CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3938	**Date: December 22, 2017**
	Change Request 10393

SUBJECT: 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

I. SUMMARY OF CHANGES: This Change Request (CR) provides a summary of policies in the CY 2018 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, Sections 190.5 and 240.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

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: 3938	Date: December 22, 2017	Change Request: 10393

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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 2018 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, 2017, 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 2018.

The final rule 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 02, 2017.

B. Policy: This Change Request provides a summary of the payment polices under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2018.

Regulation number CMS-1676-F, Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018, went on display November 02, 2017. This Change Request provides a summary of the payment polices under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2018.

Overall Payment Update and Misvalued Code Target

The overall update to payments under the PFS 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 Children's Health Insurance Program (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 value units (RVU), all required by law, the final 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

Payment Rates for Nonexcepted Off-campus Provider-Based Hospital Departments Paid Under the PFS

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 PFS as the applicable payment system for most of these items and services.

For CY 2018, CMS is finalizing a reduction to the current PFS payment rates for these items and services by 20 percent. CMS currently pays for these services under the PFS based on a percentage of the OPPS payment rate. Specifically, the final policy will change the PFS 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 2018 is 1.4 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);
- Current Procedural Terminology (CPT) code 90785 (Interactive Complexity);
- CPT codes 96160 and 96161 (Health Risk Assessment);
- HCPCS code G0506 (Care Planning for Chronic Care Management); and
- CPT codes 90839 and 90840 (Psychotherapy for Crisis).

Additionally, we are finalizing our proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners. We are also finalizing separate payment for CPT code 99091, which describes certain remote patient monitoring activities, for CY 2018. This code is payable in both the non-facility and facility setting. We stated the following in the CY 2018 MPFS Final Rule (82 FR 53014):

- We are adopting CPT prefatory guidance that this code should be billed no more than once every 30 days.
- We are allowing that CPT code 99091 can 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).
- We are 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, we are requiring 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, we will consider the stakeholder input we 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 chronic care management 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 we are clarifying a few policies regarding chronic care management in this final rule.

Improvement of Payment Rates for Office-based Behavioral Health Services

CMS is finalizing an improvement in the way physician fee schedule 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 PFS 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.

We agree 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 we provide additional avenues for collaboration with stakeholders prior to implementing any changes. We will consider the best approaches for such collaboration, and will take the public comments into account as we consider the issues for 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 Social Security Act (SSA) 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 CY 2018, 2019, 2020, 2021, or 2022, that would otherwise be made under the MPF (without application of subparagraph (B)(i) and before application of any other adjustment), be reduced by 7 percent.

Solicitations on Burden Reduction

In addition we solicited comments on burden reduction on several issues including E & M, telehealth and remote patient monitoring. We appreciate the thoughtful input we 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.

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	
10393.1	Contractors shall be aware of the policies published in the Medicare Physician Fee Schedule Final Rule (Regulation number CMS-1676-F, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018, which are summarized with this Change Request and apply those policies as appropriate.	X	X	X						
10393.2	Effective for dates of service January 1, 2018, and after Medicare contractors shall continue to pay for the Medicare telehealth originating site facility fee as 80 percent of, the lesser of the actual charge or $25.76, as described by HCPCS code Q3014 "Telehealth facility fee."	X	X	X						
10393.3	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							
10393.4	Contractors shall continue to use the codes identified in CR 9250 for the CT modifier reduction.		X							
10393.5	Contractors shall use the prolonged preventive services G0513 and G0514 as an add-on to the covered preventive services located on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html"		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10393.6	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 free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
10393. 4	CR for prolonged preventive services.

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

V. CONTACTS

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

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

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0