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2018 Medicare Physician Fee Schedule Final Rule

OVERVIEW

On November 2nd, the Centers for Medicare and Medicaid Services (CMS) issued a final rule to update 2018 Medicare payment rates under the Physician Fee Schedule (PFS) and other Medicare Part B payment policies for 2018. Provisions of the final rule include, but are not limited to: telehealth, biosimilars, the Medicare Diabetes Prevention Program (MDPP), the ACO application and waiver processes, and alignment of the Physician Quality Reporting System (PQRS) with the Quality Payment Program (QPP).

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

MISVALUED CODES

The Affordable Care Act (ACA) instructs CMS to identify misvalued codes in the PFS based on resource inputs for services associated with those codes. In addition, the Achieving a Better Life Experience (ABLE) Act requires CMS to achieve targeted net reductions in misvalued codes each year in 2016, 2017 and 2018, with a targeted 0.5% reduction in 2018. CMS estimates the net reduction from adjustments to misvalued codes to be 0.41 percent, requiring a 0.09% adjustment to the 2018 Conversion Factor, which converts relative value units (RVUs) into payment rates.

PAYMENT POLICY PROVISIONS

After applying the above adjustments and adjusting for budget neutrality, CMS is finalizing a 2018 PFS conversion factor of $35.99, increased from the prior year conversion factor of $35.89. This increase and other factors are expected to result in an overall PFS payment update of 0.41%, increased from a 0.31% update in the proposed rule.

The final rule also established new codes and payment policy changes impacting the following services.

Telehealth Services

CMS is finalizing its proposal to no longer require the use of telehealth billing modifiers. It is also finalizing the addition of the following codes to the list of allowable telehealth services:

- G0296: Visit to determine low dose computed tomography eligibility;
- G0506: Add-on code for care planning for chronic care management;
- 90785: Add-on psychiatry visit code indicating difficulty in communication;
- 96160 and 96161: Patient-focused health risk assessments; and
- 90839 and 90840: Crisis psychotherapy services.

The final rule also responds to public comments by allowing the following service relating to remote patient monitoring to be separately billable, with documented patient consent:

- 99091: Collection and interpretation of physiologic data, stored and forwarded electronically to a practitioner.

Previously, CMS had clarified that remote patient monitoring would not be designated as a telehealth service, subject to FFS Medicare telehealth restrictions. CMS sought comments regarding other allowable expansions of Medicare telehealth services within current statute and will consider the input received during future rulemaking. Stakeholders can submit proposed telehealth services through December 31, 2017 for consideration during the next rulemaking cycle.

Malpractice (MP) Relative Value Units (RVUs)

Based on commenters' concerns about the complexity of MP data and MP cost variations across specialties, the agency is not finalizing this proposal. CMS will calculate 2018 MP RVUs using specialty risk factors it used to update 2017 MP RVUs and continue updating MP RVUs and GPCIs on separate schedules.

CMS sought comments on using its more recent MP data to adjust 2018 MP RVUs. The proposed rule would have also aligned MP premium data update, which take place every 3 years, with the next update to the MP Geographic Practice Cost Index (GPCI) which is scheduled every 5 years. The proposed rule also sought comments on methodologies and sources of data that could improve the next MP premium data update.

Care Management Services

CMS is finalizing a proposal to allow use of CPT codes for several care management services established last year as billable G-codes. The final rule adds CPT codes describing cognitive impairment assessment and care planning, and behavioral health integration services.

Office-Based Behavioral Health Services

CMS is finalizing a proposal to improve the calculation of rates for office-based behavioral health services in a way that will increase payment rates. The final rule revises existing policy to better reflect overhead expenses of office-based face-to-face services provided to patients.

Evaluation and Management (E/M) Visits

CMS guidelines specify information required to justify Medicare payment for E/M visits, which require documentation of patient history, medical examination, and clinical decision making. The proposed rule sought comments on changes to E/M documentation and billing requirements, which were established in the 1990s, to align them with an emphasis on medical decision-making over history-taking or physical examinations (which can be accomplished through EMRs and health information exchanges).

Commenters advised CMS that revisions will need to take place slowly and will differ by specialty. As such, CMS is not changing E/M coding or documentation requirements but will consider comments for future rulemaking.

Initial Data Collection and Reporting Periods for the Clinical Laboratory Fee Schedule

The proposed rule sought comments on laboratory and reporting entities' experience with data reporting, collection, and other compliance activities relating to the Medicare Clinical Laboratory Fee Schedule (CLFS), which bases Medicare payment for such claims on costs billed to certain commercial payers. CMS will use the feedback to inform future rulemaking and may publish subregulatory guidance on this topic.

Payment Policy for Biosimilars

Since 2016, biosimilar products that rely on a common reference product's biologics license application have been grouped into the same payment calculation. CMS solicited comments on this policy's effects on the biosimilar products marketplace. In response to comments, CMS will change its policy beginning in 2018 to use separate codes to pay for newly approved biosimilar biological products with a common reference product.

Infusion Drugs Provided Through an Item of Durable Medical Equipment

The 21st Century Cures Act changed the Part B payment calculation for infusion drugs or biological products furnished using a Medicare-covered piece of Durable Medical Equipment (DME), transitioning it from the average wholesale price to average sales price beginning in 2017. CMS is finalizing the proposed regulatory language to conform with this statutory change.

Appropriate Use Criteria (AUC) Program

The Protecting Access to Medicare Act of 2014 directed CMS to establish a program to promote appropriate use criteria (AUC) in physician decision-making regarding advanced diagnostic imaging services. CMS is instructed to assist professionals who order and furnish advanced diagnostic imaging in making appropriate treatment decisions. CMS proposed to implement the AUC Program through a set of provider-led entities and clinical decision support (CDS) mechanisms.

CMS is finalizing a voluntary participation period from mid-2018 through 2019 during which providers can submit limited information on advanced imaging claims about whether AUC consultation took place. Medicare will reimburse for these claims and work with providers on submission requirements. In addition, CMS will allow clinician use of AUC consultation mechanisms as a Merit-Based Incentive Payment System (MIPS) improvement activity.

Medicare Diabetes Prevention Program (MDPP) Expanded Model

CMS will expand the Medicare DPP nationally beginning January 1, 2018 after determining the model meets statutory criteria for expansion. CMS is also finalizing additional supplier enrollment and compliance requirements that include new program integrity safeguards.

The final rule did not expand MDPP to reimburse for additional services provided by organizations delivering "virtual" DPP services (other than ad hoc virtual make-up sessions already part of MDPP). CMS is considering a separate Center for Medicare and Medicaid Innovation (CMMI) demonstration to test and evaluate a virtual DPP.

Physician Quality Reporting System (PQRS)

Under current CMS policy for 2018, a 2.0% payment reduction applies to eligible professionals and group practices that have not satisfactorily reported PQRS data on quality measures for CY 2016. MIPS is replacing PQRS under the Quality Payment Program (QPP), with the first MIPS reporting period from January to December 2017. CMS is finalizing proposed changes to align PQRS reporting requirements with MIPS. Under the final rule, providers need to only report 6 PQRS measures and those measures do not need to span multiple National Quality Strategy domains.

CMS is also finalizing similar changes to the quality measures reported through the Medicare Electronic Health Record (EHR) Incentive Program. These changes apply to eligible professionals who satisfactorily report measures through the PQRS portal.

Patient Relationship Codes

CMS is finalizing its proposal to require providers to report patient relationship codes as Level II HCPCS modifiers. CMS intends to work with clinicians regarding proper use of these new modifiers, and payment will not be conditioned on the presence of the modifier in 2018.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

CMS is finalizing revisions to assignment methodology for certain Medicare Accountable Care Organizations (ACOs). This includes easing the application and waiver processes, and adding to the services defined as primary care.

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

CMS is eliminating provider attestation requirements required of ACOs that include FQHCs and RHCs. Prior attribution processes used a workaround process to identify ACO beneficiaries' primary clinicians practicing in an RHC or FQHC because the claims data lacks provider-specific information included in most PFS claims. This attestation-based model was cumbersome and prone to error, and CMS is replacing it with a claims-based, step-wise methodology.

Definition of Primary Care Services

CMS is revising the definition of primary care services by adding three new chronic care management (CCM) codes and four behavioral health integration (BHI) codes to the definition of primary care used in ACO assignment.

Applications and Waivers

Finally, CMS is removing two requirements for the initial Shared Savings Program application or the application for use of the skilled nursing facility (SNF) 3-Day Rule Waiver. CMS will no longer require ACOs seeking SNF Waivers to provide a narrative describing financial relationships between the ACO, SNF affiliates, and acute care hospitals. It is also eliminating requirements for ACOs to document that each affiliated SNF has an overall rating of 3 or higher under the Quality Rating System. CMS will instead obtain this information itself.

VALUE MODIFIER

The VM program adjusts payments under the PFS based on quality and cost of care furnished. The VM program will expire in 2019 when MIPS begins. To facilitate a smoother transition to MIPS, CMS is finalizing the following changes to the 2018 VM:

- CMS is reducing the automatic downward payment adjustment applicable when practitioners fail to satisfy the criteria for avoiding such adjustments. CMS will lower the adjustment from -4% to -2% for groups consisting of 10 or more clinicians, and from -2% to -1% for physician and non-physician solo practitioners, and groups with 2-9 clinicians.
- CMS will hold all physician groups and individual practitioners harmless from such adjustments if they met criteria to avoid performance-based payment adjustments under quality-tiering provisions;
- CMS is also doubling the maximum allowable upward adjustments factor applicable to all physician groups and solo practitioners.

CMS is additionally finalizing its proposal not to report 2018 VM data in CMS' Physician Compare database because these data will be relevant for only one year. The data will be accessible through public use and research identifiable files.

CERTAIN OFF-CAMPUS PROVIDER-BASED HOSPITAL DEPARTMENTS PAID UNDER THE PFS

Beginning in 2017, reimbursement for certain items and services provided in nonexempt, off-campus hospital outpatient provider-based departments were no longer reimbursed under the Hospital Outpatient Provider Payment System (OPPS). CMS initially set PFS payment for these items at 50% of the relevant OPPS rate.

To better align payments across hospital- and office-based settings, CMS is reducing PFS payments for these items and services by 10%, to 40% of the OPPS rate. The proposed rule would have lowered payments to 25% of the OPPS rate.

The PFS final rule is available here.