Medicare Physician Fee Schedule Final Rule for Calendar Year 2018
Detailed Summary of the Payment Provisions

The American College of Radiology (ACR) has prepared this detailed analysis of changes to the payment provisions of the Medicare Physician Fee Schedule (PFS) in calendar year (CY) 2018. The rule changes will be effective Jan. 1, 2018.

Conversion Factor

CMS estimates a CY 2018 conversion factor of $35.9996, which reflects the 0.5 percent update specified by the Medicare Access and CHIP Reauthorization Act (MACRA), a budget neutrality adjustment and a target recapture amount mandated by the Protecting Access to Medicare Act of 2014 (PAMA). Overall, this is a slight increase from the current conversion factor of $35.8887.

TABLE 48: Calculation of the Final 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**

CMS estimates the CY 2018 net reduction in expenditures resulting from proposed adjustments to relative values of misvalued codes to be 0.41 percent. Since this amount does not meet the 0.5 percent target established by the Achieving a Better Life Experience Act of 2014 (ABLE), payments under the fee schedule must be reduced by the difference between the target for the year and the estimated net reduction in expenditures, known as the target recapture amount. The estimated target recapture amount for 2018 will result in a 0.09% reduction to the conversion factor.

The Act requires that increases or decreases in relative value units (RVUs) may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS must make adjustments to preserve budget neutrality.

CMS estimates an overall impact of the PFS proposed changes to radiology, interventional radiology and nuclear medicine to be a neutral 0 percent change while radiation oncology and radiation therapy centers will see an overall impact of a 1 percent increase. The proposed rule included an estimated 6 percent decrease in reimbursement for Independent Diagnostic Testing Facilities due to practice expense relative value unit (RVU) changes to codes outside of the radiology code set. The estimated impact to IDTFs in the final rule is a 4 percent reduction.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Background and Overview

The Protecting Access to Medicare Act of 2014 included a provision for the mandatory use of appropriate use criteria (AUC) for advanced diagnostic imaging services. Through the CY 2016 rulemaking process, CMS addressed the initial component of the AUC program, specifying applicable AUC. CMS established a process for the development of AUC, defined provider-led entities (PLEs), and established the process by which PLEs may become qualified to develop AUC. The first list of qualified PLEs was posted on the CMS website in late June 2016.

The CY 2017 PFS final rule identified the requirements clinical decision support mechanisms (CDSMs) must meet for qualification including an opportunity for preliminary qualification for mechanisms still working toward full adherence, and established a process by which CDSMs may become qualified. The first list of qualified CDSMs was posted to the CMS website in conjunction with the CY 2018 proposed rule in July 2017.

In addition, CMS defined applicable payment systems under this program (PFS, Hospital Outpatient Prospective Payment System (OPPS), and Ambulatory Surgical Center (ASC) payment system), specified the first list of priority clinical areas for the identification of outlier ordering professionals, and identified exceptions to the requirements that ordering professionals consults specified applicable AUC when ordering applicable imaging services.

The CY 2018 proposed rule included proposals for the start date of the Medicare AUC program, modification of policies related to significant hardship exceptions, and details regarding how AUC consultation information must be included on the Medicare claim. In this final rule, CMS makes changes to the proposals in response to comments received.

Program Implementation Date

Proposals

CMS proposed that ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2019. The agency stated that this proposed effective date was necessary to allow time for ordering practitioners not already aligned with a qualified CDSM to research and evaluate the CDSMs so they may make an informed decision.

CMS noted that the proposed implementation date substantially lags the statutory requirement of January 1, 2017. The agency also indicated that unless a statutory exception applies, an AUC consultation must take place for ***every*** order for an applicable imaging service furnished in an applicable setting and under an applicable payment system.

Given the delayed start date of the AUC program, CMS anticipated that implementation of the prior authorization component for outlier ordering professionals would also be delayed beyond

January 1, 2020. The agency will outline details around outlier calculations and prior authorization in the CY 2019 proposed rule.

Comments and CMS Response to Comments

1. CMS received comments in support of the January 1, 2019 start date as well as comments from stakeholders who do not want the AUC program implemented in 2019 or at any point in the future. These commenters want the program to be delayed indefinitely, discontinued or modified to the extent that participation is only voluntary as opposed to mandatory. Some of these commenters stated that the quality goals of the AUC program are duplicative of the quality goals of the Quality Payment Program (QPP) and that the AUC program runs counter to the agency's goal of reducing administrative burden for practitioners and providers.

   CMS responded by reminding stakeholders that the AUC program and the QPP are the result of two distinct statutory requirements within PAMA and the Medicare Access and CHIP Reauthorization Act (MACRA) respectively. The agency agrees that the goals of the QPP are consistent with those of the AUC program. In addition, the AUC program promotes AUC to ensure the patient gets the right test at the right time and reduces inappropriate imaging.

2. Some commenters who support the AUC program suggested that CMS participate in additional stakeholder engagement, including creation of an advisory panel, listening sessions, town hall meetings and open door forums.

   CMS agrees that additional stakeholder engagement would be beneficial and intends to establish these opportunities over the coming months.

3. CMS received comments requesting clarification on who is required to perform the AUC consultation and whether a designee within an ordering professional's practice could consult on behalf of the ordering professional and/or whether an ordering professional could delegate the consultation to another individual, third party vendor or contracted agent.

   CMS reiterated the statutory requirement that an "ordering professional" consult with a qualified CDSM. The agency will consider developing policy to address this issue.

4. Some commenters requested clarification on how imaging order changes by the furnishing professional or radiology technician will be handled under the AUC program. Commenters recommended that furnishing professionals have the flexibility to adjust exam parameters or modify orders without consulting AUC, submit orders themselves if they have relevant patient clinical information and occasionally use AUC as appropriate to demonstrate that a test was warranted.

   CMS does not believe it was the intent of the PAMA to reverse existing rules around imaging order changes and ordering of additional studies by furnishing professionals. The

agency will establish a means to account for instances when the order must be updated or modified in future rulemaking.

In response to public comments, CMS is further delaying the effective date for the AUC consultation and reporting requirements to January 1, 2020. The agency is also finalizing a voluntary reporting period where early adopters can begin to report some consultation information on Medicare claims from July 2018 through December 2019.

On January 1, 2020, the program will begin with an educational and operations testing period and during this time CMS will continue to pay claims whether or not they correctly include such information. Ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2020, and furnishing professionals must report the AUC consultation information on the Medicare claim for these services ordered on or after January 1, 2020.

Claims Processing

CMS notes that furnishing professionals are required to report the following information on Medicare claims for applicable imaging services:

1. Which qualified CDSM was consulted by the ordering professional;
2. Whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered;
3. The NPI of the ordering professional (if different from the furnishing professional).

This information is required for both the technical and professional component claims for applicable advanced diagnostic imaging services in all three applicable payment systems (PFS, OPPS and ASC).

The rule acknowledges the possibility that AUC may not be available in a particular qualified CDSM to address every applicable imaging service that might be ordered and as such, the furnishing professional can meet the requirement to report information on the ordering professional's AUC consultation by indicating that AUC is not applicable to the service ordered. CMS points out that qualified CDSMs must make available, at a minimum, AUC that reasonably address common and important clinical scenarios within all priority clinical areas, which represent about 40 percent of advanced diagnostic imaging services paid for by Medicare in 2014. Additionally, the agency notes that they expect the "not applicable" situations to be limited in scope and number and to decrease over time as qualified PLEs continue to build out their AUC libraries and qualified CDSMs update their content and collaborate with more PLEs.

To implement the reporting requirement, CMS proposed to establish a series of HCPCS level 3 codes. These G-codes would describe the specific CDSM that was used by the ordering professional. Ultimately there would be one G-code for every qualified CDSM with the code description including the name of the CDSM. CMS also proposed to establish a G-code to

identify circumstances where there was no AUC consultation through a qualified CDSM. The description of this code would indicate that a qualified CDSM was not consulted by the ordering professional.

These G-codes would be a line-item on both practitioner and facility claims. CMS would expect that one AUC consultation G-code would be reported for every advanced diagnostic imaging service on the claim. Each G-code would be expected, on the same claim line, to contain at least one new HCPCS modifier. CMS proposed to develop a series of modifiers to provide necessary information on whether or not the service would adhere to the applicable AUC or whether an exception is met.

Due to the complex nature of the program, CMS proposed an "educational and operations testing period" of one year, beginning January 1, 2019. During this period, ordering professionals would consult AUC and furnishing professionals would report AUC consultation information on the claim, but CMS would continue to pay claims whether or not they correctly include the information. This educational period allows providers to actively participate in the program while avoiding claims denials during the first year. It also gives CMS the opportunity to make any needed claims processing adjustments before payments are impacted.

CMS sought comment on whether the program should be delayed beyond the proposed start date of January 1, 2019 and/or if the educational and operations testing period should be longer than one year. The agency expected a voluntary reporting period to be available prior to January 1, 2019, possibly in July 2018, depending on the readiness of the Medicare claims system to accept and process claims that include AUC consultation information.

Comments and CMS Response to Comments

1. While some commenters agreed with the proposed G-code and modifier approach to capture AUC consultation information on Medicare claims, numerous other commenters expressed concern that the proposal would be excessively burdensome to practitioners. Several recommendations were made to CMS to avoid this burden, including the ACR's recommendation that CMS require the use of a unique consultation identifier. This would allow CMS to match the claim with the more robust consultation data that is collected within the CDSM. This information may then be used for the identification of outlier ordering professionals. Commenters indicated that this would be the least administratively burdensome method approach. Other commenters suggested development of a registry to hold all AUC consultation information across CDSMs.

   CMS agreed with commenters that a less burdensome approach should be considered. In response to the comments received, the agency decided not to move forward with the G-code an modifier approach and will instead further explore and pursue the use of the unique consultation identifier for reporting on Medicare claims. CMS will conduct stakeholder outreach during 2018 to develop a standard taxonomy and will discuss such changes in future rulemaking ahead of the 2020 effective date. CMS does expect that limited use of modifiers will be required in the future to identify exceptions to AUC consultation requirements.

During the voluntary reporting period, one HCPCS modifier will be available to furnishing professionals and facilities reporting AUC consultation information. This modifier will identify only that AUC was consulted and not the result of the consultation and will be temporary as CMS moves forward to implement reporting with the unique consultation identifier.

2. One commenter asked whether claims for physicians billing Medicare Part B services for the professional component of advanced imaging services will require AUC consultation when the patient is an inpatient.

   CMS responded that the physician's Part B professional claim would not require reporting of an AUC consultation when the technical component is billed under Medicare Part A.

3. A few commenters asked if orders for advanced diagnostic imaging services for patients in critical access hospitals (CAHs) are subject to the AUC consultation and reporting requirement.

   CMS responded that any advanced diagnostic imaging service furnished within a CAH would not be furnished in an applicable setting. Applicable settings currently include physician offices, hospital outpatient departments and ambulatory surgical centers. CAH patients who are furnished an advanced diagnostic imaging service in an applicable setting but the claim for that imaging service is not paid under one of the applicable payment systems would not require consultation and reporting of the AUC consultation. This may apply in situations when a CAH has elected Method II billing.

4. CMS received several comments on the communication of AUC consultation information between the ordering and furnishing professionals.

   CMS recognizes that there is a burden placed on furnishing professionals since ultimately they will be penalized if AUC consultation information is not provided; however, the PAMA specifically requires that the information be reported on the furnishing professional's claim. CMS will continue to seek opportunities to reduce the reporting burden.

5. CMS received numerous other comments on detailed aspects of communication of AUC consultation information and claims reporting. The agency responded that these comments are helpful and important as they develop and build out the outreach and education strategies.

   CMS is exploring claims-reporting options for situations when the imaging service is ordered before January 1, 2020 but furnished after January 1, 2020 and AUC consultation information is not available for inclusion on the claim.

CMS indicated that if they adopt a policy to require reporting of the unique AUC consultation identifier on the furnishing professional's claim, they would expect the ordering professional to include that identifier on the order for the advanced diagnostic imaging service. Additional guidance will be provided once the details of the unique consultation identifier taxonomy are developed.

Voluntary and Educational and Operations Testing Periods

CMS recognizes that there are many areas for potential missteps and errors in the implementation of this new AUC program. For these reasons, an educational and operations testing period is needed. During this period, ordering professionals would consult AUC and furnishing professionals would report AUC consultation information on the claim, but CMS would continue to pay claims whether or not they correctly include such information. This educational and operations testing period allows professionals to actively participate in the program while avoiding claims denials during the learning curve. It also gives the agency an opportunity to make any needed claims processing adjustments before payments are impacted. CMS does not expect to continue this educational and operations testing period beyond the first year of the AUC program.

In addition, CMS expects a voluntary reporting period to be available prior to the beginning of the operations and testing period in July 2018. CMS will make announcements through their educational channels (i.e. listservs and website) when the voluntary reporting period becomes available.

Comments and CMS Response to Comments

1. Many stakeholders commented on the burden of the program and the need to further delay implementation.

   CMS believes this program can be implemented in a manner that would minimize burden, but this will require additional stakeholder outreach, collaboration and time. **For practitioners and facilities that are ready to use qualified CDSMs or that are new to CDSMs and want to practice and refine their workflow, CMS will provide the voluntary period starting in July of 2018 that runs through CY 2019.**

   Given the agency's intention to use the educational and operations testing period to make needed adjustments to the program as well as identify any needs for further guidance and education, CMS will evaluate whether a second educational and operations testing year is necessary. The agency would like to retain this option in the event that, to be responsive to stakeholder feedback and the lessons learned, it is expedient to take additional time to fully implement the AUC consultations and reporting requirements. However, since there are currently qualified PLEs and qualified CDSMs, CMS expects to be prepared to quickly begin a voluntary participation period. Since the educational and operations testing period will not start until 2020, CMS is extending the voluntary participation period to 18 months from July 2018 through December 2019.

2. Some commenters asked for clarification on what is expected/required during the voluntary reporting period and the educational and testing period.

   Since the first year of required AUC consultation and reporting will be an educational and operations testing period, CMS will not deny claims that fail to properly include AUC consultation information. The agency expects to adopt and communicate additional details and expectations for AUC consultation and reporting during the educational and operations testing period through further rulemaking and guidance before January 1, 2020.

Alignment with Other Medicare Quality Programs

The CY 2018 Quality Payment Program final rule included a finalization of the proposal to give Merit-based Incentive Payment System (MIPS) credit to ordering professionals for consulting AUC using a qualified CDSM as a high-weight improvement activity for the performance period beginning January 1, 2018. The agency believes this will incentivize early use of qualified CDSMs to consult AUC by motivated eligible clinicians looking to improve patient care and better prepare themselves for the AUC program.

CMS is also considering how the AUC program could serve to support a quality measure under the MIPS quality performance category and they seek feedback from the public regarding feasibility and value of pursuing this idea further. The agency will consider suggestions made in the public comment period as they continue to collaborate with other quality improvement programs and engage in future rulemaking.

Significant Hardship Exceptions to Consulting and Reporting Requirements

CMS proposed to modify the significant hardship exceptions to reflect the sunsetting of the payment adjustments under the Medicare EHR Incentive Program substituted an alignment with the advancing care information performance category of MIPS. The agency proposed the following categories for the AUC program significant hardship exceptions:

- Insufficient Internet Connectivity
- Extreme and Uncontrollable Circumstances
- Lack of Control over the Availability of CEHRT
- Lack of Face-to-Face Patient Interaction

The agency proposed to remove the hardship exception for those practicing for less than two years. CMS noted that only the ordering professional is allowed to seek a significant hardship exception, not the furnishing professional.

CMS proposed to establish a process for identifying ordering professionals in need of a significant hardship exception to the Medicare AUC requirements that is outside of the MIPS re-weighting process. A significant hardship exception for this program would be granted for no longer than 12 months, with the option to establish an exception for a shorter period where

warranted by the circumstances. Further information on this process will be provided in future rulemaking.

Comments and CMS Response to Comments

Many commenters supported CMS' proposals to align the hardship exception with the QPP program and many also expressed concern. Other commenters expressed concern about the burden to the furnishing professional of identifying, tracking and reporting which ordering professionals have significant hardship exceptions.

In response to public comments that varied widely, CMS decided not to finalize the proposed changes to the significant hardship exceptions in this final rule. The agency will take time to consider both the public comments on the proposals and the policies adopted in the CY 2018 QPP final rule and will revisit the issue in rulemaking for CY 2019.

Some of the specific suggestions for expansion of the hardship exceptions included:

- Imaging services ordered as part of clinical research
- Emergency clinicians attempting to meet the current exclusion criteria
- Physicians nearing retirement or dealing with hardships who may not have data systems, capital, or the desire to invest in a qualified CDSM system
- Any time when a PLE or CDSM is de-qualified
- Complex medical systems
- Any physician who does not have access to free integrated CDSMs
- Physicians who EHR cannot integrate into an existing qualified registry
- Ordering professionals that order a low-volume of advanced imaging services

More than one commenter cited the GAO's 2015 evaluation of the Medicare Imaging Demonstration which reported frustration on the part of ordering professionals when decision support was not integrated with their EHRs.

CMS agreed with concerns raised that the communication about a significant hardship exception from an ordering professional to a furnishing professional introduces potential challenges. The agency will continue to explore opportunities to use a more automated process for providing additional information to ordering and furnishing professionals in a timely manner in order to facilitate such communication and make the information readily accessible.

Unintended Consequences and Other Comments

CMS notes that some stakeholders have expressed concern that AUC program requirements may inadvertently encourage physicians to order imaging services that they do not believe are right for their patients. The goal of the evidence-based AUC is to assist clinicians in ordering the most appropriate imaging services for their patients' specific clinical scenarios. To ensure the program is implemented effectively, CMS asked for public comment on such potential unintended consequences. The **agency** also sought comments on how they can continue to engage interested participants in developing AUC in a transparent and scientifically robust manner. CMS was

particularly interested in how qualified PLEs develop or modify AUC in collaboration with non-PLE entities and what additional challenges such entities might face.

Comments and CMS Response to Comments

1. Comments on unintended consequences included:

    - Decreased patient access or choices
    - Inappropriate underutilization of imaging studies and harm to patients because of such a reduction
    - Delays in beneficiaries receiving needed tests or even denial of services by furnishing professionals and facilities if AUC is not consulted or information is not provided by the ordering professional
    - Healthcare rationing
    - Shift in referral patterns
    - Disruptions in physicians' practices and workflows
    - Reduction in patient facing time for providers
    - Unwarranted financial penalties for imaging facilities
    - Increases in the cost of tests as CDSMs may recommend higher cost imaging
    - Risk of impeding clinical research involving imaging

    CMS stated that they appreciate being alerted to these potential unintended consequences so that they can closely monitor and mitigate these issues should they arise during the voluntary and educational and operations testing as the agency proceeds to implement this program.

2. Some commenters expressed concerns regarding the definition of PLE codified in regulations in the CY 2016 PFS final rule and the avenues by which entities not meeting the definition PLE can participate in the AUC program. These commenters reiterated their previously expressed opposition to the regulatory definition of PLE and requested revisions to allow participation by more organizations, inclusive of independent content developers, which they deem to be more reflective and in the spirit of the language in the statute describing a PLE.

    CMS continues to believe the definition of PLE as established in the CY 2016 final rule is an accurate and appropriate interpretation of the statute. The agency does not feel a modification to the regulatory definition is necessary.

3. Commenters questioned the endorsement pathway whereby qualified PLEs may endorse the AUC of other qualified PLEs, under agreement by the respective parties, to enhance an AUC set. Some commenters stated that independent content developers and third party entities cannot participate in the AUC program under the current definition and requested that the regulations be revised to reflect the intent and language in the statute and to allow PLEs to endorse AUC from any author or developer.

CMS does not believe that AUC endorsed by any organization that could not meet the definition of PLE should be considered specified AUC under this program.

CMS strongly believes that non-PLE organizations can play a valuable role under the AUC program. This has already been demonstrated by collaboration arrangements between qualified PLEs and third party organizations such as independent content developers, and CMS expects these collaborations to continue to grow and evolve. The agency encourages stakeholders to explore options for collaboration under the guidelines of this policy.

4. Some commenters expressed opposition to the transparency requirements for qualified PLEs. These commenters stated that the transparency requirements are inappropriate because they require developers to place their intellectual property in the public domain. Commenters recommended instead that CMS allow alternative methods for making AUC information available upon request. For example, commenters suggested that requirements can be met by granting access to providers, beneficiaries and CMS to AUC on an as-needed basis or to customers through password protected portals.

   CMS believes that to assure the public that all the statutory considerations are taken into account, transparency of the process is essential. This includes making publicly available the people, methodologies, and evidence used by developers. Failing to be transparent calls into question the degree to which AUC are indeed evidence based. AUC developed using non-evidence based sources could result in physicians and patients making the wrong decisions to guide care. Transparency allows AUC to be vetted by all stakeholders, including the patient and his/her physician, therefore allowing them to make informed decisions.

Summary

CMS continues to believe the best implementation approach is one that is diligent, maximizes the opportunity for public comment and stakeholder engagement, and allows for adequate advance notice to physicians and practitioners, beneficiaries, AUC developers, and CDSM developers.

The following changes were made to the policies proposed in the CY 2018 PFS proposed rule:

1. Extending the voluntary reporting period to 18 months starting July 2018 and continuing through CY 2019.
2. Making the AUC consultation and reporting requirements effective for an educational and operations testing period beginning on January 1, 2020, instead of January 1, 2019 as proposed, to last through CY 2020.
3. Not finalizing the changes to the significant hardship exceptions in this final rule as further evaluation is necessary. This will be addressed in rulemaking for CY 2019.
4. CMS will reevaluate the claims processing instructions and will further explore opportunities for stakeholder engagement.

Mammography Services

In the 2017 rulemaking cycle, CMS discussed potential 50 percent reduction to the technical component (TC) payment for the mammography services. The ACR submitted extensive comments to CMS on this issue. In addition, the ACR met with CMS and reiterated our concerns and recommended that CMS not move forward with the 50 percent reduction and that the current payment rates are maintained. Based on the information presented in the addendum, the payment rates for the mammography services in the PFS rule are essentially the same as the current payment rate.

Additionally, due to technical issues, CMS was not able to accept the new Current Procedural Terminology (CPT®) codes that bundle computer-aided detection (CAD) with mammography services. Instead, CMS changed the descriptors for the Healthcare Common Procedure Coding System (HCPCS) Level II "G" codes G0202, G0204 and G0206 to match the new bundled codes and instructed providers to continue to use the G-codes for 2017. While the 2018 PFS final rule does not specifically address coding for mammography, the ACR notes that the mammography G-codes are not listed in Addendum B of the rule, but the category I CPT codes, 77065 (Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral), 77066 (Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral) and 77067 (Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed) are listed. As such, the ACR believes CMS intends to operationalize use of the category I CPT codes in 2018.

Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services

The Consolidated Appropriations Act of 2016 provides for a 7 percent reduction in payments for the TC of imaging service made under the PFS that are X-rays taken using computed radiography technology furnished during Calendar Years 2018-2022 and a 10 percent reduction for such services furnished during CY 2023 and beyond. Computed radiography technology is defined as cassette-based imaging that uses an imaging plate to create the image involved.

To implement this provision, CMS created a new modifier, "FY" (X-ray taken using computed radiography technology/cassette-based imaging) to be used on claims for these services beginning on January 1, 2018. The modifier will be required on claims for the technical component of the X-ray service, including when the service is billed globally because the PFS payment adjustment is made to the technical component regardless of whether it is billed globally or billed separately using the –TC modifier. The modifier must be used to report the specific services that are subject to the payment reduction. Its accurate use is subject to audit.

Potentially Misvalued Services

CMS did not propose any new screens for CY 2018; however, the Agency sought comment on the best approach for developing new screens as well as what particular new screens it may consider.

One commenter suggested revisiting reports by the Urban Institute and RAND. Other commenters discussed the burden of the misvalued codes initiative on specialty societies. Some commenters recommended that CMS work collaboratively with the RUC and that codes recently reviewed by the RUC not be re-reviewed by CMS. The Agency will consider these ideas for future rulemaking.

Valuation of Specific Codes

In the proposed rule, CMS presented alternative values for several of the code families due to concerns that some changes in physician time were not accurately (or proportionally) reflected by changes in physician work RVU. CMS applied magnitude estimation, crosswalk, or building block methodologies to the RUC-recommended values to come up with these alternative values. However, based on feedback from stakeholders and reassurances from the RUC that considerations about overlapping activities and changes in time were taken into account in their valuation, CMS has generally accepted the RUC-recommended values for the CPT 2018 new, revised, and potentially misvalued codes. CMS has stated that they have shifted their approach to reviewing the RUC recommendations, as they believe the majority of practitioners would prefer they rely more heavily on RUC recommended values.

Cryoablation of Pulmonary Tumor (CPT codes 32998 and 32994)

For CY2018, the CPT Editorial Panel created a new code (32994) to report cryoablation of pulmonary tumors, and revised the descriptor for CPT code 32998 to include imaging for ablation of tumor. Cat III code 0340T will be deleted. After reviewing the comments, CMS accepted the RUC-recommended values at 9.03 RVUs for both CPT codes 32998 and 32994.

CMS claims data showed that imaging was billed with 32998 less than 50% of the time, and CMS entertained comments as to whether they should consider a work RVU of 7.69 for both 32998 and 32994. While they accepted the RUC values, CMS stresses that when two services are bundled, that they "be reported together so frequently that the valuation is not inadvertently overestimating resource costs."

Endovascular Repair Procedures (CPT codes 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34709, 34710, 34711, 34712, 34713, 34812, 34714, 34820, 34833, 34834, 34715, and 34716)

The CPT Editorial Panel bundled endovascular abdominal aortic aneurysm repair (EVAR) codes with radiologic supervision and interpretation codes to create 16 new codes and revise four existing codes for a total of 20 EVAR codes. 14 codes other related to endovascular repair procedures were deleted through this process.

While CMS had considered alternative values for the codes in the proposed rule, CMS accepted the RUC-recommended values at of 23.71 RVUs for CPT code 34701, 36.00 RVUs for CPT code 34702, 26.52 RVUs for CPT code 34703, 45.00 RVUs for CPT code 34704, 29.58 RVUs for CPT code 34705, 45.00 RVUs for CPT code 34706, 22.28 RVUs for CPT code 34707, 36.50 RVUs for CPT code 34708, 6.50 RVUs for CPT code 34709, 15.00 RVUs for CPT code 34710,

6.00 RVUs for CPT code 34711, 12.00 RVUs for CPT code 34712, 2.50 RVUs for CPT code 34713, 4.13 RVUs for CPT code 34812, 5.25 RVUs for CPT code 34714, 7.00 RVUs for CPT code 34820, 8.16 RVUs for CPT code 34833, 2.65 RVUs for CPT code 34834, 6.00 RVUs for CPT code 34715, and 7.19 RVUs for CPT code 34716.

Selective Catheter Placement (CPT codes 36215, 36216, 36217, and 36218)

CPT code 36215 was identified as potentially misvalued on a screen of Harvard-valued codes with utilization over 30,000, as well as by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT codes 36216, 36217, and 36218. CMS accepted the RUC-recommended values at 4.17 RVUs for CPT code 36215, 5.27 RVUs for CPT code 36216, 6.29 RVUs for CPT code 36217, and 1.01 RVUs for CPT code 36218.

Treatment of Incompetent Veins (CPT codes 36470, 36471, 36482, 36483, 36465, and 36466)

The CPT Editorial Panel created four new codes and revised two existing codes (36470 and 36471) for a total of 6 codes pertaining to the treatment of incompetent veins. CMS accepted the RUC-recommended values at 0.75 RVUs for CPT code 36470, 1.50 RVUs for CPT code 36471, 3.50 RVUs for CPT code 36482, 1.75 RVUs for CPT code 36483, 2.35 RVUs for CPT code 36465, and 3.00 RVUs for CPT code 36466.

Insertion of Catheter (CPT codes 36555, 36556, 36620, and 93503)

CPT code 36556 was identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. The family was expanded to include CPT codes 36555, 36620, and 93503. CMS accepted the RUC-recommended values at 1.93 RVUs for CPT code 36555, 1.75 RVUs for CPT code 36556, 1.00 RVUs for 36220, and 2.00 RVUs for CPT code 93503

Insertion of PICC Catheter (CPT code 36569)

CPT code 36569 was identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. CMS accepted the RUC-recommended value at 1.70 RVUs for CPT code 36569.

Bone Marrow Aspiration (CPT codes 38220, 38221, 38222, and 20939)

CPT code 38221 was identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. CPT codes 38220 and 38221 were revised, and two new CPT codes were created to describe bone marrow aspiration. CMS accepted the RUC-recommended values at 1.20 RVUs for CPT code 38220, 1.28 RVUs for CPT code 38221, 1.44 RVUs for CPT code 38222, and 1.16 RVUs for CPT code 20939.

CMS had considered hanging the global period for codes 38220, 38221, and 38222 from XXX to 000. However, following mixed feedback from commenters, CMS will not finalize their proposal to change the global period.

CT Soft Tissue Neck (CPT codes 70490, 70491, and 70492)

CPT codes 70490 and 70492 were identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. The family was expanded to include CPT code 70491. CMS accepted the RUC-recommended values at 1.28 RVUs for CPT code 70490, 1.38 RVUs for CPT code 70491, and 1.62 RVUs for CPT code 70492.

Magnetic Resonance Angiography (MRA) Head (CPT codes 70544, 70545, and 70546)

CPT code 70544 was identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. The family was expanded to include CPT codes 70545 and 70546. CMS accepted the RUC-recommended values at 1.20 RVUs for CPT code 70544, 1.20 RVUs for CPT code 70545, and 1.48 RVUs for CPT code 70546.

Magnetic Resonance Angiography (MRA) Neck (CPT codes 70547, 70548, and 70549)

CPT code 70549 was identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT codes 70547 and 70549. CMS accepted the RUC-recommended values at 1.20 RVUs for CPT code 70547, 1.50 RVUs for CPT code 70548, and 1.80 RVUs for CPT code 70549.

CT Chest (CPT Codes 71250, 71260, and 71270)

CPT codes 71260 and 71270 were identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT code 71250. CMS accepted the RUC-recommended values at 1.16 RVUs for CPT code 71250, 1.24 RVUs for CPT code 71260, and 1.38 RVUs for CPT code 71270.

MRI of Abdomen and Pelvis (CPT codes 72195, 72196, 72197, 74181, 74182, and 74183)

CPT codes 74182 and 72196 were identified as part of a screen involving high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. The family was expanded to include CPT codes 74181, 74183, 72195, and 72197. CMS accepted the RUC-recommended values at 1.46 RVUs for CPT code 72195, 1.73 RVUs for CPT code 72196, 2.20 RVUs for CPT code 72197, 1.46 RVUs for CPT code 74181, 1.73 RVUs for CPT code 74182, and 2.20 RVUs for CPT code 74183.

MRI Lower Extremity (CPT codes 73718, 73719, 73720)

CPT codes 73718 and 73720 were identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT code 73719. CMS accepted the RUC-recommended values at 1.35 RVUs for CPT code 73718, 1.62 RVUs for CPT code 73719, and 2.15 RVUs for CPT code 73720.

For practice expense, CMS agreed with commenters that 5 minutes, 7 minutes, and 7 minutes should be allotted for preparing the "room, equipment, supplies" for CPT codes 73718, 73719, and 73720, respectively, which is consistent with other MR codes.

Abdominal X-Ray (CPT Codes (CPT codes 74022, 74018, 74019, and 74021)

CPT codes 74000 and 74022 were identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The CPT Editorial Panel then created CPT codes 74018, 74019, and 74021 to replace CPT codes 74000, 74010, and 74020, and retained CPT code 74022. CMS accepted the RUC-recommended work values for these codes, at 0.18 RVU for CPT code 74018, 0.23 RVU for CPT code 74019, 0.27 RVU for CPT code 74021, and 0.32 for CPT code 74022.

Regarding utilization for the new codes, the RUC suggested that 25 percent of services currently reported with CPT code 74010 would be reported with CPT code 74019 and 75 percent will be reported with CPT code 74021; and 75 percent of services currently reported with CPT code 74020 will be reported with CPT code 74019 and 25 percent will be reported with CPT code 74021. Since a rationale was not provided for these assumptions, CMS is applying an even distribution of services previously reported as CPT codes 74010 and 74020 to CPT codes 74019 and 74021. They believe that the services previously reported with codes 74010 and 74020 will be reported in equal volume between the code representing two views and the code representing three views.

Angiography of Extremities (CPT codes 75710 and 75716)

CPT code 75710 was identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT code 75716. CMS accepted the RUC-recommended values at 1.75 RVUs for CPT code 75710 and 1.97 RVUs for CPT code 75716.

Ultrasound of Extremity (CPT codes 76881 and 76882)

The RUC identified CPT codes 76881 and 76882 for review of PE inputs.

CMS reviewed the 2016 claims data, which indicates that podiatry is the dominant specialty for both 76881 and 76882. Therefore, CMS is implementing the RUC-recommended PE inputs for CPT code 76881, and made changes to the proposed PE inputs for 76882 to reflect those typical for podiatry. For CPT code 76882, this includes removing the RUC-recommended ultrasound room and replacing it with a portable ultrasound unit. These changes yield an overall resource

cost savings instead of a shift of costs within the family, as initially proposed by the RUC. Due to the significant RVU reductions for CPT code 76881, CMS will phase-in the RVU reductions, limiting it to 19% the first year.

Radiation Therapy Planning (CPT codes 77261, 77262, and 77263)

CPT code77263 was identified as potentially misvalued by the CMS High Expenditure by Specialty Screen. The family was expanded to include CPT codes 77261 and 77262. CMS accepted the RUC-recommended values at 1.30 RVUs for CPT code 77261, 2.00 RVUs for CPT code 77262, and 3.14 RVUs for CPT code 77263.

Comment Solicitation on Dialysis Vascular Access Codes (CPT codes 36901-36909)

The dialysis vascular access codes were implemented by CMS in CY 2017. In the 2017 MPFS, CMS did not accept the RUC-recommended values, and instead implemented refined values based on their own methodology, stating that they needed more robust data to warrant an increase in value. Following additional comment and explanations about the complexities of the procedure, CMS accepted the following 2017 RUC-recommended values: 3.36 RVUs for CPT code 36901, 4.83 RVUs for CPT code 36902, 6.39 RVUs for CPT code 36903, 7.50 RVUs for CPT code 36904, 9.00 RVUs for CPT code 36905, 10.42 RVUs for CPT code 36906, 3.00 RVUs for CPT code 36907, 4.25 RVUs for CPT code 36908, and 4.12 RVUs for CPT code 36909.

Practice Expense Inputs for Digital Imaging Services

In the CY 2017 PFS final rule, CMS finalized their proposal to add a professional PACS workstation used for interpretation of digital images to a series of CPT codes and to address costs related to the use of film that had previously been incorporated as direct PE inputs for these services.

Following the publication of the CY 2017 PFS final rule, CMS received comments from stakeholders requesting that the professional PACS workstation be included for a series of vascular ultrasound codes that use the technical PACS workstation. Based on comments received on the proposed rule, CMS decided to assign equipment time for the professional PACS workstation in the nonfacility setting according to the equipment time formula finalized in CY 2017. The Agency assigned equipment minutes equal to half the preservice physician work time plus the full intraservice physician work time, consistent with the previously finalized policy. For the relatively smaller group of diagnostic codes with no service period time breakdown, CMS assigned equipment time equal to half of the total physician work time, consistent with the previously finalized policy. The equipment time to be added is shown in Table 4 below.

TABLE 4: Additional Codes with Professional PACS Workstation

HCPCS	Procedure Type	ED053 Minutes
93880	Diagnostic	18
93882	Diagnostic	13
93886	Diagnostic	20
93888	Diagnostic	13
93890	Diagnostic	20
93892	Diagnostic	25
93893	Diagnostic	25
93925	Diagnostic	18
93926	Diagnostic	13
93930	Diagnostic	18
93931	Diagnostic	13
93970	Diagnostic	17
93971	Diagnostic	12
93975	Diagnostic	23
93976	Diagnostic	18
93978	Diagnostic	18
93979	Diagnostic	13
93980	Diagnostic	21
93981	Diagnostic	10
93990	Diagnostic	14
76706	Diagnostic	13

Preservice Clinical Labor for 0-Day and 10-Day Global Services

Several years ago, the RUC's PE Subcommittee reviewed the preservice clinical labor times for CPT codes with 0-day and 10-day global period and concluded that these codes are assumed to have no preservice clinical staff time unless the specialty can provide evidence that the preservice time is appropriate. CMS noted that for CY 2018, 41 of the 53 reviewed codes with 0-day or 10-day global periods include preservice clinical labor of some kind. Because 77 percent of the reviewed codes for the current calendar year deviate from the "standard", CMS sought comment on the value and appropriate application of the standard in their review of RUC recommendations in future rulemaking.

After consideration of comments received, CMS does not believe that the standard preservice clinical labor time of 0 minutes should be consistently applied for 0-day and 10-day global codes in future rulemaking. The Agency will work with stakeholders to obtain recommendations for preservice clinical labor that maintain relativity among the different kind of procedures classified as 0-day and 10-day globals.

Obtain Vital Signs Clinical Labor

CMS has traditionally assigned a clinical labor time of 3 minutes for the "Obtain vital signs" clinical labor activity, based on the amount of time typically required to check a patient's vitals.

Over time, that number of minutes has increased as codes are reviewed. Many of the reviewed codes for the current CY 2018 rulemaking cycle have a recommended clinical labor time of 5 minutes for "Obtain vital signs" because of the measuring of two additional vital signs: the patient's height and weight.

To preserve relativity among the PFS codes, CMS proposed 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. CMS also proposed to update the equipment times of the codes with this clinical labor task accordingly to match the changes in clinical labor time.

After consideration of comments received, CMS did not finalize the proposal to establish 5 minutes as the new standard for the "Obtain vital signs" clinical labor task. However, since the Agency continues to believe that the review standards associated with the clinical labor time for obtaining vital signs have changed over time, they will assign 5 minutes as the input for all codes that include the "Obtain vital signs" task for CY 2018, as proposed. CMS will consider code-level recommendations for this activity in future rulemaking.

The list of all codes affected by these vital signs changes to direct PE inputs is available on the CMS website.

Equipment Recommendations for Scope Systems

CMS found unexplained inconsistencies with the use of scopes and the video systems associated with them during its routine reviews of direct PE input recommendations. Some of the scopes include video systems bundled into the equipment item. Some include scope accessories as part of their price, and some are standalone scopes with no other equipment included. The variations do not appear to be consistent with the different code descriptions.

In the CY 2017 PFS proposed rule, CMS proposed a structure that separates the scope and the associated video system as distinct equipment items for each code. The Agency proposed to define the scope video system as including a monitor, a processor, a form of digital capture, a cart and a printer, which they believe represents the typical case for a scope video system. CMS proposed to separately price any scope accessories and individually evaluate their inclusion or exclusion as direct PE inputs for particular codes under the current policy, based on whether they are typically used in furnishing the services described by the particular codes.

CMS also proposed standardizing refinements to the way scopes have been defined in the direct PE input database and classified the existing scopes in the direct PE database under a new classification system. The Agency indicated in last year's rule that proposed input prices for these equipment items would be included in future rulemaking.

In the CY 2018 proposed rule, CMS made further proposals to continue to clarify scope equipment inputs and sought comments regarding these proposals.

The Agency considered creating a single scope equipment code for each of the five categories detailed in the proposed rule: (1) a rigid scope; (2) a semi-rigid scope; (3) a non-video flexible

scope; (4) a non-channeled flexible video scope; and (5) a channeled flexible video scope. As a result of information supplied by commenters illustrating the significant differences in price and usage across specialties, CMS did not finalize the proposal to create and price a single scope equipment code for each of the five categories.

For CY 2018, CMS proposed two minor changes to PE inputs related to scopes. They are proposing to add an LED light source into the cost of the scope video system (ES031), which would remove the need for a separate light source in these procedures. CMS did not finalize this proposal despite support from commenters. Rather, the Agency will update the price of the scope video system with changes as part of a reorganization project for CY 2019.

After consideration of comments received, CMS did not finalize the proposal to create and price a single scope equipment code for each of the five categories previously identified. Instead, the Agency is supportive of a recommendation from commenters to create scope equipment codes on a per-specialty basis for these five, or potentially six, categories of scopes as applicable. This will be addressed in future rulemaking.

Clarivein Kit for Mechanochemical Vein Ablation

In the CY 2017 PFS final rule, CMS finalized work RVUs and direct PE inputs for two new codes related to mechanochemical vein ablation, CPT codes 36473 and 36474. Following the publication of the final rule, stakeholders contacted CMS and requested that a Clarivein kit supply item (SA122) be added to the direct PE inputs for CPT code 36474, the add-on code for ablation of subsequent veins. The Agency stated that the Clarivein kit was accidentally omitted from the RUC recommendations and that an additional kit is necessary to perform the service described by the add-on procedure.

After consideration of comments received, CMS did not finalize the addition of the Clarivein kit to CPT code 36474 at this time, though recommendations received will be considered for future rulemaking.

Interest Rates

CMS did not make any changes to the interest rates used in developing the equipment cost per minute calculations for CY 2018.

Determination of Malpractice Relative Value Units

In the CY 2016 PFS final rule, CMS finalized a policy to begin conducting annual malpractice (MP) RVU updates to reflect changes in the mix of practitioners providing services and to adjust MP RVUs for risk, intensity and complexity. CMS also finalized a policy to modify the specialty mix assignment methodology to use an average of the 3 most recent years of data instead of a single year of data.

CMS proposed to use the most recent data for the proposed MP RVUs for CY 2018 and to align the update of MP premium data and MP GPCIs to once every 3 years. Based on comments

received, CMS did not finalize this proposal. Similar to CY 2017, the CY 2018 MP RVUs will continue to be based on the premium data that was collected for the CY 2015 MP RVU update.

CMS notes that the next MP RVU update must be made by CY 2020, however, the Agency feels that more frequent updates are ideal. This will be considered in future rulemaking.

Medicare Telehealth Services

The conditions for Medicare to make payments for telehealth services under the PFS are as follows:

- The service must be furnished via an interactive telecommunications system.
- The service must be furnished by a physician or other authorized practitioner.
- The service must be furnished to an eligible telehealth individual.
- The individual receiving the service must be located in a telehealth originating site.

The service must be on the list of Medicare telehealth services in additional to meeting the above criteria.

CMS finalized the proposal to add HCPCS code G0296 (Counseling visit to discuss need for lung cancer screening using low dose CT scan) to the list of approved telehealth services.

Due to Medicare's use of a new Place of Service (POS) Code describing services furnished via telehealth, CMS finalized the proposal to eliminate the required use of the GT modifier on professional claims for these services.

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

Sections 1833(t)(1)(B)(v) and (t)(21) of the Act require that certain items and services furnished by certain off-campus provider-based departments (PBDs) (collectively referenced in this rule as nonexcepted items and services furnished by nonexcepted off-campus PBDs) shall not be considered covered outpatient department (OPD) services for purposes of payment under the OPPS. Payment for these nonexcepted items and services furnished on or after January 1, 2017 shall be made under the applicable payment system. In the CY 2017 OPPS/ASC final rule with comment period, CMS finalized the PFS as the "applicable payment system" for most nonexcepted items and services furnished by off-campus PBDs.

As part of that discussion and in response to public comments, CMS indicated it would issue an interim final rule with comment period (the CY 2017 interim final rule) to establish payment policies under the PFS for nonexcepted items and services furnished on or after January 1, 2017. In rule, the Agency finalizes the payment policies under the PFS for nonexcepted items and services furnished during CY 2018.

Payment Mechanism

For CY 2017, CMS established a new set of payment rates under the PFS that reflected the relative resource costs of furnishing the technical component of a broad range of services to be paid under the PFS specific to the off-campus PBD of a hospital with packaging (bundling) rules that are unique to the hospital outpatient setting under the OPPS.

In principle, the coding and billing mechanisms required to make appropriate payment to hospitals for nonexcepted items and services furnished by nonexcepted off-campus PBDs are parallel to those used to make payment for the technical component services for a range of supplier types paid under the PFS. CMS is finalizing the proposal to maintain this mechanism for CY 2018.

Establishment of Payment Rates

In the CY 2017 interim final rule, CMS established site-specific rates under the PFS for the technical component of the broad range of nonexcepted items and services furnished by nonexcepted off-campus PBDs to be paid under the PFS that was based on the OPPS payment amount for the same items and services, scaled downward by 50 percent. CMS called this adjustment the "PFS Relativity Adjuster." The PFS Relativity Adjuster refers to the percentage of the OPPS payment amount paid under the PFS for a nonexcepted item or service to the non-excepted off-campus PBD under this policy.

CMS was concerned, however, that the 50 percent PFS Relativity Adjuster might overestimate PFS nonfacility payments relative to OPPS payments and considered the 50 percent PFS Relativity Adjuster for CY 2017 to be a transitional policy until more precise data would be available to better identify and value nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by hospitals.

In considering the appropriate PFS Relativity Adjuster for CY 2018, CMS continues to believe that claims data from CY 2017, which are not yet available, are needed to guide potential changes to the general approach. In the absence of such data, however, the Agency continued to consider the appropriate PFS Relativity Adjuster based on the information that is available. In the analysis establishing the PFS Relativity Adjuster for CY 2017, CMS attempted to identify the appropriate value by comparing OPPS and PFS payment rates for services frequently reported in PBDs and described by the same codes under the two payment systems.

For CY 2018, CMS proposed to revise the PFS Relativity Adjuster for nonexcepted items and services furnished by nonexcepted off-campus PBDs to be 25 percent of the OPPS payment rate. The Agency arrived at this proposed PFS Relativity Adjuster by making a code-level comparison for the service most commonly billed in the off-campus PBD setting under the OPPS: a clinic visit reported using HCPCS code G0463. Based on comments received, CMS finalized a PFS Relativity Adjuster of 40 percent for CY rather than the proposed 25 percent.

MACRA Patient Relationship Categories and Codes

The final rule provides background information on the Quality Payment Program (QPP) mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). To facilitate the attribution of patients and episodes to one or more clinicians, MACRA requires the development of patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service.

CMS posted the operational list of patient relationship categories on May 17, 2017 on its website. The list is based on the public comments and consultations with stakeholders and experts on a draft list of patient relationship categories posted in April 2016 and a list of modified patient relationship categories posted in December 2016.

The patient relationship categories on the operational list include the following:

- Continuous/Broad Services
- Continuous/Focused Services
- Episodic/Broad Services
- Episodic/Focused Services
- Only as Ordered by Another Clinician

CMS is required to make annual revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate using the rulemaking process.

Reporting of Patient Relationship Codes Using Modifiers

Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, must include the applicable codes established for care episode groups, patient condition groups, and patient relationship categories, as well as the NPI of the ordering physician or applicable practitioner.

CMS worked with the American Medical Association's (AMA) CPT Editorial Panel and submitted an application for the CPT modifiers for reporting of the patient relationship codes. At its June 2017 meeting the CPT Editorial Panel, determined that AMA would not include the modifiers in the CPT code set, pending future finalization of the modifiers by CMS, whereby CMS publishes the modifiers as Level II HCPCS Modifiers. Therefore, the Agency proposed the Level II HCPCS Modifiers in Table 27 (below) as the patient relationship codes.

TABLE 27: Patient Relationship HCPCS Modifiers and Categories

No.	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

CMS proposed 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 26, as well as the NPI of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner). To give clinicians time to gain familiarity with the modifiers to report patient relationships, the Agency proposed to initially permit voluntary reporting of the HCPCS modifiers on Medicare claims. The uses and selection of the modifiers would not be a condition of payment. Claims would be paid regardless of whether and how the modifiers are included. CMS would work with clinicians to educate them about the proper use of the modifiers.

After consideration of comments received, CMS finalized 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 as well as the NPI of the ordering physician or applicable practitioner. CMS is also finalizing the proposal that the HCPCS modifiers may be voluntarily reported with the use and selection of modifiers not impacting payment. The Agency believes that the voluntary reporting approach will allow them to gain information about the patient relationship codes and allow for a long period of education and outreach to clinicians.

For questions on the Medicare Physician Fee Schedule final rule, please contact Katie Keysor at kkeysor@acr.org.