OVERVIEW OF THE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) FINAL RULE FY 2018

SUMMARY OF CALCULATION ELEMENTS

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Rule to take effect January 1, 2018

INDEX TO CY 2018 CHANGES IN MPFS FACTORS

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- Calculation with 2018 Conversion Factor
- Coding and Payment Changes
- *Payment Provisions:*
  - Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services
  - Misvalued codes
  - Updates to certain services
  - Geographic Practice Cost Indices
- Appropriate Use Criteria for Advanced Imaging Services
- Medicare Shared Savings Program
- Medicare Diabetes Prevention Program

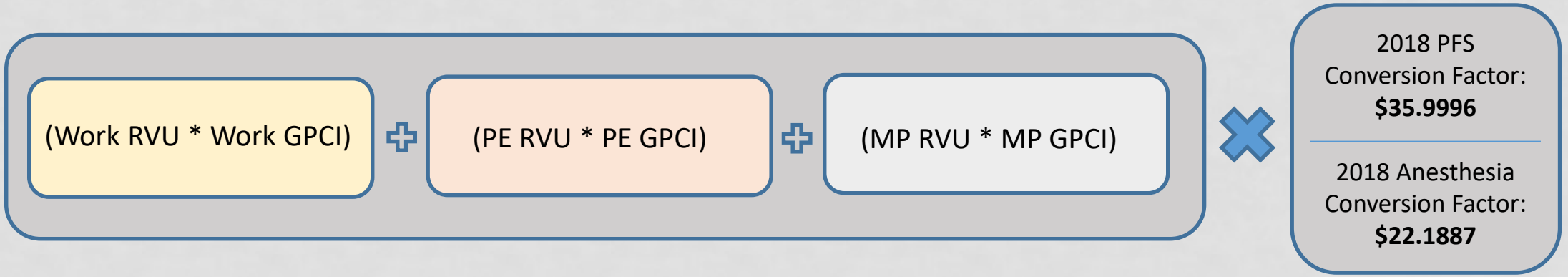
BACKGROUND

- Pays for services furnished by physicians and other practitioners in all sites of service:
  - Office visits
  - Surgical procedures
  - Diagnostic tests
  - Therapy services
  - Certain preventive services
- Payments are based on the relative resources typically used to furnish the service

FORMULA

Relative Value Units (RVUs) are applied to each service based on geographical location, physician work, practice expense (PE) and malpractice (MP), becoming payment rates when a conversion factor is applied.

Physician Fee Schedule Calculation =



- Revisions to RVUs may not cause expenditures to vary by more than $20 million.
  - Budget neutrality adjustments will be made in the event that this occurs.

Overall updated to payments → 0.41 percent increase

CALCULATION OF CONVERSION FACTORS

CY 2018 PFS Conversion Factor

CY 2017 Conversion Factor	35.8887
Statutory Update Factor	0.50 percent (1.0050)
CY 2018 RVU Budget Neutrality Adjustment	-0.10 percent (0.9990)
CY 2018 Target Recapture Amount	-0.09 percent (0.9991)
CY 2018 Conversion Factor	**35.9996**

CY 2018 Anesthesia Conversion Factor

CY 2017 National Average Anesthesia Conversion Factor	22.0454
Statutory Update Factor	0.50 percent (1.0050)
CY 2018 RVU Budget Neutrality Adjustment	-0.10 percent (0.9990)
CY 2018 Target Recapture Amount	-0.09 percent (0.9991)
CY 2018 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	0.34 percent (1.0034)
CY 2018 Conversion Factor	**22.1887**

CODING AND PAYMENT CHANGES

Intended to better identify and value primary care, care management, and cognitive services

- Further reduce the administrative burden associated with the use of chronic care management codes by seeking better alignment between Medicare requirements and CPT guidance
- Replace the G-codes that were initially assigned to psychiatric care management services with CPT codes:
  - G0502, G0503, G0504, and G0507 become 99492, 99493, 99494, and 99484
- Separate payment for CPT code 99091 which describes specific remote patient monitoring
- Addition of 6 telehealth service codes
  - Removal of modifier requirement in certain cases

PAYMENT PROVISIONS: MISVALUED CODES

Target for adjustments to misvalued codes in the fee schedule for CY 2017 and 2018:

0.5%

- CMS finalized misvalued code changes that achieve **0.41 percent in net expenditure reductions**
- Since these changes do not meet misvalued code target of 0.5 percent, the 2018 PFS conversion factor is **reduced by 0.09 percent** and results in a conversion factor of **$35.9996**, reflective of other adjustments.

UPDATING THE VALUATION OF NON-MODERATE SEDATION SERVICES

Removal of oxygen from non-moderate sedation post-procedure monitoring

- In CY 2017, separately billable codes were created for moderate sedation
  - Oxygen gas supply inherently included as part of these procedures
- The continued inclusion of oxygen in non-moderate sedation post-procedure monitoring creates a duplicative effect
  - SD084 (oxygen gas supply) to be removed from 15 CPT codes

MEDICARE TELEHEALTH SERVICES

Addition of several codes to the list of services eligible to be furnished via telehealth:

- Counseling to discuss need for lung cancer screening (HCPCS code: G0296)
- Psychotherapy for crisis (CPT codes: 90839 and 90840)
- Additional services to be added (as add-ons when other telehealth services are provided):
  - CPT Codes: 90785 (Interactive Complexity) and 96160 and 96161 (Patient-focused health risk assessment)
  - HCPCS Code: G0506 (Comprehensive assessment of and care planning for patients requiring chronic care management services)

ELIMINATION OF TELEHEALTH MODIFIER ON PROFESSIONAL CLAIMS

- Previous guidance has required providers to submit claims for telehealth services using the appropriate CPT/HCPCS code plus the telehealth modifier: GT
  - Certifies that telehealth requirements have been met
- In CY 2017, the use of a Place of Service (POS) code was finalized that describes telehealth services
  - Continued use of the GT modifier introduces redundancy
- Because institutional claims do not use a POS code, they will continue to use the GT modifier.

PAYMENT FOR NONEXCEPTED ITEMS AND SERVICES PROVIDED BY OFF-CAMPUS HOSPITAL PBD

- Nonexcepted items & services furnished by off-campus PBDs are not consider OPD services and must be paid under their applicable payment system
  - Most nonexcepted items and services will be covered under the PFS
  - Institutional claims billed with modifier “PN” paid under the PFS

- Coding and billing – payments are made to hospitals for the technical aspects of the services provided and to the practitioner for the professional portion

- PFS Relativity Adjuster: the percentage of the OPPS payment paid for a nonexcepted item/service

CY 2018 PFS Relativity Adjuster: 25%

GEOGRAPHIC PRACTICE COST INDICES

General GPCI Update

CMS adjusts payments under PFS to reflect local differences in practice costs using GPCIs for each component of PFS payment: physician work, practice expense, malpractice expense

GPCI rates are based both on hospital wage index areas and the hospital wage index values

Class-specific GPCIs are parallel to the geographic adjustments made under the OPPS based on the hospital wage index

APPROPRIATE USE CRITERIA FOR ADVANCED IMAGING SERVICES

- **AUC** is a library of **appropriate use criteria**
  - CMS established first four components of appropriate use criteria (AUC) in the CY 2016 MPFS final rule

- 2018 final rule focuses on the third major component of the Medicare AUC Program:

  Consultation with Applicable Appropriate Use Criteria

  - Starting Jan. 1, 2018, an ordering professional must consult with a qualified CDSM when ordering an applicable imaging service

- No change in the list of priority clinical areas from CY 2017 to CY 2018

MEDICARE SHARED SAVINGS PROGRAM

Medicare Shared Savings Program was established to **promote accountability** for a patient population, **coordinate items and services** under parts A and B, **and encourage investment** in infrastructure and redesigned care processes for high quality and efficient service **delivery through provider and supplier participation in an ACO**

The CY 2018 MPFS final rule includes the following finalized policies

Modification to the Beneficiary Assignment Methodology

- Modify assignment of beneficiaries to ACOs that include RHCs and/or FQHCs
  - Treat services provided at RHCs and/or FQHCs as primary care services
- Revision of definition of primary care to include 3 additional CCM codes and 4 BHI codes
- Reduce operational burden placed on ACOs that include RHCs and FQHCs as participants

ACO Quality Reporting

- Flexibility to change a measure's pay structure if there has been a substantial change
- Refining the process used to validate ACO Quality Data Reporting
  - Lowering the required match rate from 90% (est. CY 2017) to 80% (CY 2018 and beyond)

Reduction in Program Application Burden

- Changes to the SNF 3-day Rule
  - Removal of requirement of proof of 3 star rating or higher for the SNF affiliate
- Reduce application burden
  - Submission of narratives no longer required

MEDICARE DIABETES PREVENTION PROGRAM

CMS finalized expansion of the Medicare Diabetes Prevention Program (MDPP) in CY 2017

- Program is a structured behavioral change intervention that aims to prevent the onset of type 2 diabetes among Medicare beneficiaries diagnosed with pre-diabetes

Further program clarification in CY 2018:

- Payment for MDPP services will begin April 1, 2018
- Clarification of MDPP Services Period
  - A core services period of 1 year and an ongoing maintenance services period of 1 year
  - MDPP services available only once for each eligible Medicare beneficiary

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