CY 2018 Medicare Physician Fee Schedule
Final Rule Summary

On November 3, 2017 the Center for Medicare and Medicaid Services (CMS) released the final Medicare Physician Fee Schedule (MPFS) for 2018. The rule updates payment policies and payment rates for services furnished under the MPFS and will be effective on January 1, 2018 unless stated otherwise.

The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found here.

The following summarizes the major provisions of the final rule.

Conversion Factor and Specialty Impact

The conversion factor for 2018 is $35.9996, a slight increase over 2017. The update to payments was 0.31 percent. The table below, extracted from the rule, shows how the proposed conversion factor was calculated.

Conversion Factor in effect in CY 2017		35.8887
Update Factor	0.50 percent	
CY 2018 RVU Budget Neutrality Adjustment	-0.10 percent	
CY 2018 Target Recapture Amount	-0.09 percent	
CY 2018 Conversion Factor		**35.9996**

Table 50 (see Attachment 1), extracted from the rule, provides a summary of the impact of the 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 final rule includes changes in the range of minus 4% to plus 1%, with neurology seeing no change.

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 sought comment on both the RUC-recommended value and the value derived from the agency's alternative approach.

Several stakeholders, including the RUC, objected to the methodologies employed by CMS used to adjust the RUC-recommended work RVUs, as well as the adjustment of the RUC-recommended values in general. CMS responded that they have previously requested comments on potential alternatives to the methodologies they currently employ when adjusting these values, but did not receive any potential alternatives.

After receiving reassurance from the RUC that the agency's concerns, including those regarding changes in time, have been considered and incorporated or dismissed, CMS shifted its approach to rely more heavily on the RUC recommendations.

The agency also received comments expressing disappointment with the agency's proposed approach for valuing services for CY 2018. MedPAC believes CMS is moving in the wrong direction by proposing to accept

all of the RUC-recommended work values and the agency should independently evaluate the RUC-recommended RVUs based on objective data and revise them as appropriate. Other commenters expressed concern that the RUC undervalued primary care services, as well as concern that the RUC's final recommendations do not necessarily strike the balance across different provider types and services. In response, CMS reiterated they are open to reviewing additional and supplemental sources of data furnished by stakeholders.

Practice Expense RVU Methodology

PE RVU Methodology – Specialty Mix for Low Volume Codes

When determining the RVUs for a code's practice expense, CMS has used 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 finalized its proposal and has posted a list of low volume codes and their expected specialty assignment, which is can be found in the "downloads" section here. This list will be displayed annually with the proposed rule. CMS will review recommendations from stakeholders on changes to the list annually and will be using these assignments for both its PE and malpractice determinations.

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. Since so many services deviated from the RUC standard, CMS sought comment on the value and appropriate application of this preservice time RUC recommendation. Furthermore, the agency noticed a general correlation between the inclusion of preservice clinical labor and recent RUC review and sought comment specifically on whether the standard preservice clinical labor time of 0 minutes should be consistently applied for these globals in future rulemaking. The agency received comments that 0-day and 10-day globals are increasingly being used for procedures that are not minor in nature and agrees there is a need to identify circumstances where deviations from the standard clinical labor times would be appropriate and develop clear definitions and criteria for these situations. The agency will not be consistently applying the standard preservice clinical labor time of 0 minutes to 0-day and 10-day global codes in 2018 or in future rulemaking, but may develop standards in the future.

Obtain Vital Signs Clinical Labor

CMS assumes that the direct PE inputs for each CPT code paid under the PFS include minutes assigned to a series of standard clinical labor tasks which is typical for the service in question. To preserve relativity among the PFS codes, CMS proposed assigning 5 minutes of clinical labor time for all codes that include the "Obtain vital signs" task, regardless of the date of the last review of the code, but agreed with comments that said the determinations for individual clinical labor activities are best made at the individual code level. CMS will assign 5 minutes as the input for all codes that include the "Obtain vital signs" task for CY 2018 as proposed, but will not automatically apply this standard in the future.

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 and the comments received, CMS finalized the proposal 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)

Elimination of the Required Use of the GT Modifier on Professional Claims

For CY 2017, CMS finalized a new place of service (POS) code for services delivered via telehealth. With the implementation of this new POS code, CMS is eliminating the requirement to report the telehealth modifier GT (via interactive audio and video telecommunications systems) with the appropriate HCPCS or CPT code. CMS is retaining the GQ modifier for the purposes of the federal telemedicine demonstration programs in Alaska or Hawaii to distinguish between synchronous and asynchronous telehealth services

Payment Rates under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by 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 were paid at a rate that was 50 percent of the 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 proposed 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. After receiving stakeholder input on this issue, CMS decided not to finalize its proposal and decided to reimburse at 40 percent of the OPPS rate, which represents a middle ground.

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 and primary care services 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 codes and improve payment accuracy for Behavioral Health Integration (BHI), cognitive impairment assessment/management, and prolonged services. CMS sought 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 agreed, particularly for the requirements for the history and physical exam. The agency has also been told 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 and requested 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. The agency requested 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, the agency believes it may be possible to allow MDM and/or time to serve as the key determinant of E/M visit level. CMS sought 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.

CMS received many comments on the potential updates and revisions to the E/M documentation requirements. While there was support for this reform effort, commenters did not agree on how the existing requirements should be changed. The challenges and recommendations commenters articulated differed by specialty. There was some consensus that the documentation requirements for history and physical exam are particularly outdated, but there was no consensus on whether they could be eliminated entirely. Also, commenters did not agree on what changes would need to be made to the MDM and time rules if CMS were to rely more heavily on these components. Based on these comments, CMS is considering the best approaches to collaborate with stakeholders before making any changes.

Care Management Public Comment Solicitation

CMS sought 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. The agency finalized its proposal to adopt the CPT codes for these procedures rather than using G-codes and will continue to work with stakeholders to further refine the code set.

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

CMS requested comments regarding its Medicare Part B biosimilar biological product payment policy. The agency received more than 200 comments on this topic, and in response, changed its proposal to separately

code and pay for biological biosimilar products. As of January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. They will be assigned separate HCPCS codes. CMS believes this change will result in the licensing of more biosimilar products, which will drive competition and stabilize the market.

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 finalized its proposal to modify the requirements to successfully report under the PQRS and avoid a penalty in 2018. Physicians are not required to submit any further information to CMS. The agency has revised 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 finalized changes to better align with MIPS for what was reported as part of the 2016 meaningful use program. Again, this will not require physicians to report any further information. CMS is changing 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 to mirror those of the PQRS. 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 did not change the previously finalized requirements for 2016 for EPs participating in the Medicaid EHR Incentive Program.

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 and will allow these codes to be reported voluntarily for an initial period.

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.

ATTACHMENT 1

TABLE 50: 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	$93,149	0%	0%	0%	0%
ALLERGY/IMM UNOLOGY	$247	0%	-3%	0%	-3%
ANESTHESIOLOGY	$2,018	-1%	0%	0%	-1%
AUDIOLOGIST	$66	0%	0%	0%	0%
CARDIAC SURGERY	$312	0%	0%	0%	0%
CARDIOLOGY	$6,705	0%	-1%	0%	1%
CHIROPRACTOR	$779	0%	1%	0%	1%
CLINICAL PSYCHOLOGIST	$762	0%	2%	0%	2%
CLINICAL SOCIAL WORKER	$670	0%	3%	0%	3%
COLON AND RECTAL SURGERY	$167	0%	0%	0%	0%
CRITICAL CARE	$334	0%	0%	0%	0%
DERMATOLOGY	$3,485	0%	1%	0%	1%
DIAGNOSTIC TESTING FACILITY	$773	0%	-4%	0%	-4%
EMERGENCY MEDICINE	$3,191	0%	0%	0%	0%
ENDOCRINOLOGY	$480	0%	0%	0%	0%
FAMILY PRACTICE	$6,350	0%	0%	0%	0%
GASTROENTEROLOGY	$1,801	0%	0%	0%	0%
GENERA L PRACTICE	$458	0%	0%	0%	0%
GENERA L SURGERY	$2,170	0%	0%	0%	0%
GERIATRICS	$212	0%	0%	0%	0%
HAND SURGERY	$201	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	$1,809	0%	0%	0%	0%
INDEPENDENT LABORATORY	$690	0%	-1%	0%	-1%
INFECTIOUS DISEASE	$656	0%	0%	0%	1%
INTERNAL MEDICINE	$11,107	0%	0%	0%	0%
INTERVENTIONAL PAIN MGMT	$834	0%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	$360	0%	0%	0%	0%
MULTISPECIALTY CLINIC/OTHER PHYS	$140	0%	0%	0%	0%
NEPHROLOGY	$2,270	0%	0%	0%	0%
NEUROLOGY	$1,554	0%	0%	0%	0%
NEUROSURGERY	$811	0%	0%	0%	0%
NUCLEAR MEDICINE	$50	0%	0%	0%	0%
NURSE ANES / ANES ASST	$1,243	-2%	0%	0%	-2%
NURSE PRACTITIONER	$3,566	0%	0%	0%	0%
OBSTETRICS/ GYNECOLOGY	$662	0%	0%	0%	0%
OPHTHALMOLOGY	$5,498	0%	1%	0%	0%
OPTOMETRY	$1,269	0%	0%	0%	0%
ORAL/MAXILLOFACIA L SURGERY	$57	0%	-1%	0%	-1%
ORTHOPEDIC SURGERY	$3,801	0%	0%	0%	0%
OTHER	$29	0%	0%	0%	0%
OTOLARNGOLOGY	$1,237	0%	-1%	0%	-2%
PATHOLOGY	$1,154	0%	0%	0%	-1%
PEDIATRICS	$64	0%	0%	0%	0%
PHYSICAL MEDICINE	$1,112	0%	0%	0%	0%
PHYSICAL/ OCCUPATIONA L THERAPY	$3,807	1%	-2%	0%	-2%
PHYSICIAN ASSISTANT	$2,242	0%	0%	0%	0%
PLASTIC SURGERY	$384	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**
PODIATRY	$1,994	0%	1%	0%	1%
PORTABLE X-RAY SUPPLIER	$102	0%	1%	0%	1%
PSYCHIATRY	$1,247	0%	1%	0%	1%
PULMONARY DISEASE	$1,761	0%	0%	0%	0%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	$1,745	0%	1%	0%	1%
RADIOLOGY	$4,896	0%	0%	0%	0%
RHEUMATOLOGY	$554	0%	1%	0%	1%
THORACIC SURGERY	$358	0%	0%	0%	0%
UROLOGY	$1,777	0%	0%	0%	-1%
VASCULAR SURGERY	$1,125	0%	-1%	0%	-1%

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