
Medicare Physician Fee Schedule 2018 Overview

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Within just hours of the release of the Final Rule concerning the 2018 revisions to the Quality Payment Program (QPP) on November 2, the Centers for Medicare & Medicaid Services (CMS) published the ruling that governs the Medicare Physician Fee Schedule (PFS) for the coming year. Although overshadowed by the QPP announcement on the same day, the impact of the Medicare PFS Final Rule on physician reimbursement is arguably the more far-reaching of the two announcements. Let's break down the highlights of CMS' ruling.

First, the Medicare Access to Care and CHIP Reauthorization Act (MACRA) promised a 0.50% bump in reimbursement. While CMS granted that increase, its efforts to remain under a Congressionally imposed target for the recapture of mis-valued service codes, as well as to offset spending for new services, effectively whittled away a good portion of that amount. In the end, the PFS conversion factor for 2018 is \$35.99, compared to 2017's \$35.89.

Impacts on Specialties

As usual, there are winners and losers. Based on CMS' assessment of reimbursement changes included in the Final Rule, Allergy, Anesthesiology, Pathology, Urology, Otolaryngology, Oral/Maxillofacial Surgery, and Vascular Surgery will experience declines of 1% to 3%, while Cardiology, Dermatology, Infectious Disease, Radiation Oncology, Rheumatology, Podiatry, Psychiatry, and Plastic Surgery are projected to gain 1%.

Related to individual services, Primary Care performing behavioral health is a victor, with a payment increase resulting from an assessment of related office expenses. The set of care management codes introduced in 2017 – such as G0502 – migrate to permanent status by requiring the use of a CPT code. Primary Care Practitioners will also benefit from new prolonged services codes, G0513 and G0514. These new codes should be used when a clinician provides a prolonged (30-plus minutes) Medicare-covered preventive service.

VBPM Penalties Modified

Perhaps the biggest beneficiaries of the PFS Final Rule, however, are the physicians who were slated to be penalized via the Value-based Payment Modifier program. Except for

those who had opted out of Medicare, all US-based health care professionals “participated” in the VBPM program, which piggy-backed on the Physician Quality Reporting System (PQRS). For those who did not report for PQRS, penalties for practices of 10 or more eligible clinicians were scheduled to be 4%, with smaller practices faced with a 2% reduction. In the Final Rule, these automatic downward adjustments — that were being imposed in addition to the PQRS penalty of 2% — were changed to 2% and 1%, respectively. Even if the program determined you were “high” cost or “low” quality, all clinicians participating in reporting are being held harmless in 2018. In addition to reducing the penalties, the negative information won’t be reported to the public via Physician Compare. On the flip side, the maximum upward adjustments for high-quality, low-cost physicians were sliced to half of what CMS originally proposed.

Telehealth and Mobile Health

For nearly a decade, CMS has added CPT codes to the list of services that are covered for Medicare when provided via telehealth. This year is no different with the addition of new codes – such as G0506 (Care Planning for Chronic Care Management). Furthermore, CMS is eliminating the need to use the GT modifier for telehealth services, which was considered a duplicate effort as a result of the designated telehealth POS code, 02. This special POS code, which was introduced in 2017, will still be required.

Mobile health gets a huge boost from this Final Rule with CMS pledging to pay separately for CPT 99091.* Historically considered bundled, this code, which incorporates “remote patient monitoring,” is now valued at 1.1 work relative value units. CMS’ policies for its use are: (1) the patient must be informed in writing, and the consent be documented in the patient’s record; (2) a face-to-face service must be provided to the patient within the previous year, at which time the remote monitoring is initiated; and (3) the service can only be billed once in a 30-day period.

Additional Impacts

Still unknown is the impact of the Final Rule on Oncology, Rheumatology and other specialties using biologics because CMS says it intends “to provide for the separate coding and payment for products approved under each individual abbreviated application, rather than grouping all biosimilars with a common reference product into codes.”

Those who provide advanced imaging services learn in the Final Rule that the Medicare Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging will begin with “educational and operations testing” in 2020. CMS provides a 24-month period for physicians to focus on the Quality Payment Program (QPP) before the AUC Program is launched.

CMS also provides a peek into comments based on its request to assess the evaluation and management (E/M) coding guidelines by referring to the differences between the 1995 and 1997 guidelines, as well as the impact of electronic health records, as among the several challenges that providers confront in appropriately using the set of codes. CMS will

continue to accept comments; however, the agency also announced: “We are immediately focused on revision of the current E/M guidelines in order to reduce unnecessary administrative burden.” This statement would suggest there will be future changes, which will affect the vast majority of physicians and advanced practice providers.

All in all, 2018 will be another tumultuous year, yet this fact should come as no surprise in an ever-changing and challenging reimbursement environment.

**99091 is the collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time.*

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