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2018 Medicare Physician Fee Schedule

Final Rule Summary

On November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) issued the Medicare Physician Fee Schedule (MPFS) final rule. The final rule updates the payment policies, payment rates, and quality provisions for services furnished under the MPFS effective January 1, 2018.

The MPFS pays for services furnished by physicians and other practitioners in all sites of service. These services include visits, surgical procedures, diagnostic tests, therapy services, specified preventative services and more. Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for physician work, practice expense and malpractice. These RVUs become payment rates through the application of a conversion factor, which is updated annually.

MPFS Impact Table

The MPFS Impact Table shows the estimated impact on total allowed charges by specialty of all the RVU changes. CMS estimates a one percent increase for radiation oncology and radiation therapy centers as a result of the changes to the 2018 MPFS. Radiation oncology is again benefitting from the ASTRO-backed Patient Access and Medicare Protection Act, which froze payments for key treatment delivery and image guidance codes at 2016 levels. However, this legislative freeze expires after 2018.

Table 50: CY 2018 PFS Impact on Total Allowed Charges by Specialty

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Total	$93,149	0%	0%	0%	0%
Radiation Oncology and Radiation Therapy Centers	$1,745	0%	1%	0%	1%

Conversion Factor/Target

The overall update to payments under the MPFS, based on the 2018 rates, is set at 0.41 percent. This update reflects the 0.50 percent update established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, reduced by 0.09 percent, due to the misvalued code

target recapture amount, required under the Achieving a Better Life Experience (ABLE) Act of 2014. After applying these adjustments, and the budget neutrality adjustment to account for changes in RVUs, all required by law, the 2018 MPFS conversion factor is $35.99, an increase over the 2017 PFS conversion factor of $35.89.

CMS Approach to RUC Recommended Values

In the final 2018 MPFS rule, CMS clarified its obligation for establishing RVUs for the MPFS. The Agency stated that it makes an independent assessment of the available recommendations, supporting documentation, and other available information from the RUC and other commenters in determining the appropriate valuations. Where there is agreement, CMS will propose the RUC recommended values in future rule making. Additionally, the Agency committed to updating its internal review of RUC recommendations in the future.

Valuation of Specific Radiation Oncology Codes

Radiation Therapy Planning (CPT Codes 77261-77263)

CPT Code 77263 *Therapeutic radiology treatment planning; complex* was identified in a High-Expenditure Services Screen in the 2016 MPFS Final Rule. The Clinical Treatment Planning code set, CPT Codes 77261-263, were reviewed and revalued by the RUC in April 2016. The RUC accepted the recommended values with no revisions.

In the 2018 MPFS proposed rule, CMS agreed with the RUC recommended work RVUs; however, the Agency expressed concerns with the recommended values given the decreases in service times as recommended by the RUC and reflected in the survey data compared to current values. CMS offered an alternative for consideration that would crosswalk the codes to CPT code 96111 *Developmental testing, includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report,* which has similar intraservice and total time to the RUC recommended values for CPT code 77263.

After considering ASTRO's concerns regarding the alternative proposal, CMS is finalizing the RUC recommended values for the Radiation Therapy Planning Codes. The chart below depicts the final RVU values effective January 1, 2018:

Radiation Therapy Planning Final RVU Value

CPT Code	CPT Descriptor	Global Period	Final RVU Value
77263	Therapeutic radiology treatment planning; complex	XXX	3.14
77162	Therapeutic radiology treatment planning; intermediate	XXX	2.00

77261	Therapeutic radiology treatment planning; simple	XXX	1.30

CPT Code 55847 Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed

In 2016, the CPT Editorial Panel deleted CPT Category III code 0438T and created new CPT Code 55847 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed.* The RUC recommended an RVU value of 3.03 at its January 2017 meeting.

In the proposed 2018 MPFS, CMS proposes to accept the RUC-recommended value. However, the Agency expressed concern regarding the decrease in preservice time (30 minutes) compared to the current preservice time. To account for this change in time, CMS proposed an alternative methodology, which involved calculating the intraservice time ratio between the key reference code (CPT code 49411), which has an intraservice time of 40 minutes, and the RUC-recommended intraservice time (30 minutes) and multiplying that against the work RVU for CPT code 49411 (3.57), which would have resulted in a work RVU of 2.68. Again, based on ASTRO's comments regarding the alternative valuation, CMS is finalizing the RUC recommended RVU value of 3.03 RVUs.

The Agency finalized a two-minute modification to the equipment time to conform with changes in the clinical labor formula as a result of the revaluation of the code. CMS also finalized the following supply and equipment prices:

Supply/Equipment Item	Price
SD325 - Endocavity Balloon	$39.90 per device
SA126 - Biodegradable Material Kit – Periprostatic	$2,850
EQ386 - Endocavitary US Probe	$16,146

In the proposed 2018 MPFS rule, CMS questioned whether the invoice price of $29,999 for existing equipment item *EQ250 Portable Ultrasound Unit* included probes. Several commenters, including ASTRO, indicated that it did not. ASTRO urged CMS to recognize the direct practice inputs for the probe, in addition to the portable unit, as it is necessary to perform the procedure. In the final 2018 MPFS, CMS requests that invoices be submitted by February 2018 for future pricing updates associated with the probe.

CPT Code 77401 Radiation Treatment Delivery, Superficial and/or Orthovoltage, per day

In the proposed 2018 MPFS, CMS proposed to make separate payment for the professional planning and management associated with Superficial Radiation Therapy (SRT) using HCPCS code *GRRR1 Superficial Radiation Treatment Planning and Management Related Services, including but not limited to, when performed, clinical treatment planning (e.g., 77261, 77262, 77263), therapeutic radiology simulation-aided field setting (e.g., 77280, 77285, 77290, 77293),*

basic radiation dosimetry calculation (i.e., 77300), treatment devices (e.g., 77332, 77333, 77334), isodose planning (e.g., 77306, 77307, 77316, 77318), radiation treatment management (e.g., 77427, 77431, 77432, 77435, 77469, 77470, 77499), and associated evaluation and management per course of treatment. The Agency stated that it intended to use this code to describe the range of professional services associated with a course of SRT, including services similar to those not otherwise separately reportable under CPT guidance and the NCCI manual.

CMS received numerous responses regarding this proposal, none of which formulated any consensus around valuing the professional services associated with delivering SRT. In the final 2018 MPFS, CMS did not finalize GRRR1. The Agency state that it would continue to explore alternative solutions with stakeholders to be introduced in future rulemaking.

Calculation of Malpractice RVUs

CMS collects malpractice insurance premium data from all 50 states, the District of Columbia and Puerto Rico in order to update the Malpractice RVUs for each specialty. Rate filings must be available from at least 35 states to establish the minimum amount of premium data necessary to establish a malpractice RVU rate.

CMS crosswalks specialties for which there is not sufficient premium data to similar specialties to establish a malpractice RVU. Data for radiation oncology was only available based on 23 states' worth of premium rate filings data. In the proposed 2018 MPFS, CMS proposed a cross walk of the risk factor for diagnostic radiology to the radiation oncology Malpractice RVU. This would provide radiation oncology with a risk factor of 2.82 for application in the calculation of a Malpractice RVU for the specialty.

After consideration of public comments made by ASTRO and other specialty groups concerning the validity of the malpractice insurance premium data. CMS is not finalizing the proposal to develop malpractice RVUs using the most recent data for the 2018 Malpractice RVUs. The 2018 Malpractice RVUs will be based on the premium data that was collected for the 2015 Malpractice RVU update. CMS notes that the next Malpractice RVU update must occur by 2020. The Agency believes that updating the data on a more frequent basis would enable the resulting RVUs that better reflect malpractice insurance trends by specialty.

Proposed Payment Rates under the MPFS Schedule for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital

In the 2017 Hospital Outpatient Prospective Payment System final rule, CMS finalized new MPFS payment amounts for nonexcepted items and services furnished by nonexcepted provider based departments (PBDs) that bill under the Hospital Outpatient Prospective Payment System. Nonexcepted items and services, as well as nonexcepted providers, are those items and services that are rendered by providers in provider based departments, that are billed under the HOPPS after November 2, 2015.

The Agency adopted payment rates for these items and services that were based on a 50 percent reduction, also known as the Physician Fee Schedule (PFS) Relativity Adjuster, to the OPPS

payment rates for 2017. At the time, CMS stated that the application of the adjuster would be a transitional policy until more precise data became available.

CMS recognizes that the comparison between the OPPS and PFS rates for other services varies greatly, and that there are other factors, including the specific mix of services furnished by non-excepted PBDs, policies related to packaging of codes under OPPS, and payment adjustments like Multiple Procedure Payment Reductions (MPPRs) and bundling under the PFS that rely on empirical information about whether or not codes are billed on the same day, that contribute to the differences in aggregate payment amounts for a broader range of services.

In the proposed 2018 MPFS rule, CMS expressed concern that the 50 percent PFS Relativity Adjuster is too small, resulting in greater overall payments to hospitals for non-excepted services furnished by PBDs, and proposed to reduce the PFS Relativity Adjuster to 25 percent of HOPPS payment rates. In the final 2018 MPFS, CMS modified its proposal and finalized a PFS Relativity Adjuster of 40 percent for 2018.

Coding Consistency for Radiation Oncology Services

In 2014, major revisions were made to the conventional treatment delivery, intensity modulated radiation treatment (IMRT) delivery and image guided radiation therapy (IGRT) codes. In 2015, CMS declined to assign values in the MPFS to the new conventional radiation treatment delivery, IMRT and IGRT codes. In place of the new codes, CMS created HCPCS G-codes to report many of these services effective January 1, 2015. However, the new conventional radiation treatment delivery, IMRT and IGRT codes were assigned to Ambulatory Payment Classifications (APCs) under the HOPPS. This distinct difference in code classification by payment system will remain in place through 2018, due to the passage of the ASTRO-supported Patient Access and Medicare Protection Act of 2015, which freezes the MPFS payments.

In the final 2018 MPFS, CMS finalized its proposal that those nonexcepted items and services denoted by the radiation oncology G-codes that are provided by nonexcepted off-campus PBDs will continue to be billed as G-codes with an appended PN modifier. The PFS Relativity Modifier would not apply to these codes and the payment amount would be set to reflect the technical component rate for the G-Codes under the MPFS.

Application of Supervision Rules

CMS confirmed in the final 2018 MPFS rule that supervision rules that apply to hospitals will also apply to nonexcepted off-campus PBDs that furnish nonexcepted items and services.

2019 and Future Years

For 2019 and for future years, CMS intends to examine the claims data in order to determine not only the appropriate PFS Relativity Adjuster(s), but also to determine whether additional adjustments to the methodology are appropriate – especially with the goal of attaining site neutral payments to promote a level playing field under Medicare between physician office settings and nonexcepted off-campus PBD settings, without regard to the kinds of services

furnished by particular off-campus PBDs.

MACRA Patient Relationship Categories and Codes

The Medicare and CHIP Reauthorization Act (MACRA) requires the development of patient relationship categories and codes that define and distinguish the relationship and responsibility of physician or applicable practitioner with a patient at the time of care delivery. CMS is required to post a list of patient relationship categories and codes by November 1 of each year, beginning in 2018.

In the final 2018 MPFS, CMS finalized a voluntarily reporting policy for the following list of HCPCS codes. This allows physicians time to incorporate the application of the modifier into their regular practice routine. ASTRO believes that radiation oncologists would fall into the categories of Episodic/Focused or Continuous/Focused based on the diagnosis, comorbidities, and disease progression of a particular patient. Due to the nature of the work involved with radiation oncology it is likely that physicians will vacillate between these two categories over a period of time. The voluntary reporting policy will likely demonstrate these types of shifts based on clinical indications for each individual patient.

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

2018 PQRS and Value Modifier

In the 2018 MPFS, CMS finalized a change to the current Physician Quality Reporting System (PQRS) program policy that requires reporting of 9 measures across 3 National Quality Strategy domains to only require reporting of 6 measures for the PQRS with no domain requirement. The Agency also finalized similar changes to the clinical quality measure reporting requirements under the Medicare Electronic Health Record Incentive Program for eligible professionals who reported electronically through the PQRS portal. The changes were finalized to better align with the Merit-based Incentive Payment System (MIPS) data submission requirements for the quality performance category. For MIPS, eligible clinicians need only report 6 quality measures for the quality performance category, except those reporting via the Web Interface, and there is no requirement to ensure that the measures span across 3 National Quality Strategy domains.

CMS also finalized several changes to the Value Modifier that the agency says would better align incentives and provide a smoother transition to the new Merit-based Incentive Payment System under the Quality Payment Program:

- Reducing the automatic downward payment adjustment for not meeting the criteria to avoid the PQRS adjustment from negative four percent to negative two percent (-2.0 percent) for groups of ten or more clinicians; and from negative two percent to negative one percent (-1.0 percent) for physician and non-physician solo practitioners and groups of two to nine clinicians;
- Holding harmless all physician groups and solo practitioners who met the criteria to avoid the PQRS adjustment from downward payment adjustments for performance under quality-tiering for the last year of the program; and
- Aligning the maximum upward adjustment amount to 2 times the adjustment factor for all physician groups and solo practitioners.

Given these changes to PQRS and the Value Modifier, the Agency will not report 2018 Value Modifier data in the Physician Compare downloadable database as this would be the first and only year such data would have been reported. However, to promote transparency CMS will continue to make available the Value Modifier public use and research identifiable files.

Additional information about the proposed 2018 MPFS can be found at the following links:

The final rule is available online at:
https://www.federalregister.gov/documents/2017/11/15/2017-23953/medicare-programs-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

Other supporting documents and tables referenced in this final rule are available through the Internet on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html

The CMS Press Release and the CMS Fact Sheet on the final rule are available at:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-02.html