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CY 2017 Medicare Physician Fee Schedule Final Rule

OVERVIEW

On November 2nd, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that updates the Physician Fee Schedule (PFS) and other Medicare Part B payment policies for CY 2017. Provisions of the rule include: enrollment and data transparency updates to the Medicare Advantage (MA) program, modifications to the Medicare Shared Savings Program (MSSP), and the expansion of the Diabetes Prevention Program to Medicare.

This document summarizes several major provisions of the final rule. The final rule is available here.

MISVALUED CODES

Under the Affordable Care Act (ACA), CMS is instructed to identify misvalued codes in the PFS. The Achieving a Better Life Experience (ABLE) Act further requires CMS to achieve targeted net reductions in misvalued codes for 2016, 2017, and 2018. CMS initially proposed changes that would achieve an estimated 0.5 percent reduction in net expenditures from misvalued codes in 2017 to comply with the ABLE Act.

In the final rule, CMS finalized misvalued code changes that achieve a 0.32 percent reduction in net expenditures. Since these changes do not fully meet the target of 0.5 percent, an adjustment to the 2017 overall physician update is required. The 2017 PFS conversion factor is $35.89, a 0.25 percent increase to the 2016 PFS conversion factor of $35.80.

PAYMENT PROVISIONS

The rule finalized a number of new codes and payment updates to improve reimbursement accuracy for the following services.

Sedation Services

CMS finalized new codes for moderate sedation services. The new codes will include an endoscopy-specific moderate sedation code and will reflect the difference in physician survey data between gastroenterology and other specialties.

Telehealth Services

CMS finalized its proposal to add the following codes to the list of services eligible to be delivered via telehealth:

- End-stage renal disease related services for dialysis;
- Advanced care planning services; and
- Critical care consultations.

CMS also finalized a "place of service" code for the reporting of services that are delivered via telehealth. As early as January 1, 2017, providers will be required to report the telehealth place of service code.

Mammography Services

The rule finalized new codes for mammography services. The code set will be updated to reflect the current use of technology in providing mammography services.

Chronic Care Management

The rule finalized new care management payment codes for comprehensive assessment and care planning that are provided by a physician or practitioner to patients with multiple chronic conditions. The add-on codes will be billed separately from monthly care management services.

Behavioral Health

CMS finalized payments for codes that describe behavioral health services that are delivered through the Collaborative Care Model. Under the Collaborative Care Model, a primary care practitioner, behavioral health care manager, and psychiatric consultant will provide integrated care to the patient.

Cognitive Impairment Care

The rule finalized a new code to reimburse for cognitive and functional assessment and care planning for patients with cognitive impairments.

VALUE MODIFIER (VM)

The VM program adjusts payments under the PFS based on the quality and cost of the care furnished. The VM program will expire in CY 2019, when the Merit-based Incentive Payment System (MIPS) begins. To support the transition to MIPS, CMS finalized its proposal to update the VM informal review process and establish how the quality and cost composites under VM would be affected if unanticipated program issues arise in 2017 and 2018.

MA UPDATES

The final rule makes several changes to enhance data transparency and data and supplier enrollment in the MA program.

Provider and Supplier Enrollment

Under the final rule, health care providers and suppliers will be required to enroll in Medicare to provide covered services to MA beneficiaries. Providers or suppliers that fail to meet CMS requirements may have their enrollment revoked, be prevented from billing Medicare, and be barred from participating in MA. These changes will be reflected in CMS contracts with MA and MA Prescription Drug (MA-PD) plans. Plans that fail to meet these requirements may be sanctioned or have their contracts terminated.

These provisions will begin two years after the rule is published and will be effective on the first day of the plan year.

Data Transparency

CMS finalized a proposal to release two new datasets on plan participation in MA and MA-PD:

- **MA Bid Pricing Data** – CMS will release data associated with MA bids. The dataset will be released annually, but will contain data that is at least five years old and would exclude any proprietary information as well as beneficiary-identifying information.
- **Medical Loss Ratio (MLR) Data** – CMS will make MA and MA-PD MLR data publicly available on an annual basis.

MSSP

The final rule makes several changes to the MSSP. CMS finalized its proposal to update the MSSP quality measure set so that it is aligned the Physician Quality Reporting System and Quality Payment Program. The rule also enhances to the Quality Measure Validation audit process.

The final rule also modifies the beneficiary assignment algorithm so that beneficiaries may elect to be assigned to the accountable care organization that their provider participates in.

MEDICARE DIABETES PREVENTION PROGRAM (DPP)

The National DPP is a health behavior change model that was developed by the Centers for Disease Control and Prevention (CDC) to provide preventive care to individuals who are at risk of Type 2 diabetes. Through the DPP, care is delivered in community and health care settings by trained community health workers or health professionals.

The final rule expands the program by implementing the Medicare DPP (MDPP) nationally on January 1, 2018. Under the final rule, authorized DPP suppliers will be eligible to submit claims to Medicare for delivering diabetes prevention services. Payments will be tied to the beneficiary’s session attendance and weight loss. Any organization that is authorized by the CDC to provide DPP services will be eligible to apply for Medicare enrollment beginning on January 1, 2017.