CY 2018 Medicare Physician Fee Schedule
Proposed Rule Summary

On July 13, 2017, the Center for Medicare and Medicaid Services (CMS) released the proposed Medicare Physician Fee Schedule (MPFS) for 2018. The proposed rule updates payment policies and payment rates for services furnished under the MPFS.

The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found here. Comments on the proposal must be submitted by September 11, 2017. The final MPFS is typically published in early November with most of the provisions being effective January 1, 2018 unless stated otherwise.

The following summarizes the major provisions of the proposed rule.

Conversion Factor and Specialty Impact

The conversion factor for 2018 is $35.9903, a slight increase over 2017. CMS has been statutorily directed to set an annual target for reductions in the MPFS of 0.5 percent from adjustments to relative values of misvalued codes. The agency estimated the 2018 net reduction in expenditures from proposed adjustments to RVUs of misvalued codes to be 0.31 percent. CMS is imposing a 0.19 percent across the board reduction since the target of 0.5 percent was not met. The table below, extracted from the rule, shows how the proposed conversion factor was calculated.

Conversion Factor in effect in CY 2017		35.7751
Update Factor	0.50 percent	
CY 2018 RVU Budget Neutrality Adjustment	-0.03percent	
CY 2018 Target Recapture Amount	-0.19 percent	
CY 2018 Conversion Factor		**35.9903**

Table 40 (see Attachment 1), extracted from the rule, provides a summary of the impact of the proposed changes in the rule by specialty. The changes in the rule are budget-neutral in the aggregate which explains why the impact for all physicians is shown as zero. The 2018 proposed rule is showing changes in the range of minus 6% to plus 3%, with neurology seeing a 0% change.

Practice Expense RVU Methodology

PE RVU Methodology – Specialty Mix for Low Volume Codes

When determining the RVUs for a code's practice expense, CMS uses an average of the most recent 3 years of available Medicare claims and assigns a specialty mix value to the code. Codes with low Medicare volume require special attention since billing or enrollment irregularities can result in significant changes in specialty mix assignment. Stakeholders, including the RUC, have requested that CMS use a recommended "expected" specialty for all low volume services instead of the information contained in the claims data. The agency had hoped that using the 3-year average would avoid the need for using the "expected" specialty, however, CMS is still seeing distortions and variability among these low volume services and "service-level overrides" may be necessary to determine the specialty mix for certain low volume procedures. The agency is proposing a list of low volume codes, which is can found in the "downloads" section here, that was developed based on their medical review of the most recent RUC-provided list as well as the agency's own proposed expected specialty for certain other low-volume codes for they have

historically used expected specialty assignments. This list will be displayed annually with the proposed rule. CMS will review recommendations from stakeholders on changes to the list annually.

Preservice Clinical Labor for 0-Day and 10-Day Global Services

The AMA RUC has concluded that 0-day and 10-day global services are assumed to have no preservice clinical time unless the specialty provides evidence that preservice time is appropriate. For CY 2018, 41 of the 53 0-day and 10-day globals reviewed included preservice time. CMS is seeking comment on the value and appropriate application of this preservice time standard in its review of RUC recommendations when so many services deviate from the standard. Furthermore, the agency noticed a general correlation between the inclusion of preservice clinical labor and recent RUC review and is seeking comment specifically whether the standard preservice clinical labor time of 0 minutes should be consistently applied for these globals in future rulemaking.

Obtain Vital Signs Clinical Labor

The direct PE inputs for each CPT code paid under the PFS include minutes assigned to a series of standard clinical labor tasks assumed to be typical for the service in question. To preserve relativity among the PFS codes, CMS is proposing to assign 5 minutes of clinical labor time for all codes that include the "Obtain vital signs" task, regardless of the date of the last review. They agency is also proposing to update the equipment times of the codes with this clinical labor task accordingly to match the changes in clinical labor time.

Medicare Telehealth Services

Billing and Payment for Telehealth Services

For Medicare to pay for telehealth services, the service must be on CMS' telehealth list and meet the following requirements: the service must be furnished via an interactive communication system; the service must be furnished by a physician or another authorized practitioner; the service must be furnished to an eligible telehealth individual; and the individual receiving the service must be located in a telehealth originating site.

CMS assigns any qualifying request to make additions to the telehealth service list to one of two categories: (1) services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services; and (2) services that are not similar to the current list of telehealth services. For the latter, CMS assesses 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 services produces demonstrated clinical benefit to the patient. Based on this standard, CMS is proposing to add the following services to the telehealth list:

- HCPCS code G0296 (counseling visit to discuss need for lung cancer screening using low dose ct scan)
- CPT codes 90839 and 90840 (psychotherapy for crisis; first 60 minutes and psychotherapy for crisis; each additional 30 minutes)
- CPT code 90785 (interactive complexity)
- CPT codes 96160 and 96161 (administration of patient-focused health risk assessment instrument)
- HCPCS code G0506 (comprehensive assessment of and care planning for patients requiring care management services)

Comment Solicitation on Medicare Telehealth Services

CMS is seeking information regarding ways that they may further expand access to telehealth services within the agency's existing authority and pay appropriately for services that take full advantage of communications technologies.

Comment Solicitation on Remote Patient Monitoring

CMS is specifically seeking comment on whether to make separate payment for remote patient monitoring, which are generally not considered telehealth services. These services are paid under the same conditions as in-person physicians' services with no additional requirements regarding permissible originating sites or use of the telehealth place of service code.

The agency is particularly interested in comments on CPT code 99091 (collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health professional). CMS requests information about the circumstances under which this code might be reported for separate payment, including how to differentiate the time related to these services for other services, including care management services. Currently, this is a bundled service. CMS provides the following example: payment for the analysis of patient-generated health data is considered included in chronic care management (CCM) services (CPT codes 99487, 99489, and 99490) to the extent this activity is medically necessary and performed as part of CCM.

CMS specifically requests comments from beneficiaries and beneficiary advocacy organizations on the value of these services and what protections might be necessary to assure that beneficiaries are properly informed that they are receiving a remote monitoring service, since beneficiaries will be required to pay cost sharing for them.

For CPT code 99091, the agency is seeking information on potential utilization assumptions in order to set the PFS rate and its implications in a budget neutral system.

CMS is also seeking comment on other existing codes that describe extensive use of communications technology for consideration for future rulemaking, including CPT code 99090 (analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data).

Proposed Payment Rates under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by Non-excepted Off-Campus Provider-Based Departments (PBDs) of a Hospital

CMS was directed by the Bipartisan Budget Act of 2015 to implement a site neutral payment policy, paying for certain items and services furnished in off-campus Provider-Based Departments (PBDs) under the PFS rather than HOPPS. Services that are "excepted" from this payment change are provided in the following locations: dedicated emergency departments; an off-campus PBD that was billing for covered outpatient department services furnished prior to November 2, 2015 (the date of enacted of the BBA); in a PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital. All services that do not meet these requirements are considered "non-excepted."

In the CY 2017 HOPPS interim final rule, CMS established site-specific rates under the PFS for the technical component of all non-excepted items and services. Hospitals will be paid under the MPFS at these newly established MPFS rates for non-excepted items and services, which will be billed on the institutional claim and must be billed with a new claim line modifier "PN" to indicate that an item or service is a non-excepted item or service. For CY 2017, the payment rate for these services will generally be 50 percent of rate paid under HOPPS rate.

CMS was concerned that the CY 2017 adjuster was generally resulting in greater overall payments to hospitals for services furnished by non-excepted off-campus PBDs than otherwise would be paid under the PFS. For CY 2018, CMS is proposing to reduce the payment for non-excepted items and services furnished

by non-excepted off-campus PBDs from 50 percent to 25 percent of the HOPPS payment rate. The agency believes that outpatient visits are the best proxy in comparing PFS and HOPPS payments for the most common services furnished in off-campus PBDs, until they can study a full year of claims. To make this adjustment, CMS looked at the one code for a clinic visit (G0463) in HOPPS and 10 E/M codes that describe outpatient office visits in the PFS. CMS compared the CY 2017 OPPS national payment rate or HCPCS code G0463 ($102.12) to the difference between the office and facility PFS payment amounts using a weighted average of outpatient visits. CMS requests stakeholder input with regard to this analysis and the resulting rate, as well as whether they should adopt a different PFS Relativity Adjuster, such as 40 percent, which represents a middle ground. The agency intends to continue to study this issue and welcomes comments on future refinements.

For CY 2019 and future years, CMS want to implement payment policy to equalize payment rates between non-excepted off-campus PBDs and physician offices and will have a full year of claims data on the mix of services reported in these settings when setting rates.

Proposed Valuation of Specific Codes

Work RVU Methodology

CMS reviews information from multiple sources, including the RUC and HCPAC, when evaluating the work RVUs and time for PFS services. For CY 2018, the agency generally proposed RUC-recommended work RVUs for new, revised, and potentially misvalued codes with the understanding that the RUC considered the types of concerns the agency has previously had with their recommendations. However, CMS continued to have similar concerns about the RUC-recommended values for some of the services in the PFS and in those cases proposed alternative approaches to develop work RVUs. They are seeking comment on both the RUC-recommended value and the value derived from the agency's alternative approach.

Evaluation & Management (E/M) Guidelines and Care Management Services

CMS has been engaged in an ongoing incremental effort to identify gaps in appropriate coding and payment for care management/coordination, cognitive services and primary care within the MPFS. The agency has reduced administrative burden of the Transitional Care Management and Chronic Care Management services through rulemaking and worked with CPT to develop coding and improve payment accuracy for Behavioral Health Integration (BHI), cognitive impairment assessment/management, and prolonged services. CMS is seeking comments on ways they might further reduce administrative burden for these and similar services.

Stakeholders have maintained that both the 1995 and 1997 E/M documentation guidelines are administratively burdensome and outdated, and they fail to distinguish meaningful differences among code levels. CMS agrees, particularly for the requirements for the history and physical exam. The agency has heard feedback that the guidelines are a significant source of audit vulnerability and administrative burden.

The agency believes comprehensive reform of E/M documentation guidelines would require a multi-year, collaborative effort among stakeholders. CMS is requesting comments on specific changes to reform the guidelines, reduce the burden, and better align E/M coding and documentation with the current practice of medicine. They would like to focus the initial changes to the guidelines on the requirements for history and physician exam because they may be more significantly outdated.

The agency requests specific comments on whether it would be appropriate to remove documentation requirements for the history and physical exam for all E/M visits at all levels. Medical Decision Making (MDM) and time are the more significant factors in distinguishing visit levels and the need for extended histories and exams is being replaced by population-based screening and intervention, for some specialties.

While the MDM guidelines may need to be updated, it may be possible to allow MDM and/or time to serve as the key determinant of E/M visit level. CMS seeks comments on this approach and on how such reforms may differentially affect physicians and practitioners of different specialties, including primary care clinicians, and how the agency should account for such effects as they examine this issue. The agency is interested in whether they should largely leave it to the discretion of individual practitioners to what degree they should perform and document the history and physical exam.

The agency also noted that they have received feedback that the E/M code set is outdated and needs to be revised, stating "In prior rulemaking cycles, we acknowledged the limitations of the current E/M code set and agree that structure of the underlying code set and its valuation relative to other PFS services are also important issues that we expect to continue to explore, though we are immediately focused on revision of the current E/M guidelines in order to reduce unnecessary administrative burden."

Care Management Public Comment Solicitation

CMS is seeking comments on how the agency might further reduce the reporting burden on practitioners for care management services (CPT Codes 99487 and 99489), including through stronger alignment between CMS requirements and CPT guidance for existing and potential new codes.

Payment for Biosimilar Biological Products under Section 1847A of the Act

CMS is requesting comments regarding its Medicare Part B biosimilar biological product payment policy. The agency is seeking new or updated information on the effects of the current biosimilar payment policy that is based on experience with the United States marketplace. Specifically, CMS is interested in obtaining material, such as market analyses or research articles that provide data and insight into the current economics of the biosimilar market place. This includes patient, plan, and manufacturer data both domestic and, where applicable, from European markets that may be more established than, and provide insight for, the current United States' market. It is also seeking comment regarding other novel payment policies that would foster competition, increase access, and drive cost savings in the biological product marketplace. These solutions may include legislation, demonstrations, and administrative options.

CMS also seeks data to demonstrate how individual HCPCS codes could impact the biosimilar market, including innovation, the number of biosimilar products introduced to the market, patient access, and drug spending.

Physician Quality Reporting System (PQRS) Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment

To better align the incentives and provide a smoother transition to the new Merit-Based Incentive Payment System (MIPS) under the Quality Payment Program (QPP), CMS is proposing to modify the requirements to successfully report under the PQRS and avoid a penalty. Physicians are not required to submit any further information to CMS. The agency is not proposing to collect any additional data for the CY 2016 reporting period. Specifically, the agency is proposing to revise the previously finalized satisfactory reporting criteria for the CY2016 reporting period to lower the requirement from 9 measures across 3 NQS domains, to only 6 measures with no domain or cross-cutting measure requirement, this better aligns with the MIPS' requirements.

Clinical Quality Measurement for Eligible Professionals Participating in the Electronic Health Record (EHR) Incentive Program for 2016

CQM Requirements for EPs and Groups under the Medicare EHR Incentive Program in 2016

Like the changes CMS is proposing to the PQRS requirements, the agency is proposing changes to better align with MIPS in the meaningful use program. Again, this will not require physicians to report any further information. CMS is proposing to change the reporting criteria for EPs and groups who chose to electronically report CQMs through the PQRS Portal for purposes of the Medicare EHR Incentive Program. Specifically, it is proposing to change the reporting criteria from 9 CQMs covering at least 3 NQS domains to 6 CQMs with no domain requirement, again this is to better align with MIPS. CMS is proposing that an EP or group who satisfies the proposed reporting criteria may qualify for the 2016 incentive payment and may avoid the downward payment adjustment in 2017 and/or 2018, depending on the EP or group's applicable EHR reporting period for the payment adjustment year. CMS is not proposing to change the previously finalized requirements for 2016 for EPs participating in the Medicaid EHR Incentive Program.

Medicare Shared Savings Program

The 21st Century Cures Act requires the Secretary to assign beneficiaries to ACOs participating in the Shared Savings Program based not only on their utilization of primary care services furnished by physicians but also on their utilization of services furnished by RHCs and FQHCs, effective for performance years beginning on or after January 1, 2019. The statute provides the Secretary with broad discretion to determine how to incorporate services provided by RHCs and FQHCs into the Shared Savings Program beneficiary assignment methodology.

In order to promote participation of RHCs and FQHCs under the Shared Savings Program, CMS proposes to remove the attestation requirement and instead treat a service reported on an RHC or FQHC institutional claim as a primary care service furnished by a primary care physician. Consistent with the 21st Century Cures Act, under this proposal:

1. the requirement for an attestation identifying physicians who directly provide primary care services in each RHC or FQHC that is an ACO participant and/or ACO provider/supplier in the ACO would be removed
2. all RHC and FQHC claims would be used to establish beneficiary eligibility to be assigned to the ACO (pre-step)
3. all RHC and FQHC claims would be included in step 1

CMS proposes revising the definition of primary care services to include three additional CCM service codes 99487, 99489, and G0506, and four BHI service codes G0502, G0503, G0504 and G0507, beginning in 2018 for performance year 2019 and subsequent performance years and to include these codes when performing beneficiary assignment.

MACRA Patient Relationship Categories and Codes

Development of Patient Relationship Categories and Codes to Improve Identification of Physician-Patient Relationship

The Medicare Access and CHIP Reauthorization Act (MACRA) required CMS to draft a list of patient relationship codes and categories and publish them for review and comment. According to the statute, claims submitted on or after January 1, 2018 would be required to include a patient relationship code. However, CMS is choosing to provide flexibility for clinicians as they familiarize themselves with these requirements and codes.

These categories and codes once finalized will be used to evaluate the resources used to treat patients as part of the resource use category of MIPS. The patient relationship codes reported on claims will be used to attribute patients and episodes (in whole or in part) to one or more physicians/practitioners. MACRA requires that the operational list of patient relationship categories and codes be posted no later than

November 1st each year. In preparation for potential subsequent revisions to this list, CMS seeks comment on the operational list of patient relationship categories available at https://www.cms.gov/Medicare/Quality-InitiativesPatient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/CMSPatient-Relationship-Categories-and-Codes.pdf.

Reporting of Patient Relationship Codes Using Modifiers

CMS proposes to use Level II HCPCS Modifiers (in Table 26 extracted from the rule below) as the patient relationship codes based on public comment on how to operationalize reporting. If adopted in the final rule, these will be added to the operational list of categories and codes.

TABLE 26: Proposed Patient Relationship HCPCS Modifiers and Categories

No.	Proposed HCPCS Modifier	Patient Relationship Categories
1x	X1	Continuous/broad Services
2x	X2	Continuous/focused services
3x	X3	Episodic/broad services
4x	X4	Episodic/focused services
5x	X5	Only as ordered by another clinician

Under this proposal, Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include the applicable HCPCS modifiers, as well as the NPI of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner). For at least an initial period while clinicians gain familiarity, CMS is proposing that the HCPCS modifiers may be voluntarily reported on Medicare claims, and the use and selection of the modifiers would not be a condition of payment. Claims would be paid regardless of whether and how the modifiers are included and CMS would work with clinicians to educate them about the proper use of the modifiers.

CMS is soliciting comment on its proposal for voluntary reporting of the proposed HCPCS modifiers on claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018 and on the proposed list of HCPCS modifiers in Table 26. It also seeks comments on its intention to resubmit these patient relationship modifiers to AMA for future consideration into the CPT modifier code set.

ATTACHMENT 1

TABLE 40: CY 2018 PFS Estimated Impact on Total Allowed Charges by Specialty*

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
TOTAL	$92,628	0%	0%	0%	0%
ALLERGY/IMM UNOLOGY	$245	0%	-3%	0%	-3%
ANESTHESIOLOGY	$2,009	-1%	0%	0%	0%
AUDIOLOGIST	$66	0%	0%	-1%	-1%
CARDIAC SURGERY	$311	0%	0%	-1%	-2%
CARDIOLOGY	$6,671	0%	-1%	-1%	-2%
CHIROPRACTOR	$772	0%	1%	0%	1%
CLINICAL PSYCHOLOGIST	$756	0%	2%	0%	2%
CLINICAL SOCIAL WORKER	$664	0%	3%	0%	3%
COLON AND RECTAL SURGERY	$166	0%	0%	-1%	-1%
CRITICAL CARE	$332	0%	0%	0%	0%
DERMATOLOGY	$3,475	0%	0%	-1%	-1%
DIAGNOSTIC TESTING FACILITY	$765	0%	-6%	0%	-6%
EMERGENCY MEDICINE	$3,176	0%	0%	-1%	-1%
ENDOCRINOLOGY	$477	0%	0%	0%	0%
FAMILY PRACTICE	$6,307	0%	0%	0%	0%
GASTROENTEROLOGY	$1,792	0%	0%	-1%	-1%
GENERA L PRACTICE	$452	0%	0%	0%	0%
GENERA L SURGERY	$2,154	0%	0%	0%	-1%
GERIATRICS	$211	0%	0%	0%	1%
HAND SURGERY	$200	0%	0%	0%	1%
HEMATOLOGY/ONCOLOGY	$1,802	0%	0%	0%	0%
INDEPENDENT LABORATORY	$684	0%	-1%	0%	-2%
INFECTIOUS DISEASE	$651	0%	0%	1%	1%
INTERNAL MEDICINE	$11,022	0%	0%	0%	0%
INTERVENTIONAL PAIN MGMT	$830	0%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	$357	0%	-1%	0%	-1%
MULTISPECIALTY CLINIC/OTHER PHYS	$139	0%	0%	0%	0%
NEPHROLOGY	$2,257	0%	0%	0%	0%
NEUROLOGY	$1,545	0%	0%	0%	0%
NEUROSURGERY	$805	0%	0%	-1%	-1%
NUCLEAR MEDICINE	$50	0%	0%	0%	0%
NURSE ANES / ANES ASST	$1,238	-1%	0%	1%	-1%
NURSE PRACTITIONER	$3,541	0%	0%	0%	0%
OBSTETRICS/ GYNECOLOGY	$658	0%	0%	-1%	-1%
OPHTHALMOLOGY	$5,480	0%	0%	0%	0%
OPTOMETRY	$1,259	0%	0%	0%	0%
ORAL/MAXILLOFACIA L SURGERY	$57	0%	-2%	0%	-2%
ORTHOPEDIC SURGERY	$3,784	0%	0%	0%	0%
OTHER	$28	0%	0%	0%	0%
OTOLARNGOLOGY	$1,232	0%	-1%	0%	-2%
PATHOLOGY	$1,147	0%	0%	0%	-1%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
PEDIATRICS	$63	0%	0%	0%	0%
PHYSICAL MEDICINE	$1,105	0%	0%	0%	1%
PHYSICAL/ OCCUPATIONAL THERAPY	$3,780	1%	1%	0%	1%
PHYSICIAN ASSISTANT	$2,232	0%	0%	0%	0%
PLASTIC SURGERY	$379	0%	0%	0%	0%
PODIATRY	$1,973	0%	1%	1%	1%
PORTABLE X-RAY SUPPLIER	$100	0%	-1%	0%	-1%
PSYCHIATRY	$1,233	0%	1%	0%	1%
PULMONARY DISEASE	$1,753	0%	0%	0%	0%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	$1,784	0%	1%	1%	1%
RADIOLOGY	$4,863	0%	-1%	0%	-1%
RHEUMATOLOGY	$553	0%	0%	0%	0%
THORACIC SURGERY	$356	0%	0%	-1%	-1%
UROLOGY	$1,772	0%	-1%	0%	-1%
VASCULAR SURGERY	$1,115	0%	-1%	0%	-2%

** Column F may not equal the sum of columns C, D, and E due to rounding.