CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3676	**Date: December 16, 2016**
	Change Request 9844

SUBJECT: 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

I. SUMMARY OF CHANGES: This Change Request (CR) provides a summary of policies in the CY 2017 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. The attached Recurring Update Notification applies to Publication 100-04, Chapter 12, Section 190.5.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3676	Date: December 16, 2016	Change Request: 9844

SUBJECT: 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

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request is to provide a summary of the policies in the CY 2017 Medicare Physician Fee Schedule (MPFS). Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary 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 02, 2016, that updates payment policies and Medicare payment rates for services furnished by physicians and nonphysician practitioners (NPPs) that are paid under the MPFS in CY 2017.

The final rule also addresses public comments on Medicare payment policies proposed earlier this year. The proposed rule "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017" was published in the Federal Register on July 15, 2016.

B. Policy: This Change Request provides a summary of the payment polices under the Medicare Physician Fee Schedule (PFS) and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2017.

Regulation number CMS-1654-F, Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017, went on display November 02, 2016. This Change Request provides a summary of the payment polices under the Medicare Physician Fee Schedule (PFS) and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2017.

CT modifier reduction changes from 5% to 15%

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 physician fee schedule. The payment reduction increases to 15 percent in 2017 and subsequent years.

(See CR 9250 for more information.)

MPPR on the PC of certain diagnostic imaging procedures

As required by Medicare law we revised the Multiple Procedure Payment Reduction (MPPR) of the Professional Component (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.

We currently make 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 CR 9647 for more information.)

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 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 services 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 and Telehealth consultation HCPCS codes G0508 through G0509. *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, CNS, NP, or 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

Place of Service 02: Telehealth. Description: The location where health services and health related services are provided or received, through telecommunication technology.

(See CR 9726 for more information.)

X-ray reduction for film

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

To implement this provision, the Centers for Medicare and Medicaid Services (CMS) has created modifier FX (X ray taken using film). Beginning in 2017, claims for X-rays using film must include modifier FX that

will result in the applicable payment reduction.

(See CR 9727 for more information.)

Primary care, care management, and cognitive services

We are 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 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, 30.6.15.2). **As of January 1, 2017, these codes are separately payable under the PFS; changes to the manual are forthcoming.**

· 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 CCM services (CPT codes 99487, 99489), reduced administrative burden for CCM (CPT codes 99487, 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 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.

(See CR 9547 for more information)

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

CMS is revising the methodology used to calculate GPCIs in the U.S. territories, whereby Puerto Rico will be assigned the national average of 1.0 to each GPCI, as is currently done in the Virgin Islands in an effort to provide greater consistency in the calculation of the territories' GPCIs.

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 will be 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 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 web site. 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 PFS 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.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9844.1	Contractors shall be aware of the policies published in the Medicare Physician Fee Schedule Final Rule (Regulation number CMS-1654-F, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017, which are summarized with this Change Request and apply those policies as appropriate.	X	X	X						
9844.2	Effective for dates of service January 1, 2017, and after Medicare contractors shall pay for the Medicare telehealth originating site facility fee as 80 percent of, the lesser of the actual charge or $25.40, as described by HCPCS code Q3014 "Telehealth facility fee."	X	X	X						
9844.3	Contractors shall use the list of telehealth services found on the CMS web site at http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.	X	X							
9844.4	Contractors shall continue to use the codes identified in CR 9250 for the CT modifier reduction.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9844.5	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are	X	X	X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Gail Addis, 410-786-4522 or Gail.Addis@cms.hhs.gov , Donta Henson, 410-786-1947 or Donta.Henson1@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0