Executive Summary: CMS 2018 PFS Final Rule

Key Financial and Operational Impacts from the Final 2018 Physician Fee Schedule (PFS) rule:

The 2018 PFS final rule was made available on November 2, 2017. A detailed summary of the rule will be available on HFMA's Regulatory Resources page shortly.

1) **Conversion Factor**: While the Medicare Access and CHIP Reauthorization Act (MACRA) mandates a .5% update to the physician fee schedule for CY18, adjustments for mis-valued codes result in a net increase of .41%. Therefore, the final CY18 conversion factor is $35.9996. This is a slight increase from the CY17 conversion factor of $35.8887.

   The anesthesia conversion factor is $22.1887 (compared to CY17's $22.0454).

2) **Specialty Specific Impact**: Relative value unit (RVU) repricing and other policies in the final rule have a significant negative impact on the following specialties:

Specialty	Estimated Allowed Charges ($, Millions)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP Changes	Total Combined Impact
Diagnostic Testing Facility	773	0%	-4%	0%	-4%
Allergy/Immunology	247	0%	-3%	0%	-3%
Physical/Occup. Therapy	3,807	1%	-2%	0%	-2%
Nurse Anesnetist/Anes. Asst.	1,243	-2%	0%	0%	-2%
Otolaryngology	1,237	0%	-1%	0%	-2%
Independent Laboratory	690	0%	-1%	0%	-1%
Oral/Maxillofacial Surgery	57	0%	-1%	0%	-1%
Vascular Surgery	1,125	0%	-1%	0%	-1%
Anesthesiology	2,018	-1%	0%	0%	-1%
Pathology	1,154	0%	0%	0%	-1%
Urology	1,777	0%	0%	0%	-1%

The following specialties will see an increase in payment greater than 1% resulting from policy changes in the final rule:

Specialty	Estimated Allowed Charges ($, Millions)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP Changes	Total Combined Impact
Clinical Psychologist	762	0%	2%	0%	2%
Clinical Social Worker	670	0%	3%	0%	3%

Please see the appendix at the end of the document for a complete list of impacts by specialty.

3) **Non-Exempt Provider Based Sites of Service**: CMS reduces payments to non-exempt provider based clinics (new clinics that were not in process by November 2, 2015) from 50% of the outpatient prospective payment system payment for the service in question to 40% of the service in question.

4) **Physician Relationship Modifier**: MACRA requires that physician claims submitted for items and services on or after January 1, 2018, include the physician relationship Healthcare Common Procedure Coding System (HCPCS) modifier(s) which were recently developed. CMS finalizes its proposal that 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 in Table 27 in the final rule (reproduced below), as well as the National Provider Identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner). CMS also finalizes its proposal that for at least an initial period while clinicians gain familiarity, *the HCPCS modifiers may be voluntarily reported, and the use and selection of the modifiers will not be a condition of payment.*

Below is a list of modifiers.

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

Additional information related to the modifiers is available here.

5) **Changes to Medicare Shared Savings Program (MSSP)**: CMS finalizes minor changes to the MSSP program. These include:

a. *Modification of Application Requirements to Reduce Administrative Burden*: Rather than requiring every applicant to submit detailed supporting documents or narratives for all application requirements, CMS will request supporting documents or narratives only if additional information is needed to fully assess an accountable care organization's (ACO's) application before making a decision to approve or deny the application. CMS makes a similar change to the documentation requirements for MSSP Track 3 participants applying for the "SNF 3-day waiver."

b. *TINs Participating in Multiple ACOs:* If, during a benchmark or performance year, an ACO participant that participates in more than one ACO begins billing for services that would be used in assignment, CMS will not consider any services billed through that tax identification number (TIN) during the relevant performance year when performing beneficiary assignment for the applicable benchmark or performance year. The ACOs in which the overlapping TIN is an ACO participant may be subject to compliance action or termination.

c. *Beneficiary Assignment:* CMS will consider all services furnished in federally qualified health centers and rural health clinics in the assignment methodology as primary care services starting in the 2019 performance year.

Additionally, CMS includes three complex condition management service codes (99487, 99489, and G0506) and four behavioral health integration service codes (G0502, G0503, G0504 and G0507) in the definition of primary care services, and will utilize these codes in the beneficiary assignment methodology under the Shared Savings Program beginning in 2018 for performance year 2019 and subsequent years.

6) **Diabetes Prevention Program (DPP)**: CMS incorporates a pay for performance system into the DPP. Payments to providers will vary between a maximum of $195 and $670 depending on whether or not beneficiaries participating in the program achieve selected weight-loss targets. Below is a summary of the payment levels based on goal attainment:

TABLE 39: Final Performance Payments for the Set of MDPP Services

Performance Goal	**Performance Payment Per Beneficiary (*with* the required minimum weight loss)**	**Performance Payment Per Beneficiary (*without* the required minimum weight loss)**
1st core session attended	$25	
4 total core sessions attended	$50	
9 total core sessions attended	$90	
2 sessions attended in first core maintenance session interval (months 7-9 of the MDPP core services period)	*$60	$15
2 sessions attended in second core maintenance session interval (months 10-12 of the MDPP core services period)	*$60	$15
5 percent weight loss achieved	$160	$0

9 percent weight loss achieved	$25	$0
2 sessions attended in ongoing maintenance session interval (4 consecutive 3-month intervals over months 13-24 of the MDPP ongoing services period)	*$50	**$0
Total performance payment	**$670**	**$195**

* = The required minimum weight loss from baseline must be achieved or maintained during the core maintenance session 3-month interval or maintained during the ongoing maintenance session 3-month interval.
** = A beneficiary attends at least 1 core session during the core services period to initiate the MDPP services period; must attend at least 1 session during the final core maintenance session 3-month interval; and must achieve or maintain the required minimum weight loss at least once during the final core maintenance session 3-month interval to have coverage of the first ongoing maintenance session interval. Then, a beneficiary must attend at least 2 sessions and maintain the required minimum weight loss at least once during an ongoing maintenance session 3- month interval to have coverage of the next ongoing maintenance session interval.

7) **Telehealth Services**: CMS adds the following CPT and HCPCS codes in CY18:

- HCPCS code G0296 (Counseling visit to discuss need for lung cancer screening using low dose CT scan (ldct) (service is for eligibility determination and shared decision making))
- HCPCS code G0506 (Comprehensive assessment of and care planning for patients requiring chronic care management services (List separately in addition to primary monthly care management service))
- CPT code 90785 (Interactive complexity (List separately in addition to the code for primary procedure))
- CPT codes 90839 and 90840 (Psychotherapy for crisis; first 60 minutes) and (Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary procedure))
- CPT codes 96160 and 96161 (Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument) and (Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument))

Additionally, CMS eliminates the required reporting of the telehealth modifier GT for professional claims to reduce administrative burden for practitioners. The rule also finalizes separate payment for CPT code 99091, which describes certain remote patient monitoring, for CY18.

8) **Imaging Appropriate Use Criteria**: CMS continues to implement the requirement[1] that professionals who furnish advanced imaging services report on the claim information about the appropriate use criteria reviewed by the ordering professional. Instead of 2019 as proposed, the rule finalizes CY20 as "an education and operations year." Therefore, CMS will pay claims for impacted services regardless of whether the required information is included on the claim. Beginning in mid-2018, CMS will make an 18-month voluntary reporting period available for professionals.

9) **Physician Quality Reporting Program (PQRS)**: CMS revises the previously finalized criteria for the CY16 reporting period (CY18 payment period) to lower the requirement from 9 measures across 3 National Quality Strategy domains, where applicable, to only 6 measures with no domain or cross-cutting measure requirement. This will align PQRS with the Quality Payment Program.

10) **Physician Value Modifier (VM)**: CMS makes the following modifications to the VM program:

    a. Reduce the automatic downward adjustment for groups and solo practitioners in Category 2 (those who do not meet the criteria to avoid the 2018 PQRS payment adjustment). For groups with 10 or more eligible professionals (EPs), and at least one physician, the final rule reduces the adjustment to negative 2 percent (from negative 4 percent). It decreases to negative 1 percent (from negative 2 percent) for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs.

    b. Hold all groups and solo practitioners who are in Category 1 (those who meet the criteria to avoid the 2018 PQRS payment adjustment) harmless from downward payment adjustments under quality tiering for the last year of the program.

    c. Reduce the maximum upward adjustment under the quality-tiering methodology to two times an adjustment factor (+2.0x) for groups with 10 or more EPs. This is the same maximum upward adjustment under the quality-tiering methodology that CMS finalized, and will maintain for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs.

[1] Included Protecting Access to the Medicare Act of 2014 (PAMA)

Appendix I: Specialty Specific Payment Impact of Final CY18 PFS Rule

Specialty	Estimated Allowed Charges ($, Millions)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP Changes	Total Combined Impact
Diagnostic Testing Facility	773	0%	-4%	0%	-4%
Allergy/Immunology	247	0%	-3%	0%	-3%
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Otolaryngology	1,237	0%	-1%	0%	-2%
Independent Laboratory	690	0%	-1%	0%	-1%
Oral/Maxillofacial Surgery	57	0%	-1%	0%	-1%
Vascular Surgery	1,125	0%	-1%	0%	-1%
Anesthesiology	2,018	-1%	0%	0%	-1%
Pathology	1,154	0%	0%	0%	-1%
Urology	1,777	0%	0%	0%	-1%
Cardiac Surgery	312	0%	0%	0%	0%
Critical Care	334	0%	0%	0%	0%
Emergency Medicine	3,191	0%	0%	0%	0%
Family Practice	6,350	0%	0%	0%	0%
General Practice	458	0%	0%	0%	0%
General Surgery	2,170	0%	0%	0%	0%
Hand Surgery	201	0%	0%	0%	0%
Internal Medicine	11,107	0%	0%	0%	0%
Interventional Radiology	360	0%	0%	0%	0%
Multi-specialty Clinic	140	0%	0%	0%	0%
Nuclear Medicine	50	0%	0%	0%	0%
Nurse Practitioner	3,566	0%	0%	0%	0%
Orthopedic Surgery	3,801	0%	0%	0%	0%
Physical Medicine	1,112	0%	0%	0%	0%
Physician Assistants	2,242	0%	0%	0%	0%
Pulmonary Disease	1,761	0%	0%	0%	0%
Thoracic Surgery	358	0%	0%	0%	0%
Interventional Pain Mgmt	834	0%	0%	0%	0%
Colon and Rectal Surgery	167	0%	0%	0%	0%
Audiologist	66	0%	0%	0%	0%
Endocrinology	480	0%	0%	0%	0%
Gastroenterology	1,801	0%	0%	0%	0%
Geriatrics	212	0%	0%	0%	0%
Hematology/Oncology	1,809	0%	0%	0%	0%
Nephrology	2,270	0%	0%	0%	0%

Neurology	1,554	0%	0%	0%	0%
Neurosurgery	811	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%
Other	29	0%	0%	0%	0%
Pediatrics	64	0%	0%	0%	0%
Radiology	4,896	0%	0%	0%	0%
Infectious Disease	656	0%	0%	0%	1%
Plastic Surgery	384	0%	0%	0%	1%
Portable X-Ray Supplier	102	0%	1%	0%	1%
Cardiology	6,705	0%	-1%	0%	1%
Chiropractor	779	0%	1%	0%	1%
Dermatology	3,485	0%	1%	0%	1%
Podiatry	1,994	0%	1%	0%	1%
Psychiatry	1,247	0%	1%	0%	1%
Radiation Oncology & Radiation Therapy Centers	1,745	0%	1%	0%	1%
Rheumatology	554	0%	1%	0%	1%
Clinical Psychologist	762	0%	2%	0%	2%
Clinical Social Worker	670	0%	3%	0%	3%
Total	$93,149	0%	0%	0%	0%