



## **CMS Releases 2018 Medicare Payment Rules Tri-Society Regulatory Summary for Members of ACG, AGA & ASGE**

CMS has released two calendar year (CY) 2018 rules that finalize policy and payment changes for the **Medicare Physician Fee Schedule (PFS)** and the **Hospital Outpatient Prospective Payment System (OPPS)** and **Ambulatory Surgical Centers (ASC) Payment System**.

The [PFS final rule](#) will appear in the *Federal Register* on November 15 and [OPPS and ASC final rule](#) on November 13.

### **2018 Medicare Physician Fee Schedule Final Rule**

- **2018 Proposed Conversion Factor: The 2018 PFS conversion factor is \$35.99**, an increase of +0.41 percent from the 2017 PFS conversion factor of \$35.89. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience Act of 2014.
- **Payment Changes for Anesthesia for GI Procedures:** For CY 2018, the AMA CPT Editorial Panel is deleting CPT codes 00740 (Anesthesia for upper GI procedures) and 00810 (Anesthesia for lower GI procedures) and replacing them with the following five new codes. The current CY 2017 base unit for upper and lower GI services is 5 base units.  
**CMS finalized the following values for CY 2018:**
  - 00731 (Anesthesia for upper GI, not otherwise specified) = 5 base units
  - 00732 (Anesthesia for upper GI, ERCP) = 6 base units
  - 00811 (Anesthesia for lower GI, not otherwise specified) = 4 base units
  - 00812 (Anesthesia for screening colonoscopy) = 3 base units
  - 00813 (Anesthesia for upper and lower GI during the same session) = 5 base units**Each base unit is approximately \$22.**
- **Equipment for Scope Systems: CMS will not implement proposed changes to its pricing methodology for scope systems.** The agency is now asking for additional stakeholder feedback before addressing the following issues in a future rulemaking period.
  - Creation of a single scope equipment code and price for each of five categories including flexible endoscopy – not implemented for CY 2018 Addition of an LED light source and an increase to the price of the scope video system of \$1,000.00 to cover the expense of miscellaneous small equipment associated – not implemented for CY 2018

- **Chronic Care Management Services:** CMS finalized the addition of chronic care management (G0506) to the list of telehealth services and will eliminate the requirement for reporting telehealth modifier "GT" for professional claims in an effort to reduce administrative burden for practitioners. The agency continues to seek comment on how to further reduce burden on reporting practitioners for chronic care management and similar services.
- **Payment Rates for Off-campus Provider-based Hospital Departments (PBDs):** For CY 2018, CMS finalized a change to the PFS payment rates for items and services from 50 percent of the OPPS payment rate to 40 percent of the OPPS rate. CMS currently pays for these services under the PFS based on a percentage of the OPPS payment rate. CMS had sought to strike an appropriate balance that avoided potentially underestimating the relative resources involved in furnishing services in nonexcepted off-campus PBDs as compared to the services furnished in other settings for which payment was made under the PFS.
- **PQRS and EHR Incentive Program Reporting Requirements for Payment Year 2018:** CMS finalized a change to only require reporting of six measures for the Physician Quality Reporting System (PQRS) with no domain requirement. Previously, PQRS required reporting of nine measures across three National Quality Strategy domains. CMS finalized similar changes to the clinical quality measure reporting requirements under the Medicare Electronic Health Record Incentive ("Meaningful Use") Program for eligible professionals who reported electronically through the PQRS portal. CMS finalized these changes to better align with the Merit-based Incentive Payment System (MIPS) data submission requirements for the quality performance category.
- **Value Modifier Program:** CMS finalized changes to reduce penalties and hold groups harmless if they meet minimum quality reporting requirements to smooth the transition to the Quality Payment Program.
- **Patient Relationship Categories - Level II HCPCS Modifiers:** CMS finalized use of five Level II HCPCS Modifiers (X1 – Continuous/broad services; X2 – Continuous/focused services; X3 – Episodic/broad services; X4 – Episodic/focused services; and X5 – Only as ordered by another clinician) as patient relationship codes (PRCs), which are intended to help attribute patients and episodes to one or more clinicians for cost measurement. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required development of patient relationship categories to define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Voluntary reporting of the five PRC modifiers on Medicare claims is effective for items and services furnished by a physician or applicable practitioner on or after January 1, 2018. While reporting is voluntary, use of the modifiers is not a condition of Medicare payment.
- **Malpractice (MP) RVUs:** CMS did not finalize its proposal to update CY 2018 MP RVUs using premium data collected for the CY 2018 update of the MP geographic practice cost indices (GPCIs). Currently, MP RVUs are updated every five years and the last review and update of MP RVUs was implemented by CMS in the CY 2015 Medicare PFS final rule. The next update is not required until CY 2020. Proposed changes would have reduced

**MP RVUs for many gastroenterology services.** CMS' decision not to finalize this policy acknowledges a need to resolve variances in the available data and to review methods used to apply these data in the calculation of MP RVUs.

- **Evaluation and Management (E/M): CMS did not finalize any changes to current E/M document guidelines.** CMS continues to acknowledge that current E/M documentation guidelines are in need of modernization to reduce physician burden and better align E/M documentation with the current practice of medicine. The agency remains focused on simplifying documentation requirements specific to the past family social history (PFSH) and physician exam portions of the E/M guidelines to allow medical decision making (MDM) and time to serve as the key determinants of level of E/M service. **CMS will consider further submitted comments and explore approaches for collaborating with the physician community on these issues.**
- **Payment Policy for Biosimilars: CMS finalized the policy to separately code and pay for biological biosimilar products under Medicare Part B.** Effective January 1, 2018, approved biosimilar biological products with a common reference product will no longer be grouped into the same HCPCS code. CMS will issue new codes for biosimilars that are currently grouped into the same HCPCS code as well as detailed coding guidance. Full implementation of this policy change, which will require claims processing system and other changes, is anticipated by mid-2018. CMS plans to continue to monitor Part B biosimilar payment and utilization, particularly as they relate to access, including the number of products available to beneficiaries with Part B and cost savings associated with Medicare and beneficiary payments.

### **2018 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule**

- **OPPS Conversion Factor: CMS finalized the CY 2018 conversion factor at \$78.636** for those that meeting quality reporting requirements. The effective update is 1.35 percent.
- **ASC Conversion Factor: CMS finalized the CY 2018 conversion factor at \$45.575** for ASCs that meet quality reporting requirements. Effective adjusted update factor is 1.2 percent.
- **Definition of ASC surgical procedures: CMS will not make changes to the definition of surgical procedures in CY 2018.** The agency received many comments to its request for input on services that do not currently meet the established definition, but may be appropriate to include as covered surgical procedures payable when performed in an ASC. CMS will take the comments into consideration for a future rulemaking period and could potentially broaden the list to include more GI-related procedures (e.g., GI tests in the 91010-91122, infusions services codes).
- **Date of Service (DOS) Policy – Laboratory: CMS created a new exception for some advanced diagnostic laboratory tests (ADLTs) and molecular pathologist tests.** Effective January 1, 2018, a new exception to the current laboratory DOS regulations will generally permit laboratories to bill Medicare directly for ADLTs and molecular pathology tests excluded from OPPS packaging policy, if the specimen was collected from a hospital

outpatient during a hospital outpatient encounter and the test was performed following the patient's discharge from the hospital outpatient department. The current rule for clinical diagnostic laboratory test states that the DOS is typically the date the specimen was collected, unless certain conditions are met.

- **Modifications to the ASC Quality Reporting (ASQCR) Program: CMS will delay mandatory implementation** of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) under the ASCQR Program for CY 2018 data collection until a future rule.
- **Modifications of Hospital Outpatient Department Quality Reporting Program: CMS finalized proposals that balance the value of quality data with efforts to limit provider burden.** Proposals include expansion of the CMS online data submission tool, QualityNet, to also allow for batch submission of ASCQR Program measure data beginning with data submitted during CY 2018, as well as alignment of the naming of the Extraordinary Circumstances Exceptions policy with other quality reporting programs and corresponding regulatory updates to reflect these proposals.