



Summary of Policies in the Calendar Year (CY) 2018 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List

MLN Matters Number: MM10393

Related Change Request (CR) Number: 10393

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Effective Date: January 1, 2018

Related CR Transmittal Number: R3938CP

Implementation Date: January 2, 2018

Note: This article was revised on March 28, 2018, to add a link to MLN Matters Article [MM10152](#). That article advises providers that Change Request (CR) 10152 eliminates the requirement to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services, effective January 1, 2018. All other information is unchanged.

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services paid under the Medicare Physician Fee Schedule (MPFS) and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 10393 provides a summary of policies in the Calendar Year (CY) 2018 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2018. Make sure your billing staffs are aware of these updates.

BACKGROUND

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary of Health and Human Services to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule on November 2, 2017, that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2018.

The final rule, CMS-1676-F, also addresses public comments on Medicare payment policies

proposed earlier this year. The final rule, "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018," was published in the Federal Register on November 2, 2017. The key changes are as follows:

Overall Payment Update and Misvalued Code Target

The overall update to payments under the MPFS based on the finalized CY 2018 rates will be +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 Relative Resource Units (RVUs), all required by law, the final 2018 Physician Fee Schedule (PFS) conversion factor is \$35.99, an increase to the 2017 PFS conversion factor of \$35.89.

Payment Rates for Non-excepted Off-Campus Provider-Based Hospital Departments Paid Under the MPFS

Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the Outpatient Prospective Payment System (OPPS) beginning January 1, 2017. For CY 2017, CMS finalized the MPFS as the applicable payment system for most of these items and services.

For CY 2018, CMS is finalizing a reduction to the current MPFS payment rates for these items and services by 20 percent. CMS currently pays for these services under the MPFS based on a percentage of the OPPS payment rate. Specifically, the final policy will change the MPFS payment rates for these services from 50 percent of the OPPS payment rate to 40 percent of the OPPS rate. CMS believes that this adjustment will provide a more level playing field for competition between hospitals and physician practices by promoting greater payment alignment.

Telehealth originating site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for 2017 is 1.2 percent. Therefore, for CY 2018, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or \$25.76. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Medicare Telehealth Services

For CY 2018, CMS is finalizing the addition of several codes to the list of telehealth services, including:

- HCPCS code G0296 (visit to determine Low Dose Computed Tomography (LDCT) eligibility)
- CPT code 90785 (Interactive Complexity)
- CPT codes 96160 and 96161 (Health Risk Assessment)
- HCPCS code G0506 (Care Planning for Chronic Care Management)
- CPT codes 90839 and 90840 (Psychotherapy for Crisis)

Additionally, CMS is finalizing its proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners. CMS is also finalizing separate payment for CPT code 99091, which describes certain remote patient monitoring, for CY 2018. This code is payable in both non-facility and facility settings.

In addition, CMS stated the following in the CY 2018 MPFS Final Rule (82 FR 53014):

- CMS is adopting CPT prefatory guidance that this code should be billed no more than once every 30 days.
- CMS is allowing CPT code 99091 to be billed once per patient during the same service period as chronic care management (CCM) (CPT codes 99487, 99489, and 99490), Transitional Care Management (TCM) (CPT codes 99495 and 99496), and behavioral health integration (BHI) services (CPT codes 99492, 99493, 99494, and 99484).
- CMS is requiring that the practitioner obtain advance beneficiary consent for the service and document this in the patient's medical record.
- For new patients or patients not seen by the billing practitioner within one year prior to billing CPT code 99091, CMS requires initiation of the service during a face-to-face visit with the billing practitioner, such as an Annual Wellness Visit or Initial Preventive Physical Exam, or other face-to-face visit with the billing practitioner.

Lastly, CMS will consider the stakeholder input received in response to the proposed rule's comment solicitation on how CMS could expand access to telehealth services, within the current statutory authority.

Care Management Services

CMS is continuing efforts to improve payment within traditional fee-for-service Medicare for CCM and similar care management services to accommodate the changing needs of the Medicare patient population. CMS is finalizing its proposals to adopt CPT codes for CY 2018 for reporting several care management services currently reported using Medicare G-codes. Also, CMS is clarifying a few policies regarding CCM in this final rule.

Improvement of Payment Rates for Office-based Behavioral Health Services

CMS is finalizing an improvement in the way MPFS rates are set that will positively impact office-based behavioral health services with a patient. The final policy will increase payment for these important services by better recognizing overhead expenses for office-based face-to-face services with a patient.

Evaluation and Management Comment Solicitation

Most physicians and other practitioners bill patient visits to the MPFS under a relatively generic set of codes that distinguish level of complexity, site of care, and in some cases whether or not the patient is new or established. These codes are called Evaluation and Management (E/M) visit codes. Billing practitioners must maintain information in the medical record that documents that they have reported the appropriate level of E/M visit code. CMS maintains guidelines that specify the kind of information that is required to support Medicare payment for each level.

CMS agrees with continued feedback from stakeholders that these guidelines are potentially outdated and need to be revised. CMS thanks the public for the comments received in response to the proposed rule's comment solicitation on the E/M guidelines and summarizes these comments in the final rule. Commenters suggested that CMS provide additional avenues for collaboration with stakeholders prior to implementing any changes. CMS will consider the best approaches for such collaboration and will take the public comments into account as it considers the issue in future rulemaking.

Prolonged Preventive Services

CMS is adding new codes for prolonged preventive services. Prolonged preventive services are add-on codes payable by Medicare when billed with an applicable preventive service that is both payable from the MPFS, and both deductible and coinsurance do not apply. For the complete list of codes that may be billed with prolonged preventive services visit <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html>.

Payments for Imaging Services that are X-rays Taken Using Computed Radiography

CMS is finalizing policy required by Section 1848(b)(9) of the Act, which requires payments for imaging services that are X-rays taken using computed radiography (including the technical component portion of a global service) furnished during CYs 2018-2022, that would otherwise be made under the MPFS (without application of subparagraph (B)(i) and before application of any other adjustment), be reduced by 7 percent.

Solicitations on Burden Reduction

CMS solicited comments on burden reduction on several issues including E/M, telehealth and remote patient monitoring. CMS appreciates the thoughtful input it received in response to these comment solicitations and will consider their input in future rulemaking.

Cognitive Therapy Services

CMS will retain the coding and valuation of cognitive therapy services through the creation of HCPCS code G0515 that will mirror CPT code 97532 deleted for CY 2018 instead of valuing CPT code 97127. CMS will assign status indicator “I” to CPT code 97127 to indicate that it is “Invalid” for Medicare purposes. HCPCS code G0515 has been added to the therapy code list, see CR 10303 for more information. MLN Matters article MM10303 discusses CR10303 and it is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10303.pdf>.

ADDITIONAL INFORMATION

The official instruction, CR10393, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3938CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>

DOCUMENT HISTORY

Date of Change	Description
March 28, 2018	This article was revised to add a link to MLN Matters Article MM10152 . That article advises providers that CR 10152 eliminates the requirement to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services, effective January 1, 2018.
December 26, 2017	Initial article released

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