MEMORANDUM

Date: November 10, 2017

Re: CMS Releases CY 2018 Medicare Physician Fee Schedule Final Rule

The Centers for Medicare & Medicaid Services (CMS) on Nov. 2, 2017, posted the Calendar Year (CY) 2018 Medicare Physician Fee Schedule (MPFS) Final Rule (CMS-1676-F). The MPFS is an annual update of the Medicare payment policies and rates for services provided by physicians and a variety of non-physician practitioners. These policy changes and payment rates are effective as of Jan. 1, 2018.

For further details, see the MPFS Final Rule and the related CMS Fact Sheet.

Summary of Rule Highlights

- Sets the CY 2018 MPFS conversion factor at $35.9996 and the CY 2018 national average anesthesia conversion factor at $22.1887, both of which reflect a modest payment increase under the Medicare Access and CHIP Reauthorization Act (MACRA)
- Delays mandatory appropriate-use criteria consultation until Jan. 1, 2020
- Adds several codes to the list of telehealth services, including HCPCS code G0506 (Care Planning for Chronic Care Management)
- Retroactively lowers physician quality reporting system (PQRS) reporting requirements to six measures
- Reduces Value-Based Payment Modifier penalties and holds groups harmless if they met minimum quality reporting requirements
- Establishes the new Medicare Diabetes Prevention Program, which begins April 1.

Key Highlights

2018 Conversion Factor: CMS finalized the 2018 conversion factor at $35.9996, 10 cents more than the 2017 conversion factor. This year’s conversion factor takes into account the 0.5 percent update factor as mandated under MACRA. However, in line with what we’ve seen in previous years, this update factor was cut short by cuts imposed under the Misvalued Codes Initiative.

Each year in the final rule, CMS estimates the total impact of its payment changes on specific types of clinicians and facilities. This year, diagnostic testing facilities face the greatest possible payment cuts of an estimated 4 percent in their relative value units (RVUs). Notably, this is 2 percent less than estimated under the proposed rule, which predicted a 6 percent decrease.

Further, CMS made a number of adjustments to specialties. Specifically, physical/occupational therapy shifted from a 1 percent increase to a 2 percent cut from the proposed to the Final Rule. Similarly,
anesthesiology, urology and pathology are now expected to see 1 percent cuts. On the flip side, several specialties with proposed cuts – including radiology, cardiology and cardiac surgery – will now see no change or modest gains under the Final Rule.

**Reduced Payment Rates for Non-Excepted, Off-Campus Provider-Based Hospital Departments (PBDs) Paid Under the MPFS:** The Bipartisan Budget Act of 2015 directs CMS to pay lower doctor-office rates to physician practices that hospitals buy and turn into outpatient departments. The policy applies to off-campus outpatient facilities that were not billing Medicare by Nov. 2, 2015. In response to stakeholder feedback, Congress used the 21st Century Cures Act to exempt hospital outpatient departments that were in development when the site-neutral law took effect.

For off-campus sites that were not mid-build, CMS paid half of hospital outpatient rates in 2017. The agency initially proposed to further cut those rates and pay 25 percent of hospital rates in 2018. The final rule, however, backed away from that proposal and instead CMS finalized a 20 percent reduction in payment rates for certain items and services to foster greater payment alignment between non-excepted off-campus PBDs and physician practices. Specifically, the final policy will change the PFS payment rates for these services from 50 percent of the Outpatient Prospective Payment System (OPPS) rate to 40 percent of the OPPS rate.

**Medicare Diabetes Prevention Program (MDPP) Expanded Model Finalized:** CMS finalized that MDPP services will be available under the expanded model as a Part B service beginning on April 1, 2018. This program began as a limited demonstration program under the Center for Medicare & Medicaid Innovation (CMMI) but has been expanded to a permanent nationwide program that begins in 2018. Its purpose is to provide a structured behavior change intervention that aims to prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes. CMS finalized a number of policies related to this new program, including policies related to the services provided as part of the program, beneficiary eligibility criteria, the payment structure, and supplier enrollment requirements and compliance standards. Further information about the MDPP model expansion is available on the CMS website.

**Evaluation and Management (E/M) Guidelines:** CMS will seek additional opportunities to collaborate with stakeholders on revising the 1995 and 1997 Documentation Guidelines for E/M Services. Modifications to these guidelines would have implications across providers choosing levels of E/M.

The 1995 guidelines provide a great level of detail regarding the history and examination elements but leave medical decision-making relatively vague. This, in turn, led physicians and coders to assign codes based on those components that they could easily quantify, giving negligible importance to the medical decision-making component. Another difficulty that arose with the 1995 guidelines was that the requirements for a comprehensive physical exam were very broad. To address some of these problems, CMS introduced the 1997 Documentation Guidelines for E/M Services. The differences between the two sets of guidelines lie mainly in the portion that addresses the examination. Accordingly, CMS is seeking how it might focus on initial changes to the guidelines for history and exam, because they believe documentation for these elements may be significantly outdated.

**No Change to Malpractice (MP) RVUs:** CMS did not finalize its proposal to develop malpractice RVUs using the most recent data available. CMS also did not finalize its proposal to align the update of MP premium data with the MP geographic practice cost indices.
Expansion of Telehealth Eligible Services: In the 2003 MPFS final rule, CMS established a process for adding or deleting services from the Medicare telehealth list. CMS assigns requests to new categories: Category 1 and Category 2. Category 1 services are similar to services that are currently on the telehealth list. Category 2 services are not similar to services on the telehealth list and CMS requires evidence demonstrating that the service furnished by telehealth improves the diagnosis or treatment of an illness or injury, or improves the functioning of a malformed body part. Requests to add services must be submitted and received no later than Dec. 31 of each year to be considered for the next rulemaking cycle.

CMS finalized its proposal to add seven services to the Medicare telehealth list. In response to requests received in 2016, CMS added three codes because it believes that these services are sufficiently similar to services currently on the telehealth services list (this is known as qualifying on a Category 1 basis):

- Healthcare Common Procedure Coding System (HCPCS) code G0296: Counseling visit to discuss the need for lung cancer screening using low dose computed tomography (LDCT)
- Current Procedural Terminology (CPT) codes 90839 and 90840: Psychotherapy for crisis (first 60 minutes) and Psychotherapy for crisis (each additional 30 minutes)

CMS adds the above codes with the explicit condition that for payment the distant site practitioner must be able to mobilize resources at the originating site to diffuse the crisis and restore safety, when applicable, when the codes are furnished by telehealth. CMS states this requirement is consistent with the CPT prefatory language that the treatment described by these codes requires, "mobilization of resources to defuse the crisis and restore safety." CMS states it believes "mobilizing resources" is the ability to communicate with and inform staff at the originating site to the extent necessary to restore safety.

CMS also added four add-on CPT and HCPCS codes to the telehealth list. CMS notes that these add-on codes describe additional elements for services currently on the telehealth services list and would be considered telehealth services only when billed as add-on to codes on the telehealth list.

- CPT code 90785: Interactive complexity
- CPT codes 96160 and 96161: Administration of patient-focused health risk assessment instrument and Administration of caregiver-focused health risk assessment instrument
- HCPCS code G0506: Comprehensive assessment or/and care planning for patients requiring chronic care management services

CMS also finalized separate payment for CPT code 99091, which will allow providers to be reimbursed for time spent collecting and interpreting health data that are generated by a patient remotely, digitally stored and transmitted to the provider. Physicians must spend at least 30 minutes on these activities to bill the code, in addition to other requirements. This is significant because it is a first step by CMS to establish separate payment for remote payment monitoring services.

Biosimilars Payment Policy Change: Effective Jan. 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. CMS will separately code and pay for biological biosimilar products under Part B. This policy reverses a past
decision to give multiple biosimilars of the same reference product one reimbursement code and effectively pay for all the products at the same rate.

CMS will issue detailed guidance on coding, including instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers. CMS notes that completion of these changes will require changes to the claims processing system, which will occur as soon as possible but might not be completed until mid-2018. CMS will issue instructions using sub-regulatory means. CMS plans to continue to monitor Part B biosimilar payment and utilization.

**Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging:** Section 218(b) of the Protecting Access to Medicare Act of 2014 requires CMS to establish a program to promote the use of appropriate use criteria among physicians and other professionals who order advanced diagnostic imaging services by requiring them to consult clinical decision support mechanisms (CDSMs). The statute states that, beginning Jan. 1, 2017, professionals who furnish advanced diagnostic imaging may only be paid for those services if they report on the Medicare claim information about the clinical decision support system consulted by the ordering professional. Because of the complexity of the new program, CMS did not meet the statutory deadline, instead implementing its requirements over the past couple of years.

The agency finalized (another) delay to the Imaging AUC Program. Although the program originally was slated to take effect in January 2018, CMS is finalizing a start date of 2020. However, physicians may begin consulting available CDSMs during a voluntary participation period beginning in mid-2018 and running through 2019. In 2020, CMS will operate an "educational and operations testing year," during which the agency will make payment for advanced diagnostic imaging services regardless of whether the furnishing professional provides information regarding the CDSM consulted. Full implementation of the appropriate use criteria program is slated to begin in 2021.

**Mammography with Computer Aided Detection (CAD):** Last year, CMS made a slight increase to the professional component of mammography and maintained the 2016 payment rates for the technical component rather than implementing a 50 percent cut to the technical component of mammography services. CMS did not address this issue within the CY 2018 MPFS Final Rule. However, the values listed for mammography in the practice expense (PE) file remain essentially the same. Additionally, Addendum B of the rule includes new category CPT codes so presumably CMS will no longer use the existing G-codes and begin processing the new CPT codes in 2018.

**PE Inputs for Digital Imaging Services:** CMS notes that in the 2017 MPFS Final Rule, CMS finalized its proposal to add a professional picture archiving and communication system (PACS) workstation (ED053) used for interpretation of digital images to a series of CPT codes and addressed costs related to the use of film that had previously been incorporated into as direct PE inputs for these services. In total, CMS added the professional PACS workstation to 525 codes in its direct PE input database: 94 therapeutic codes and 431 diagnostic codes. CMS also took the opportunity to respond to a commenter that stated that the costs associated with storing digital images should be included as a direct PE. Using the analogy of electronic health records, CMS disagreed that costs associated with storing digital images are excluded, as CMS stated that these costs are incorporated into the indirect PE methodology that covers administrative costs and office rent. CMS further explained that film was treated as a direct PE input as it was allocable to an individual patient and that the better analogy for storage of images would be the office cabinets and office space in which the film was stored.
Implementation of Reduced Payment for Film-Based Imaging Services: CMS finalized its proposal to establish a new modifier to be used on claims for the technical component (TC) of X-rays taken using computed radiography technology during CY 2018 or subsequent years. The use of the modifier is expected to result in a 7 percent reduction for CYs 2018-2022 and a 10 percent reduction for CY 2023 or subsequent calendar years for the TC for these services.

Modifications to the PQRS: CMS finalized a change to the current PQRS program policy that requires reporting of six measures for the PQRS with no domain requirement instead of nine measures across three National Quality Strategy domains to better align with the merit-based incentive payment system (MIPS) data submission requirements for the quality performance category. For MIPS, eligible clinicians will only need to report six quality measures for the quality performance category, except those reporting via the Web Interface. Further, there is no requirement to ensure that the measures span across three National Quality Strategy domains.

Modifications to the Medicare Shared Savings Program (MSSP): CMS will revise the assignment methodology for accountable care organizations (ACOs) with rural health clinic (RHC) and federally qualified health center (FQHC) participants; add new chronic care management codes and four behavioral health integration (BHI) codes to the definition of primary care services used in the ACO assignment methodology; and reduce the required amount of submission materials for MSSP applications and skilled nursing facility three-day rule waivers.

CMS is adopting the following regarding assignment of beneficiaries to ACOs that include RHCs and FQHCs:

• removing the attestation requirement by eliminating §425.204(c)(5)(iii) and instead treating a service reported on an RHC or FQHC claim as a primary care service furnished by a primary care physician

• revising §425.404, which lays out the assignment process for beneficiaries treated by RHCs and FQHCs to indicate that, for performance year 2019 and thereafter, beneficiaries assigned to ACOs will be assigned using the general assignment methodology in §425.102, and by treating a service reported on an RHC or FQHC institutional claim in the same way as a primary care service performed by a primary care physician

• making changes to the list of revenue center codes in the definition of primary care to eliminate revenue center codes that are no longer needed

CMS is also adopting a number of changes to the definition of Primary Care Services:

• adding, beginning in 2018 for the 2019 performance year, three additional chronic care management (CCM) service codes (99487, 99489 and G0506) to incorporate complex CCM services and that differ on the basis of the amount of clinical staff service time involved, as well as four behavioral health integration (BHI) service codes (G0502, G0503, G0504 and G0507) that CMS says reflect important enhancements in primary care for people receiving behavioral health treatment

• reorganizing the list to group HCPCS codes, G codes and revenue center codes together and group by relevant performance year

Changes to the 2018 Value-Based Payment Modifier: For solo practitioners and groups, CMS finalized reducing the automatic downward payment adjustment for not meeting minimum quality reporting
requirements; holding harmless those who met minimum quality report requirements from downward payment adjustments for performance under quality-tiering for the last year of the program; and aligning the maximum upward adjustment amount to two times the adjustment factor.

**MACRA Patient Relationship Codes:** CMS finalized the use of Level II HCPCS modifiers on claims to indicate patient relationship categories. CMS also finalized its proposal that Medicare claims submitted on or after Jan. 1, 2018, should include the applicable HCPCS modifiers as well as the National Provider Identifier (NPI). The HCPCS modifiers may be voluntarily reported for at least an initial period as clinicians gain familiarity with the process; the use and selection of modifiers will not be a condition of payment during this initial period. CMS did not specify the duration of this initial period.

**Therapy Caps:** There is one therapy cap for outpatient occupational therapy (OT) services and another separate therapy cap that combines physical therapy (PT) and speech-language pathology (SLP) services. The therapy caps are updated each year based on the Medicare Economic Index (MEI). Increasing the 2017 therapy cap of $1,980 by the 2018 MEI of 1.4 percent and rounding to the nearest $10 results in a 2018 therapy cap of $2,010.

An exceptions process for the therapy caps has been in effect since Jan. 1, 2006. CMS notes that, under current law, both the existing exceptions process for therapy caps and the manual medical review process for claims exceeding a threshold amount of $3,700 expire on Dec. 31, 2017. Under current law, the therapy caps will be applicable in accordance with the statute to all outpatient therapy settings, except for services furnished by outpatient hospitals under section 1833(a)(8)(B) of the Social Security Act. Without a therapy caps exceptions process, the beneficiary becomes financially liable for 100 percent of expenses they incur for services that exceed the therapy caps.