Many requesters of additions to the telehealth list urged us to consider the potential value of telehealth for providing beneficiaries access to needed expertise. We note that if clinical guidance or advice is needed in the emergency department setting, a consultation may be requested from an appropriate source, including consultations that are currently included on the list of telehealth services.

c. Critical Care Evaluation and Management: CPT codes--

- 99291 (critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes); and 99292 (critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (list separately in addition to code for primary service).

We previously considered and rejected adding these codes to the list of Medicare

telehealth services in the CY 2009 PFS final rule (74 FR 69744) on a category 1 basis because, due to the acuity of critically ill patients, we did not believe critical care services are similar to any services on the current list of Medicare telehealth services. In that rule, we said that critical care services must be evaluated as category 2 services. Because we considered critical care services under category 2, we needed to evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter, based on the category 2 criteria at the time of that request. We had no evidence suggesting that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

The American Telemedicine Association (ATA) submitted a new request for CY 2016 that cited several studies to support adding these services on a category 2 basis. To qualify under category 2, we would need evidence that the service furnished via telehealth is still described accurately by the requested code and produces a clinical benefit for the patient via telehealth. However, in reviewing the information provided by the ATA and a study titled, "Impact of an Intensive Care Unit Telemedicine Program on Patient Outcomes in an Integrated Health Care System," published July 2014 in JAMA Internal Medicine, which found no evidence that the implementation of ICU telemedicine significantly reduced mortality rates or hospital length of stay, which could be indicators of clinical benefit. Therefore, we stated that we do not believe that the submitted evidence demonstrates a clinical benefit to patients. Therefore, we did not propose to add these services on a category 2 basis to the list of Medicare telehealth services for CY 2016 (80 FR 71061).

This year, requesters cited additional studies to support adding critical care services to the Medicare telehealth list on a category 2 basis. Eight of the studies dealt with telestroke and one with teleneurology. Telestroke is an approach that allows a neurologist to provide remote

treatment to vascular stroke victims. Teleneurology offers consultations for neurological problems from a remote location. It may be initiated by a physician or a patient, for conditions such as headaches, dementia, strokes, multiple sclerosis and epilepsy.

However, according to the literature, the management of stroke via telehealth requires more than a single practitioner and is distinct from the work described by the above E/M codes, 99291 and 99292. One additional study cited involved pediatric patients, while another noted that the Department of Defense has used telehealth to provide critical care services to hospitals in Guam for many years. Another reference study indicated that consulting intensivists thought that telemedicine consultations were superior to telephone consultations. In all of these cases, we believe the evidence demonstrates that interaction between these patients and distant site practitioners can have clinical benefit. However, we do not agree that the kinds of services described in the studies are those that are included in the above critical care E/M codes 99291 and 99292. We note that CPT guidance makes clear that a variety of other services are bundled into the payment rates for critical care, including gastric intubations and vascular access procedures among others We do not believe these kinds of services are furnished via telehealth. Public comments, included cited studies, can be viewed at https://www.regulations.gov/#!documentDetail;D=CMS-2015-0081-0002. Therefore, we did not propose to add CPT codes 99291 or 99292 to the list of Medicare telehealth services for CY 2017.

However, we are persuaded by the requests that we recognize the potential benefit of critical care consultation services that are furnished remotely. We note that there are currently codes on the telehealth list that could be reported when consultation services are furnished to critically ill patients. In consideration of these public requests, we recognize that there may be

greater resource costs involved in furnishing these services relative to the existing telehealth consultation codes. We also agree with the requesters that there may be potential benefits of remote care by specialists for these patients. For these reasons, we think it would be advisable to create a coding distinction between telehealth consultations for critically ill patients, for example stroke patients, relative to telehealth consultations for other hospital patients. Such a coding distinction would allow us to recognize the additional resource costs in terms of time and intensity involved in furnishing such services, under the conditions where remote, intensive consultation is required to provide access to appropriate care for the critically ill patient. We recognize that the current set of E/M codes, including current CPT codes 99291 and 99292, may not adequately describe such services because current E/M coding presumes that the services are occurring in-person, in which case the expert care would be furnished in a manner described by the current codes for critical care.

Therefore, we proposed to make payment through new HCPCS codes G0508 and G0509, initial and subsequent, used to describe critical care consultations furnished via telehealth. This new coding would provide a mechanism to report an intensive telehealth consultation service, initial or subsequent, for the critically ill patient, such as a stroke patient, under the circumstance when a qualified health care professional has in-person responsibility for the patient but the patient benefits from additional services from a distant-site consultant specially trained in providing critical care services. We proposed limiting these services to once per day per patient. Like the other telehealth consultations, these services would be valued relative to existing E/M services.

More details on the new coding (G0508 and G0509) and valuation for these services are discussed in section II.L. of this final rule and the final RVUs for this service are included in

Addendum B of this final rule, including a summary of the public comments we received and our responses to the comments. Like the other telehealth consultation codes, we proposed that these services would be added to the telehealth list and would be subject to the geographic and other statutory restrictions that apply to telehealth services.

d. Psychological Testing: CPT codes--

- 96101 (psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report);
- 96102 psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face);
- 96118 Neuropsychological testing (eg, Halstead-Reitan neuropsychological battery, Wechsler memory scales and Wisconsin card sorting test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report); and,
- 96119 Neuropsychological testing (eg, Halstead-Reitan neuropsychological battery, Wechsler memory scales and Wisconsin card sorting test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face).

Requesters indicated that there is nothing in the Minnesota Multiphasic Personality Inventory (MMPI), the Rorschach inkblot test, the Wechsler Adult Intelligence Scale (WAIS), the Halstead-Reitan Neuropsychological Battery and Allied Procedures, or the Wisconsin Card

Sorting Test (WCST), that cannot be done via telehealth nor is different than neurological tests done for Parkinson's disease, seizure medication side effects, gait assessment, nor any of the many neurological examinations done via telehealth with the approved outpatient office visit and inpatient visit CPT codes currently on the telehealth list. As an example, requesters indicated that the MPPI is administered by a computer, which generates a report that is interpreted by the clinical psychologist, and that the test requires no interaction between the clinician and the patient.

We previously considered the request to add these codes to the Medicare telehealth list in the CY 2015 final rule with comment period (79 FR 67600). We decided not to add these codes, indicating that these services are not similar to other services on the telehealth list because they require close observation of how a patient responds. We noted that the requesters did not submit evidence supporting the clinical benefit of furnishing these services via telehealth so that we could evaluate them on a category 2 basis. While we acknowledge that requesters believe that some of these tests require minimal, if any, interaction between the clinician and patient, we disagree. We continue to believe that successful completion of the tests listed as examples in these codes require the clinical psychologist to closely observe the patient's response, which cannot be performed via telehealth. Some patient responses, for example, sweating and fine tremors, may be missed when the patient and examiner are not in the same room. Therefore, we did not propose to add these services to the list of Medicare telehealth services for CY 2017.

e. Physical and Occupational Therapy and Speech-Language Pathology Services: CPT codes--

- 92507 (treatment of speech, language, voice, communication, and auditory processing disorder; individual); and, 92508 (treatment of speech, language, voice, communication, and auditory processing disorder; group, 2 or more individuals); 92521 (evaluation of speech fluency

(eg, stuttering, cluttering)); 92522 (evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)); 92523 (evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)); 92524 (behavioral and qualitative analysis of voice and resonance); (evaluation of oral and pharyngeal swallowing function); 92526 (treatment of swallowing dysfunction or oral function for feeding); 92610 (evaluation of oral and pharyngeal swallowing function); CPT codes 97001 (physical therapy evaluation); 97002 (physical therapy re-evaluation); 97003 (occupational therapy evaluation); 97004 (occupational therapy re-evaluation); 97110 (therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility); 97112 (therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, or proprioception for sitting or standing activities); 97116 (therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)); 97532 (development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes); 97533 (sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes); 97535 (self-care/home management training (eg, activities of daily living (adl) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes); 97537 (community/work reintegration training (eg, shopping, transportation, money management, avocational activities or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-

on-one contact, each 15 minutes); 97542 (wheelchair management (eg, assessment, fitting, training), each 15 minutes); 97750 (physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes); 97755 (assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes); 97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes); 97761 (prosthetic training, upper and lower extremity(s), each 15 minutes); and 97762 (checkout for orthotic/prosthetic use, established patient, each 15 minutes).

The statute defines who is an authorized practitioner of telehealth services. Physical therapists, occupational therapists and speech-language pathologists are not authorized practitioners of telehealth under section 1834(m)(4)(E) of the Act, as defined in section 1842(b)(18)(C) of the Act. Because the above services are predominantly furnished by physical therapists, occupational therapists and speech-language pathologists, we do not believe it would be appropriate to add them to the list of telehealth services at this time. One requester suggested that we can add telehealth practitioners without legislation, as evidenced by the addition of nutritional professionals. However, we do not believe we have such authority and note that nutritional professionals are included as practitioners in the definition at section 1834(b)(18)(C)(vi) of the Act, and thus, are within the statutory definition of telehealth practitioners. Therefore, we did not propose to add these services to the list of Medicare telehealth services for CY 2017.

In summary, we proposed to add the following codes to the list of Medicare telehealth services beginning in CY 2017 on a category 1 basis:

• ESRD-related services 90967 through 90970. The required clinical examination of the catheter access site must be furnished face-to-face "hands on" (without the use of an interactive telecommunications system) by a physician, CNS, NP, or PA.

• Advance care planning (CPT codes 99497 and 99498).

• Telehealth Consultations for a Patient Requiring Critical Care Services (G0508 and G0509)

The following is summary of the comments we received regarding the proposed addition of services the list of Medicare telehealth services:

Comment: Many commenters supported one or more of our proposals to add ESRD-related services (CPT codes 90967, 90968, 90969 and 90970) and advance care planning services (CPT codes 99497 and 99498) to the list of Medicare telehealth services for CY 2017.

Response: We appreciate the commenters' support for the proposed additions to the list of Medicare telehealth services. After consideration of the public comments received, we are finalizing our proposal to add these services to the list of Medicare telehealth services for CY 2017 on a category 1 basis.

Comment: Many commenters also supported the proposal to make payment through new codes, initial and subsequent, used to describe critical care consultations furnished via telehealth. Commenters indicated that the codes will improve patient outcomes and quality of care.

Response: We thank the commenters for their support. We believe the new coding G0508 and G0509 would provide a mechanism to report an intensive telehealth consultation service, initial or subsequent, for the critically ill patient, for example a stroke patient, under the circumstance when a qualified health care professional has in-person responsibility for the patient but the patient benefits from additional services from a distant-site consultant specially

trained in furnishing critical care services. After consideration of the public comments received, we are finalizing our proposal to add these critical care consultation services to the list of Medicare telehealth services for CY 2017 on a category 1 basis. We are finalizing these services as limited to once per day per patient.

We are also finalizing our proposal to make payment for these critical care consultation services through new codes G0508 and G0509, initial and subsequent, used to describe critical care consultations furnished via telehealth. More details on the new coding and valuation for these services are discussed in section II.L. of this final rule and the final RVUs for this service are included in Addendum B of this final rule. Like the other telehealth consultation codes, we proposed and are finalizing that these services would be added to the telehealth list and would be subject to the geographic and other statutory restrictions that apply to telehealth services.

Comment: Several commenters agreed with our decision not to add psychological and neuropsychological testing services to the telehealth list, noting that the face-to-face contact between the psychologist or technician and the beneficiary is critical for detecting behaviors related to test taking, such as movements or other nonverbal signals that could be missed by using current telehealth media.

A few commenters disagreed with our decision not to add psychological and neuropsychological testing services. Commenters cited general benefits, such as increased access to care, improved health outcomes, and as a remedy to address provider shortages. One commenter maintained that the requested codes are similar to many neurological examinations done via telehealth with the approved outpatient office visit and inpatient visit CPT codes currently on the telehealth list.

Response: As noted above, we previously considered the request to add these codes to the telehealth list, on a category 1 basis, in the CY 2015 final rule with comment period (79 FR 67600). We decided not to add these codes, indicating that these services are not similar to other services on the telehealth list because they require close observation of how a patient responds. Commenters provided no evidence of clinical benefit, which is necessary to support adding these services on a category 2 basis. Therefore, we are not adding these services to the list of Medicare list telehealth services for CY 2017.

Comment: A few commenters disagreed with our decision not to add observation care and emergency department visits. Commenters cited general benefits, such as improved quality of care, reduced physician workload, reduced emergency department overcrowding, and reduced shortage of available specialty services. Concerning CPT codes 99281-99283, one commenter indicated that none of these codes include what is categorized as a "detailed" or "comprehensive" history or exam; none of these codes include complexity in medical decision making that is categorized as "high;" and none of these codes include presenting problems of "high" or "high severity/immediate significant threat to life or physiological function."

Response: As noted above, we previously considered and rejected adding these codes to the list of Medicare telehealth services in the CY 2005 PFS final rule (69 FR 66276) on a category 1 basis because of the difference in typical patient acuity relative to any services on the current list of Medicare telehealth services. While CPT codes 99281-99283 may not include a detailed or comprehensive history or exam or a high level of medical decision making, we do not agree that these codes are similar to outpatient visit codes (CPT codes 99201-99215) currently on the list of Medicare telehealth services. As previously stated, more acutely ill patients are more likely to be seen in the emergency department, and that difference is part of the reason there are

separate codes describing evaluation and management visits in the Emergency Department setting. The work in an Emergency Department setting is distinctly different from the pace, intensity, and acuity associated with visits that occur in the office or outpatient setting. Commenters provided no evidence of clinical benefit for these services when furnished via telehealth specifically, which is necessary to support adding these services on a category 2 basis. Therefore, we are not adding these services to the list of Medicare telehealth services for CY 2017.

We remind stakeholders that if consultative telehealth services are required for patients where emergency department or observation care services would ordinarily be reported, multiple codes describing consultative services are currently on the telehealth list and can be used to bill for such telehealth services.

Comment: Concerning various services primarily furnished by physical therapists, occupational therapists, and speech-language pathologists, commenters recognized that a statutory change is required to allow such services to be added to the list of Medicare telehealth services.

Response: We appreciate commenters recognizing the statutory limitation on adding these services. Therefore, we are not adding these services to the list of Medicare telehealth services for CY 2017.

4. Place of Service (POS) Code for Telehealth Services

We have received multiple requests from various stakeholders to establish a POS code to identify services furnished via telehealth. These requests have come from other payers, but may also be related to confusion concerning whether to use the POS where the distant site physician is located or the POS where the patient is located. The process for establishing POS codes is

managed by the POS Workgroup within CMS, is available for use by all payers, and is not contingent upon Medicare PFS rulemaking. We noted in the CY 2017 proposed rule (81 FR 46184) that , if such a POS code were created, in order to make it valid for use in Medicare, we would have to determine the appropriate payment rules associated with the code. Therefore, we proposed how a POS code for telehealth would be used under the PFS with the expectation that, if such a code is available, it would be used as early as January 1, 2017. We proposed that the physicians or practitioners furnishing telehealth services would be required to report the telehealth POS code to indicate that the billed service is furnished as a telehealth service from a distant site. As noted below, since the publication of the CY 2017 proposed rule, the telehealth POS code has been created.

Our requirement for physicians and practitioners to use the telehealth POS code to report that telehealth services were furnished from a distant site would improve payment accuracy and consistency in telehealth claims submission. Currently, for services furnished via telehealth, we have instructed practitioners to report the POS code that would have been reported had the service been furnished in person. However, some practitioners use the POS where they are located when the service is furnished, while others use the POS corresponding to the patient's location.

Under the PFS, the POS code determines whether a service is paid using the facility or non-facility practice expense relative value units (PE RVUs). The facility rate is paid when a service is furnished in a location where Medicare is making a separate facility payment to an entity other than the physician or practitioner that is intended to reflect the facility costs associated with the service (clinical staff, supplies and equipment). We note that in accordance with section 1834(m)(2)(B) of the Act, the payment amount for the telehealth facility fee paid to

the originating site is a national fee, paid without geographic or site of service adjustments that generally are made for payments to different kinds of Medicare providers and suppliers. In the case of telehealth services, we believe that facility costs (clinical staff, supplies, and equipment) associated with furnishing the service would generally be incurred by the originating site, where the patient is located, and not by the practitioner at the distant site. The statute requires Medicare to pay a fee to the site that hosts the patient. This is analogous to the circumstances under which the facility PE RVUs are used to pay for services under the PFS. Therefore, we proposed to use the facility PE RVUs to pay for telehealth services reported by physicians or practitioners with the telehealth POS code. We note that there are only three codes on the telehealth list with a difference greater than 1.0 PE RVUs between the facility PE RVUs and the non-facility PE RVUs. We did not anticipate that this proposal would result in a significant change in the total payment for the majority of services on the telehealth list. Moreover, many practitioners already use a facility POS when billing for telehealth services (those that report the POS of the originating site where the beneficiary is located). The policy to use the telehealth POS code for telehealth services would not affect payment for telehealth services for these practitioners.

The POS code for telehealth would not apply to originating sites billing the facility fee. Originating sites are not furnishing a service via telehealth since the patient is physically present in the facility. Accordingly, the originating site would continue to use the POS code that applies to the type of facility where the patient is located.

We also proposed a change to §414.22(b)(5)(i)(A) that addresses the PE RVUs used in different settings. These revisions would improve clarity regarding our current policies. Specifically, we proposed to amend this section to specify that the facility PE RVUs are paid for

practitioner services furnished via telehealth under §410.78. In addition, we proposed a change to resolve any potential ambiguity and clarify that payment under the PFS is made at the facility rate (facility PE RVUs) when services are furnished in a facility setting paid by Medicare, including in off-campus provider based departments. As proposed, the regulation reflected the policy being proposed, for CY 2017 only, to pay the physician the nonfacility rate for services furnished in an off-campus provider based department that was not excepted under section 603 of the Bipartisan Budget Act of 2015. Finally, to streamline the existing regulation, we also proposed to delete §414.32 of our regulation that refers to the calculation of payments for certain services prior to 2002.

The following is summary of the comments we received regarding the proposal to use a POS code for services furnished via telehealth:

Comment: Many commenters supported the proposal to use the POS code for telehealth, indicating that it would clarify and simplify billing requirements, improve payment accuracy and consistency in telehealth claims submissions, and provide more reliable data regarding telehealth services.

Response: We appreciate the support for this proposal.

Comment: One commenter asked us to reconsider the proposal, noting that the AMA's CPT Editorial Panel has adopted a telehealth modifier for those medical services that are currently covered telehealth services by Medicare or other payers, which obviates the need for the POS code.

Response: The POS code was requested by other payers, and we continue to believe that adopting it for use in the Medicare program would provide consistency in reporting and identifying services furnished via telehealth. We have had longstanding HCPCS modifiers for

telehealth. While these modifiers were not adopted by CPT, they have been available for use by other payers. Despite the availability of these HCPCS modifiers noting telehealth services, payers have requested creation of the new POS code. Therefore, we do not understand why introduction of a new CPT modifier as opposed to a HCPCS modifier would obviate the need for a POS code. Instead, we agree with other payers that the POS code would provide consistency in reporting and identifying services furnished via telehealth, since it eliminates the need for service-specific rules regarding appropriate POS reporting for telehealth services.

Comment: Another commenter stated that use of the POS code, or originating site restrictions, would place additional administrative barriers for telepsychiatric access.

Response: We note that the POS is a required field on the professional claim, regardless of whether the service is furnished via telehealth. Since a selection needs to be made, we believe that requiring the selection of a specific code is no more burdensome than requiring the claim to specify the POS appropriate to either the setting of the telehealth patient or the setting of the distant site practitioner. The POS code does not entail any new originating site restrictions.

Comment: Various commenters asked for clarification of the following:

- Whether the POS code would replace the GT modifier.
- Whether the description of telehealth as a service furnished via an interactive audio and video telecommunications system applies to the POS code as it does to the GT modifier.
- How to ensure proper payment when the distant site practitioner is at a facility, but the patient is not.

Response: Under current policy, use of the GT and GQ modifiers certifies that the service meets the telehealth requirements, and would continue to be required. The POS code would be used in addition to the GT and GQ modifiers. We did not propose to implement a

change in the requirement to use either the GT and GQ modifier because at the time of the proposed rule, we did not know whether the telehealth POS code would be made effective for January 1, 2017. However, because under our proposal the POS code would serve to identify telehealth services furnished under section 1834(m) of the Act via an interactive audio and video telecommunications system, we believe that we should consider eliminating the required use of the GT and GQ telehealth modifiers, and we may revisit this question through future rulemaking. Like the modifiers, use of the POS code certifies that the service meets the telehealth requirements. Distant site providers will be paid using the facility PE RVUs, regardless of their location. The setting of the patient does not affect the payment to the distant site provider.

Comment: Commenters also asked for clarification that the proposal to adopt the telehealth POS relates solely to payment, and not to licensure requirements. The commenter noted that practitioners who furnish telehealth services must adhere to the standard of care and licensure rules, regulations and laws of the state where the patient is located, just as the practitioner would in a traditional face-to-face encounter.

Response: The commenters are correct that the purpose of our POS proposal is to assist in determining proper payment. It will also help us to accurately track telehealth utilization and spending. The proposal to adopt the telehealth POS code has no bearing on state licensure requirements or other state regulations. We appreciate the commenters' request for clarification.

Comment: Several commenters supported the proposal to use the facility PE RVUs for telehealth services. One commenter said paying some telehealth services at non-facility rates creates undesirable financial incentives to prefer telehealth services over services that are furnished in person at the originating site.

Response: We appreciate the support for the proposal and agree with the commenter's articulation regarding the importance of developing payment rates that reflect the relative resource costs of furnishing the services and that do not create unintended financial incentives.

Comment: Many other commenters opposed the proposal. Commenters stated that it would result in lower fees for telehealth services furnished by psychologists. Commenters also stated that PE costs increase for services furnished via telehealth due to the costs of HIPAA-compliant telecommunication equipment.

One commenter remarked that use of a POS code should not be the basis for reducing payments and that many codes would experience a significant payment change. The commenter noted that a 1.0 RVU reduction would result in a $36 payment reduction for the service. One commenter stated CMS should propose budget neutral PE and originating site fees, based on data, for CY 2018. One commenter noted that there are no facility PE RVUs for several codes.

Response: We do not believe that use of the telehealth POS code produces a significant payment change in the vast majority of circumstances. For distant site practitioners who are already paid using the facility PE RVUs and for services where there is no payment difference between the facility and non-facility PE RVUs, there will be no change in payment as a result of the telehealth POS code.

There is utilization data for 56 of the 81 codes on the telehealth list. For these codes, 20 are not paid differently based on site of service, and 27 codes are paid differently by fewer than 0.5 RVUs. There are only three codes on the telehealth list with a difference greater than 1.0 PE RVUs between the facility PE RVUs and the non-facility PE RVUs.

Concerning psychotherapy and psychological testing services, we note that for the vast majority of psychiatric services the difference between the two rates is very small. For example,

the difference between the facility and non-facility national rates for 45 minutes of psychotherapy is 0.02 RVUs per service: less than $1.00. The differences between the facility PE RVUs and non-facility PE RVUS ranges from 0.01-0.03 RVUs for nine of the psychological testing codes on the Medicare telehealth list, and 0.12 RVUs lower for two other codes. We do not consider these reductions significant, nor do we have any evidence that practice expense costs are greater for furnishing such services via telehealth than for furnishing a face-to-face service. Commenters provided no evidence that practice expense costs for services furnished via telehealth are greater, due to the requirement for HIPAA-compliant equipment, than for furnishing in-person services, even in the facility setting.

There are a few HCPCS codes on the telehealth list that do not have a calculated facility PE RVU. For these services, the non-facility PE RVUs would serve as a proxy, and therefore, there would be no payment change for these codes.

Finally, we note that the originating site facility fee is established by statute (section 1834(m)(2)(B) of the Act) and is not affected by this proposal.

We note that we believe that payment using the facility PE RVUs for telehealth services is consistent our belief that the direct practice expense costs are generally incurred at the location of the beneficiary and not by the distant site practitioner. After reviewing the current list of telehealth services in the context of the comments, we continue to believe this is accurate.

After consideration of the public comments received, we are finalizing our proposal to use the POS code for telehealth and to use the facility PE RVUs to pay for telehealth service reported by physicians or practitioners with the telehealth POS code for CY 2017. However, we understand commenters' concerns and will consider the concerns regarding use of the facility payment rate as we monitor utilization of telehealth services. We will welcome information

from stakeholders regarding any potential unintended consequences of the payment policy. We will also consider the applicability of the facility rate to any codes newly added to the list of telehealth services.

We have updated the POS code list on our website at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html to include POS 02: Telehealth (Descriptor: The location where health services and health related services are provided or received, through telecommunication technology). The new code will be used for services furnished on or after January 1, 2017.

We are finalizing proposed revisions to our regulation at §414.22(b)(5)(i)(A) that addresses the PE RVUs used in different settings as described above, except that we are not finalizing the proposed change that would have resulted in the payment of the nonfacility rate for services furnished in off-campus provider based departments that are not excepted under Section 603 of the Bipartisan Budget Act of 2015 since we are finalizing that payments to such non-excepted PBDs will be made under the PFS. In a separate interim final rule with comment period issued in conjunction with the CY 2017 OPPS/ASC final rule with comment period (see Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program; Establishment of Physician Fee Schedule Payment Rates for Nonexcepted Items and Services Billed by Applicable Departments of a Hospital), we are finalizing other payment policies for nonexcepted items and services furnished by such non-excepted off-campus provider based

departments. Accordingly, physicians furnishing services in such provider-based departments will continue to be paid the facility rate. We are also finalizing the proposal to delete §414.32 of our regulation that refers to the calculation of payments for certain services prior to 2002.

We remind the public that we are currently soliciting requests to add services to the list of Medicare telehealth services. To be considered during PFS rulemaking for CY 2018, these requests must be submitted and received by December 31, 2016. Each request to add a service to the list of Medicare telehealth services must include any supporting documentation the requester wishes us to consider as we review the request. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, we refer readers to the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

5. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m)(2)(B) of the Act establishes the Medicare telehealth originating site facility fee for telehealth services furnished from October 1, 2001 through December 31, 2002, at $20.00. For telehealth services furnished on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The originating site facility fee for telehealth services furnished in CY 2016 is $25.10. The MEI increase for 2017 is 1.2 percent and is based on the most recent historical update through 2016Q2 (1.6 percent), and the most recent historical MFP through calendar year 2015 (0.4 percent). Therefore, for CY 2017, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or $ 25.40. The Medicare telehealth originating site facility fee and the MEI increase by the applicable time period is shown in Table 6.

TABLE 6: The Medicare Telehealth Originating Site Facility Fee and MEI (Increase by the Applicable Time Period)

Time Period	MEI Increase	Facility Fee
10/01/2001–12/31/2002	N/A	$20.00
01/01/2003–12/31/2003	3.0	$20.60
01/01/2004–12/31/2004	2.9	$21.20
01/01/2005–12/31/2005	3.1	$21.86
01/01/2006–12/31/2006	2.8	$22.47
01/01/2007–12/31/2007	2.1	$22.94
01/01/2008–12/31/2008	1.8	$23.35
01/01/2009–12/31/2009	1.6	$23.72
01/01/2010–12/31/2010	1.2	$24.00
01/01/2011–12/31/2011	0.4	$24.10
01/01/2012–12/31/2012	0.6	$24.24
01/01/2013–12/31/2013	0.8	$24.43
01/01/2014–12/31/2014	0.8	$24.63
01/01/2015–12/31/2015	0.8	$24.83
01/01/2016-12/31/2016	1.1	$25.10
01/01/2017-12/31/2017	1.2	$25.40