

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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Summary of Policies in the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List

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 MPFS and provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9844 provides a summary of policies in the Calendar Year (CY) 2017 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. Make sure that 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, 2016, 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 2017.

The final rule ([CMS-1654-F](#)) also addresses public comments on Medicare payment policies proposed earlier in 2016. The proposed rule, "Revisions to Payment Policies under

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the Physician Fee Schedule and Other Revisions to Part B for CY 2017,” was published in the Federal Register on July 15, 2016.

The key changes are as follows:

CT Modifier Reduction Changes from 5 percent to 15 percent

As required by Medicare law, effective January 1, 2016, a payment reduction of 5 percent applies to Computed Tomography (CT) services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the MPFS. The payment reduction increases to 15 percent in 2017 and subsequent years. See MLN Matters Article MM9250 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9250.pdf> for more details.

Multiple Procedure Payment Reduction (MPPR) on the Professional Component (PC) of Certain Diagnostic Imaging Procedures

As required by Medicare law, CMS revised the MPPR of the PC of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. The MPPR on the Technical Component (TC) of imaging remains at 50 percent.

Currently, CMS makes full payment for the PC of the highest-priced procedure and payment at 75 percent for the PC of each additional procedure, when furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day. See MLN Matters Article MM9647 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9647.pdf> for more details.

Telehealth Origination 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 CY, 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 2017, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or \$25.40. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Access to Telehealth Services

CMS is adding the following services to the list of those that can be furnished to Medicare beneficiaries under the telehealth benefit:

- ESRD-related services CPT codes 90967 through 90970
- Advance care planning CPT codes 99497 through 99498
- Telehealth consultation HCPCS codes G0508 through G0509

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Note: For the ESRD-related services, the required clinical examination of the catheter access site must be furnished face-to-face “hands on” (without the use of an interactive telecommunications system) by a physician, Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), or Physician Assistant (PA). For the complete list of telehealth services, visit <http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.

New Place of Service (POS) Code for Telehealth

The new POPS is 02 with a description of the location where health services and health related services are provided or received, through telecommunication technology.

X-ray Reduction for Film

As required by Medicare law, Medicare reduces payment amounts under the MPFS by 20 percent for the TC (and the TC of the global fee) of imaging services that are X-rays taken using film, effective January 1, 2017, and after.

To implement this provision, CMS has created Modifier FX (X-ray taken using film). Beginning in 2017, claims for X-rays using film must include Modifier FX, which will result in the applicable payment reduction. See MLN Matters Article MM9727 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9727.pdf> for more details.

Primary Care, Care Management, and Cognitive Services

CMS is finalizing the following coding and payment changes for CY 2017 to improve payment for various primary care, care management, and cognitive services. Each of these codes is included in the 2017 HCPCS update and payment information is included in the routine annual update files:

- Separate payment for existing codes describing prolonged Evaluation and Management (E/M) services without direct patient contact by the physician (or other billing practitioner) (CPT codes 99358, 99359), and increased payment for prolonged E/M services with direct patient contact by the physician (or other billing practitioner) (CPT code 99354) adopting the RUC-recommended values. CPT codes 99358 and 99359 are listed in the “Medicare Claims Processing Manual” as non-payable (Chapter 12, Section 30.6.15.2). As of January 1, 2017, these codes are separately payable under the MPFS and changes to the manual are forthcoming.
- The MPFS includes new coding and payment for Behavioral Health Integration (BHI) services including substance use disorder treatment, specifically three new codes to describe services furnished using the psychiatric Collaborative Care Model (CoCM) (HCPCS codes G0502, G0503, G0504) and one new code to describe services furnished using other BHI care models (HCPCS code G0507).
- Separate payment for complex Chronic Care Management (CCM) services (CPT codes 99487, 99489), reduced administrative burden for CCM (CPT codes 99487,

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99489, 99490), and a new add-on code to the CCM initiating visit to account for the work of the billing practitioner in assessing the beneficiary and establishing the CCM care plan (HCPCS code G0506).

- A new code for cognition and functional assessment and care planning for treatment of cognitive impairment (HCPCS code G0505).

Implementation of Alternative Medicare Physician Fee Schedule (PFS) Locality Configuration for California

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA 2014) was signed into law and Section 220(h) of the legislation adds Section 1848(e) (6) of the Act, which now requires, for services furnished on or after January 1, 2017, that the locality definitions for California be based on the Metropolitan Statistical Area (MSA) delineations as defined by the Office of Management and Budget (OMB). The resulting modifications to California's locality structure increases its number of localities from 9 under the current locality structure to 27 under the MSA based locality structure. However, both the current localities and the MSA based localities are comprised of various component counties, and in some localities only some of the component counties are subject to the blended phase-in and hold harmless provisions required by Section 1848(e)(6)(B) and (C) of the Act. Although the modifications to California's locality structure increase the number of localities from 9 under the current locality structure, to 27 under the MSA-based locality structure, for purposes of payment, the actual number of localities under the MSA based locality structure would be 32 to account for instances where unique locality numbers are needed.

Additionally, for some of these new localities, PAMA requires that the geographic practice cost index GPCI values that would be realized under the new MSA based locality structure are gradually phased in (in one-sixth increments) over a period of 6 years.

Update to the Methodology for Calculating GPICs in the U.S. Territories

CMS is revising the methodology used to calculate GPICs in the U.S. territories, whereby Puerto Rico will be assigned the national average of 1.0 to each GPIC, as is currently done in the Virgin Islands in an effort to provide greater consistency in the calculation of the territories' GPICs. This change is included in the routine PFS update files.

Data Collection Required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to Accurately Value Global Packages

CMS finalized a data collection strategy to gather information needed to value global surgical services. Practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island are required, beginning July 1, 2017, to report claims showing that a visit occurred during the post-operative period for select global services. Practitioners who only practice in settings of fewer than 10 practitioners are not required to

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report, but may do so voluntarily. Such visits will be reported using CPT code 99024. The requirement to report will only apply to specified high-volume/high-cost services. The list of services for which reporting is required will be available on the CMS website. Practitioners who are not required to report are able to report voluntarily and encouraged to do so. If reporting voluntarily, reporting should be done for all visits relating to all codes on the list of applicable codes.

In addition a survey of practitioners will be conducted to gather data on service furnished in the post-operative period.

To the extent that these data result in proposals to revalue any global packages, that revaluation will be done through notice and comment rulemaking at a future time.

CPT code 99024 is currently included on the PFS with a procedure status indicator of “B.”

Valuing Services That Include Moderate Sedation as an Inherent Part of Furnishing the Procedure

The CPT Editorial Panel created CPT codes for separately reporting moderate sedation services, which corresponded to elimination of Appendix G from the CPT Manual, effective January 1, 2017. Appendix G of the CPT Manual identified services where moderate sedation was considered an inherent part of the procedural service. The MPFS Final Rule established valuations for the new moderate sedation CPT codes and revaluation of certain procedural services previously identified in Appendix G. These coding and payment changes provide for payment for moderate sedation services only in cases where moderate sedation services are furnished.

Additional Information

The official instruction, CR9844, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3676CP.pdf>.

The final 2017 MPFS rule is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-f.html>.

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/>.

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