2018 Medicare Physician Fee Schedule

Proposed Rule Summary

On July 13, 2017, the Centers for Medicare & Medicaid Services (CMS) issued the Medicare Physician Fee Schedule (PFS) proposed rule. The proposed rule updates the payment policies, payment rates, and quality provisions for services furnished under the MPFS effective January 1, 2018. Comments are due to CMS no later than September 11, 2017.

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 proposed 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 53: CY 2018 PFS Estimated Impact on Total Allowed Charges by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (mil)</th>
<th>Impact of Work RVU Changes</th>
<th>Impact of PE RVU Changes</th>
<th>Impact of MP RVU Changes</th>
<th>Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$92,628</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Radiation Oncology and Radiation Therapy Centers</td>
<td>$1,784</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Conversion Factor/Target

The overall update to payments under the MPFS, based on the proposed 2018 rates, is set at 0.31 percent. This update reflects the 0.50 percent update established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, reduced by 0.19 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 proposed 2018 MPFS conversion factor is $35.99, an increase over the 2017 PFS conversion factor of $35.89.

2018 RUC Recommendations

For CY 2018, CMS has proposed accepting the RUC-recommended work RVUs for new, revised, and potentially misvalued codes. The Agency is proposing these values based on the understanding that the RUC generally considers the kinds of concerns CMS has historically raised regarding appropriate valuation of work RVUs. Given the relative nature of the MPFS and CMS’ obligation to ensure that the RVUs reflect relative resource use, the Agency has included descriptions of potential alternative approaches it might have considered in developing work RVUs that differ from the RUC recommended values. CMS seeks comment on both the RUC-recommended values as well as proposed alternatives.

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 recommended values with no revisions. In the 2018 MPFS proposed rule, CMS agrees with the RUC recommended work RVUs; however, the Agency expresses 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.

The Agency is concerned that despite a 15-minute decrease in intraservice time, the RUC did not recommend a corresponding decrease in work RVUs. As an alternative, CMS proposes a RVU of 2.60 based on a crosswalk 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.

The Agency proposes using a ratio of the two RVU valuations for CPT codes 96111 and 77263 (2.60 RVUs/3.14 RVUs = 0.83) to determine the values for CPT codes 77261 and 77262. The ratio of 0.83 is multiplied by the RUC-recommended RVU value for the remaining treatment planning codes to achieve the CMS proposed alternative value. CMS seeks comments on the proposed alternative RVU values for the radiation oncology treatment planning codes. The chart below depicts the RUC-recommended values, as well as the CMS proposed alternative values.
## Radiation Therapy Planning RUC Value vs. CMS Alternative

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Global Period</th>
<th>RUC Recom RVU Value</th>
<th>CMS Proposed CPT Crosswalk</th>
<th>CPT Descriptor</th>
<th>RVU Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>77263</td>
<td>Therapeutic radiology treatment planning; complex</td>
<td>XXX</td>
<td>3.14</td>
<td>96111</td>
<td>Developmental testing, includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report</td>
<td>2.60</td>
</tr>
<tr>
<td>77162</td>
<td>Therapeutic radiology treatment planning; intermediate</td>
<td>XXX</td>
<td>2.00</td>
<td></td>
<td>0.83 X 2.00 = 1.66</td>
<td>1.66</td>
</tr>
<tr>
<td>77261</td>
<td>Therapeutic radiology treatment planning; simple</td>
<td>XXX</td>
<td>1.30</td>
<td></td>
<td>0.83 X 1.30 = 1.08</td>
<td>1.08</td>
</tr>
</tbody>
</table>

### CPT Code 55X87 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 55X87 *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 expresses concern regarding the decrease in preservice time (30 minutes) compared to the current preservice time. To account for this change in time, CMS proposes an alternative methodology, which involves 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. A work RVU of 2.68 would have been further supported by a bracket of two crosswalk codes, CPT code 65779 *Placement of amniotic membrane on the ocular surface; single layer, sutured,* which, has a work RVU of 2.50; and CPT code 43252 *Esophagogastrroduodenoscopy, flexible, transoral; with optical endomicroscopy,* which, has a work RVU of 2.96. Compared with CPT code 55X87, these codes have identical intraservice and similar total times. CMS seeks comments on whether the alternative values of these codes should be considered.
CMS is proposing a minor modification to the equipment time to conform with changes in the clinical labor formula as a result of the reevaluation of the code. This results in a two-minute increase in each of the associated equipment times.

CMS reviewed invoices and pricing information for two new supply items: “endocavity balloon” and “biodegradable material kit – periprostatic”. According to the proposed rule, CMS believes that the “endocavity balloon” invoice price of $399.00 for ten devices was inadvertently included in the PE spreadsheet, rather than $39.90 for one device. The Agency proposes to modify the price of the “endocavity balloon” to $39.90. CMS proposes to accept the value of the “biodegradable material kit – periprostatic” at $2850. The Agency also proposes to use the invoice price of $16,146 for new equipment item “endocavitary US probe” to propose a per minute price of $0.0639. Finally, the Agency questions whether the invoice price of $29,999 for existing equipment item EQ250 Portable Ultrasound Unit includes probes. CMS seeks comments related to this issue.

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

In the 2015 MPFS, CMS finalized language limiting the codes that could be reported with superficial radiation therapy (SRT) delivery. In the 2016 MPFS, CMS asked for stakeholder feedback regarding the physician work associated with SRT. Stakeholder comments revealed significant differences of opinion regarding the physician work associated with 77401, which is why the issue remains unresolved. ASTRO continues to believe that the most appropriate way to resolve the physician work issue for 77401 is through the CPT/RUC process.

In the 2018 MPFS, CMS is proposing to make separate payment for the professional planning and management associated with 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 intends 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.

To value this code, CMS is including physician work and any work time associated with radiation management-related services that are typical for a course of SRT. CPT code 77261 Therapeutic radiology treatment planning; simple, CPT code 77280 Therapeutic radiology simulation-aided field setting; simple, CPT code 77300 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician, CPT code 77306 Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s), CPT code 77332 Treatment devices, design and
construction; simple (simple block, simple bolus), and CPT code 77427 Radiation treatment management, 5 treatments. The Agency is proposing a work RVU of 7.93 for HCPCS code GRRR1.

To develop the proposed direct PE inputs for this code, CMS is proposing to use the RUC recommended direct PE inputs from the aforementioned codes with several adjustments. The Agency proposes to apply the staff type “RN/LPN/MTA” for all of the clinical labor inputs for this code because the Agency believes that the typical office performing SRT will be staffed with this labor type, rather than radiation therapists. CMS seeks comments as to the appropriateness of the staff type “RN/LPN/MTA” for this SRT-related service. Some stakeholders have suggested that many services related to SRT are personally performed by the billing practitioner rather than by clinical staff.

CMS is proposing to remove the supply items "gown, patient" and "pillow case" that are associated with CPT code 77280, as these items are included in the minimum multi-specialty visit pack that is associated with CPT code 77427. The Agency is not proposing to include the equipment items “radiation virtual simulation system,” “room, CT” and “PACS Workstation Proxy” that are associated with CPT code 77280, as the Agency does not believe that a typical office furnishing SRT uses this kind of equipment.

CMS proposes to include additional time for the capital equipment used in delivering SRT in the proposed direct PE inputs. For “radiation dose therapy plan,” the Agency proposes to apply the clinical labor time that is associated with CPT code 77300 to HCPCS code GRRR1 for purposes of developing a proposed value, but it seek comments as to whether the clinical staff would typically perform the radiation dose therapy planning for this service, or if the physician would perform this and/or other tasks, and, in the case of the latter, what the appropriate physician time would be. Likewise, CMS is soliciting comment as to whether the clinical labor associated with the teletherapy isodose plan would be performed by the physician. The Agency is proposing to assign 14 minutes each to the equipment items “radiation therapy dosimetry software (Argus QC),” “computer workstation”, and “3D teletherapy treatment planning” as these are the times assigned to these equipment items for CPT code 77300.

**CY 2018 Identification and Review of Potentially Misvalued Services**

CMS is not proposing a new screen for CY 2018. CMS continues to believe that it is important to prioritize codes for review under the misvalued code initiative. As a result, the Agency is seeking public comment on the best approach for developing screens, as well as what new screens they might consider. They will consider these comments for future rulemaking.

**Pre service Clinical Labor for 0-Day and 10-Day Global Services**

CMS is seeking comment specifically on whether the standard preservice clinical labor time of 0 minutes should be consistently applied for 0-day and 10-day global codes in future rulemaking.

**Obtain Vital Signs Clinical Labor**

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 last review. The Agency is proposing to assign this 5 minutes of clinical labor time for all codes that include at least 1 minute previously assigned to this task. CMS 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. This proposal would apply to the radiation oncology treatment management code that requires the collection of vital signs as part of the process of care.

For codes that were not recently reviewed and for which there is no breakdown of equipment time denoting how times for clinical labor tasks were derived, the Agency proposes to adjust the equipment time of any equipment item that matched the clinical labor time of the full-service period to match the change in the “Obtain vital signs” clinical labor time.

**Invoices**

In the 2018 MPFS proposed rule, CMS noted that some stakeholders have submitted invoices for new, revised, or potentially misvalued codes after the February 10th deadline established for code valuation recommendations. To be included in a given year’s proposed rule, CMS generally needs to receive invoices by the same February 10th deadline. However, the Agency will consider invoices submitted as public comments during the comment period following the publication of the proposed rule, and will consider any invoices received after February or outside of the public comment process as part of the established annual process for requests to update supply and equipment prices.

**Updates to Prices for Existing Direct PE Inputs**

CMS proposes price updates for several existing direct PE inputs, including SD109 probe, radiofrequency, 3 array (StarBurstSDE). SD 109 is currently listed at $343.64. The proposed updated price is set at $2233, a 531 percent increase. The proposed increases are in response to the public submission of invoices.

**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, in order to establish a malpractice RVU. Data for radiation oncology was only available based on 23 states’ worth of premium rate filings data. CMS is proposing to crosswalk the risk factor for diagnostic radiology to the radiation oncology Malpractices 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. CMS seeks comments on the calculation of MP RVUs for 2018.
**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 nonexcepted 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. However, for 2018, the Agency again proposes the application of a PFS Relativity Adjuster prior to studying the CY 2017 claims data that might allow them to consider and incorporate many more factors, including the ones stated above.

CMS prepared an analysis comparing 2016 Hospital Outpatient Prospective Payment System (HOPPS) payment rates with 2016 PFS payment rates and provided a chart detailing the difference in payment for technical services in the top hospital billed codes in the 2018 proposed rule. Most codes listed indicated that the PFS payment rate was lower than the HOPPS rate. CPT Code 77386 *Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex* was listed at an estimated MPFS payment amount of $347.30 compared to a $505.51 HOPPS payment rate. However, CPT Code 77412 *Radiation Treatment Delivery* was listed as an outlier with the MPFS rate exceeding the HOPPS rate by 38 percent. The variation in radiation oncology code payments demonstrates the complexity of this exercise.

CMS is concerned that the current 50 percent PFS Relativity Adjuster is too small, resulting in greater overall payments to hospitals for non-excepted services furnished by PBDs. For 2018, the Agency proposes to reduce the PFS Relativity Adjuster to 25 percent of HOPPS payment rates. CMS came to this proposed adjustment by performing a code level comparison of the services most commonly billed in the office-campus PBD setting under HOPPS, which is HCPCS code G0463 *Hospital Outpatient Clinic Visit for Assessment and Management of a Patient*. The Agency seeks comment on this proposal and whether a 40 percent PFS Relativity Adjuster should be considered as an alternative
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.

Because the radiation oncology G-codes are not recognized under the HOPPS, CMS is proposing that those nonexcepted items and services denoted by the radiation oncology G-codes that are provided by nonexcepted off-campus PBDs 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 confirms in the 2018 MPFS proposed 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. The Agency seeks comments on potential changes to our methodology that would better account for these specialty-specific patterns.

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.

MACRA requires CMS to post a list of patient relationship categories and codes by November 1 of each year, beginning in 2018. In preparation for posting the first list by November 1, 2018, CMS seeks comments on the following proposed list of patient relationship categories and codes:

- Continuous/Broad Services
- Continuous/Focused Services
- Episodic/Broad Services
• Episodic/Focused Services
• Only as ordered by another clinician

The Agency is also seeking comment on the application of the following modifiers denoting the new patient relationship categories and codes:

<table>
<thead>
<tr>
<th>No.</th>
<th>Proposed HCPCS Modifier</th>
<th>Patient Relationship Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>1x</td>
<td>X1</td>
<td>Continuous/Broad Services</td>
</tr>
<tr>
<td>2x</td>
<td>X2</td>
<td>Continuous/Focused Services</td>
</tr>
<tr>
<td>3x</td>
<td>X3</td>
<td>Episodic/Broad Services</td>
</tr>
<tr>
<td>4x</td>
<td>X4</td>
<td>Episodic/Focused Services</td>
</tr>
<tr>
<td>5x</td>
<td>X5</td>
<td>Only as ordered by another clinician</td>
</tr>
</tbody>
</table>

CMS proposes that initially, modifier reporting would be optional and not a condition of payment. This would allow physicians time to incorporate the application of the modifier into their regular practice routine.

**CMS Request for Information on Flexibilities and Efficiencies**

In the 2018 MPFS proposed rule, CMS seeks recommendations for reducing unnecessary burdens for clinicians, other providers and patients and their families. The Agency states its commitment to increasing quality of care, lowering costs to improve program integrity and make the health care system more effective, simple and accessible. Further, CMS invites public comment on ideas for regulatory, subregulatory, policy, practice and procedural changes to accomplish this goal.

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

The proposed rule is available online at:  

The CMS Press Release and the CMS Fact Sheet on the proposed rule are available at:  
https://www.cms.gov/Newsroom/Newsroom/Newsroom/Newsroom/2017-Fact-Sheet-items/2017-07-13-2.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending