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MEDICARE RULES

CMS fee schedule final rule: What you should know for 2018

You won't face any earthshaking changes in 2018 thanks to a CMS Physician Fee Schedule (PFS) final rule that tables some of the most impactful provisions in the proposed rule, an exclusive analysis by *The Business of Medicine* shows. CMS is holding off on any changes to its E/M coding guidelines after suggesting in its proposed rule that it could eliminate the history and exam key components, while the appropriate use criteria (AUC) for advanced diagnostic imaging will be delayed until 2020.

In this article, we will review the highlights of the 2018 PFS final rule, including the outcome of several ambitious provisions from CMS' proposed rule, which was released in July. The Medicare conversion factor for 2018 will be $35.9996, a slight increase of approximately 0.3% from 2017's conversion factor ($35.7751).

- **No immediate action on E/M guidelines.** CMS will not make any changes to its E/M guidelines in 2018, after stating in its proposed rule that it wants to gradually reshape the guidelines, starting with reducing the emphasis on the history and exam components. While the agency received plenty of feedback on possible E/M changes, it has concluded that it must work more closely with providers before making any changes. "The commenters were appreciative and generally supportive of CMS undertaking this reform effort," the agency writes in the final rule. "However, commenters did not agree on how current standards should be changed, and different specialties expressed different challenges and recommendations regarding the guidelines. Many professional specialty associations urged CMS to employ a more considered, long-term process such as a task force rather than make immediate changes."

- **Telehealth code expansion.** In another sign that CMS is warming to the idea of applying online technology to healthcare, the agency

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is finalizing a proposal to make more codes billable as telehealth services. In 2018, the following codes are now billable as telehealth services:

- **G0296:** Visit to determine low dose computed tomography (LDCT) eligibility);
- **90785:** Interactive complexity; add-on code paired with a primary psychiatric service code to indicate the patient had difficulty communicating which made the service more difficult;
- **96160** and **96161:** Health risk assessment, patient-focused and caregiver-focused respectively;
- **G0506:** Care planning for Chronic Care Management; and,
- **90839** and **90840:** Psychotherapy for crisis.

- **Telehealth modifier eliminated in favor of POS code**. Previously CMS had required that modifier **GT** be appended to codes that are performed for telehealth services, but the agency is eliminating this requirement for 2018. Instead, the new place of service (POS) code of "02" (telehealth) is sufficient to indicate on a claim that the CPT code(s) being billed were performed via telehealth.

- **Modifier FY for X-rays using computed radiography.** CMS is finalizing a proposal to require a new modifier to be appended to all X-rays performed using computed radiography. Modifier **FY** (X-ray taken using computed radiography/cassette-based imaging) will reduce the payment for the technical component (TC) of an X-ray code by 7% in 2018 through 2022 and by 10% for 2023 and beyond. The professional component (PC) for interpretation of X-rays is not affected by the rule. This measure is part of the CMS initiative to make practices switch from computed radiography to digital radiography, for which there is no payment reduction.

- **2018 value modifier changes.** With the Value-based Modifier (VBM) being replaced as part of the transition to the Merit-based Incentive Payment System (MIPS), 2018 will be the last year that VBM will impact Part B reimbursement. The 2018 VBM payment adjustment will be based on 2016 performance, for which CMS has just released reports (see related article on QRURs, pg. 8).

- **Reduced penalties for value modifier in 2018.** In another move linked to the transition from the VBM to MIPS, CMS will implement a proposed measure to "hold harmless" any group and solo practitioners who met 2016 quality reporting requirements under the Physician Quality Reporting System (PQRS) from negative 2018 adjustments. This provision also reduces the penalty for those *not meeting* the 2016 PQRS requirements to -2% from -4% for groups of 10 or more eligible professionals, and down to -1% from -2% for groups with fewer than 10 eligible professionals.

- **AUCs for advanced imaging delayed to 2020.** CMS had proposed to implement its advanced use criteria (AUC) requirement for advanced imaging (scans utilizing CT, MRI, PET technologies) in 2019, but is pushing the date to 2020 in the final rule. The AUCs would be incorporated into EHR systems as a clinical decision support mechanism (CDSM) and many EHRs already prompt providers to meet the AUC standard before selecting CT, MRI, or PET scan codes. Once implemented, CMS will deny full payment (both professional and technical components) of all advancing imaging CPT codes if the documentation doesn't meet AUC requirements.

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CONGRESSIONAL ACTION

GOP tax plans could be a mixed bag for practices, providers

The proposed Republican tax plans, both in the House and Senate, would be something of a mixed bag in terms of their impact on medical practices, an analysis by *The Business of Medicine* shows. Both versions would reduce taxes for large healthcare organizations and their executives, while individual physicians could see lower personal taxes. But these benefits could be partially offset by less revenue from the Medicare and Medicaid programs, whose funding could be reduced to help pay for these tax cuts.

For all their similarities, there are also significant differences between the House and Senate bills which must be reconciled before a final version can be signed into law by President Donald J. Trump.

A tale of two bills

The House bill was unveiled first and could potentially cost more than the Senate version. Below is a list of key provisions in both bills along with an explanation of how they differ.

- **Corporate tax rate is reduced from 35% to 20%.** The high American corporate tax rate, which President Trump has repeatedly railed against, is at the heart of both GOP proposals. However, the House version would implement the cut immediately while the Senate version implements the cut with a one-year delay. The delay is intended to give Republicans more time to determine how to preserve popular tax deductions that the House bill would remove.

- **Reconfigured tax brackets.** Currently there are seven tax brackets which the House plan would simplify into four brackets: 12%, 25%, 35%, and a top rate of 39.6% that remains the same. The Senate bill keeps the existing seven brackets at 10%, 12%, 22.5%, 25%, 32.5%, 35%, and a newly reduced top rate of 38.5% for the highest-income individuals and couples.

- **Small businesses and the pass-through tax rate.** A controversial provision in the House bill is the creation of a special 25% tax bracket for "pass-through" businesses, including sole proprietorships, partnerships, and S corporations that are currently taxed at the individual rate of their owners. The Senate plan doesn't create a new bracket, but instead allows a 17.4% deduction on income taxes for pass-through business owners, but makes service businesses ineligible for this classification (except for households with taxable income below $75,000 for single filers and $150,000 for married filers). Unfortunately for healthcare providers, medical care would be defined as services unless not labor-related; thus as written neither version would grant a benefit to providers.

- **Differences in deductions.** A major difference between the House and Senate is how they handle two key deductions, one for state, local, sales and property taxes (called SALT) and one for mortgage interest debt. The House would gut the SALT deduction, limiting it to property taxes only and capping it at $10,000. The Senate bill goes farther, completely eliminating the SALT deductions. The SALT deductions typically benefit upper-middle-class families who own single-family homes, a demographic that includes most healthcare providers.

- **Mortgage deduction differences.** The second key difference is that the House bill would cut mortgage interest deduction by half. Currently, mortgage interest can be deducted on debt up to $1 million; the House would cap the debt limit at $500,000. This could affect many physicians. The Senate version would make no change to the deduction. This single measure is responsible for much of the deficits that the House bill is projected to cause.

Senate bill links tax reform to ACA

Most recently, the Senate has added a provision to its tax bill that would eliminate the controversial Affordable Care Act (ACA) rule that all persons must purchase health insurance. This "individual mandate" has proven unpopular though the Obama administration argued that it was needed from a policy standpoint to halt skyrocketing premiums with insurers being prohibited from not covering preexisting conditions.

For Senate Republicans, linking the ACA to tax reform is more than just an effort to keep the ACA repeal effort alive. They argue that eliminating the individual mandate means stopping federal subsidy payments to help the poor afford coverage, which will result in massive budget savings to offset the deficits that the tax provisions will incur.

Medicare, Medicaid could pay for tax cuts

The other option to mitigate the final tax bill's massive deficit cost could be cuts to Medicare and Medicaid, which often show up in GOP crosshairs. Neither the House nor Senate bill contains specific provisions cutting these programs, but such cuts could appear in a final bill or as part of a larger federal budget bill.

Despite these difficulties, Republicans seem likely to get something passed. Unlike their efforts thus far to repeal the ACA, Republicans are more unified in their approach to tax reform, and they are under heavy pressure to claim a landmark achievement before the end of the year.

COMPLIANCE

CMS tries to ease MIPS burden with 2018 final rule

You will see more benefits from participating in the Merit-based Incentive Payment System (MIPS) in 2018 and may even be exempt under relaxed eligibility requirements established by CMS' Quality Payment Program (QPP) final rule for 2018. The QPP governs both MIPS and all of Medicare's recognized Advanced Alternative Payment Models (APMs).

MIPS consolidates all of the earlier CMS quality reporting programs under a single umbrella and thus the QPP rule, as a single document, has tremendous power and scope over all of Medicare's incentive programs. Below is a list of highlights in the QPP final rule:

1. Higher bar for minimum reporting. Though CMS is trying to make MIPS less of a burden, it is required to raise the bar for minimum participation in 2018, which is year 2 of the MIPS program. This means that in 2018, the minimum MIPS composite score required to avoid a pay cut in 2020 is 15 points, up from only 3 points in 2017 (which affects 2019 payments).

2. Older EHR certifications will be accepted. In the final rule, you may use EHR software certified under either the 2014 or 2015 Edition Certified Electronic Health Record Technology (CEHRT) guidelines. In fact, if you use an EHR with the 2015 Edition certification, CMS will give you a bonus to your score under the Advancing Care Information (ACI) category of MIPS, which accounts for 25% of your overall MIPS composite score.

3. Get bonus points for treating complex patients. CMS will automatically determine whether you see any complex patients and award ***up to*** 5 points toward your MIPS composite score based on how many such patients your providers see. This determination is based on a patient's clinical risk score, as calculated by the Hierarchical Condition Categories (HCC) model (covered in depth in the October 2017 issue of *The Business of Medicine*), as well as whether a patient is a dual-eligible beneficiary (i.e., qualifies for both Medicare and Medicaid).

4. Small practices get bonus points for free. To help smaller practices cope with MIPS, CMS will simply award them 5 points to their MIPS composite score without them needing to take any action. For the purposes of this bonus, CMS is defining a "small" practice as a group of 15 or fewer providers.

5. Small practices change join Virtual Groups. CMS is allowing solo practitioners and small practices (defined as having 10 or fewer providers) to join "Virtual Groups," which are a combination of two or more entities based on their tax identification numbers (TIN). This

Alex Azar, pharmaceutical chief, tapped to lead HHS

Former pharmaceutical executive Alex Azar has been nominated to lead HHS, President Donald J. Trump announced Nov. 13. The 50-year-old Azar had previously served in President George W. Bush's administration as HHS general counsel and later deputy secretary.

Azar is best known, however, for heading the pharmaceutical company Eli Lilly's U.S. division. Azar left HHS in 2007 and spent almost a decade at Eli Lilly, though he is regarded by many observers as experienced in healthcare and well-informed on policy. Azar would take over an agency still reeling from the sudden departure of former Rep. Tom Price (R-Ga.), who resigned after a scandal involving his use of public funds for expensive private air travel.

Because Eli Lilly's U.S. headquarters is located in Indiana, Azar has long had ties to Vice President Mike Pence, who previously served as governor of the state. Azar also served with acting HHS Secretary Eric Hargan under the Bush administration.

Though Azar is known to be a conservative (he is a Yale Law graduate who clerked for Supreme Court Justice Antonin Scalia and also advised presidential hopeful Mitt Romney in 2012), he is seen as more of a pragmatist and not a hard-right ideologue, according to a recent report in *Politico*. Azar already faces detractors on the Democratic side of the aisle, who view his long tenure at Eli Lilly as a sign that he would be predisposed to favor the powerful pharmaceutical lobby on Capitol Hill.

Azar will face Senate confirmation in the coming weeks: the first hearing with the Senate Committee on Health, Education, Labor and Pensions has been scheduled for Nov. 29 and the Senate Finance Committee has indicated it will hold a hearing before the end of the year. A permanent HHS chief will play a crucial role as the agency contends with both the ongoing rollout of the Quality Payment Program and political division over the Affordable Care Act (ACA).

combined entity or Virtual Group will have their MIPS performance assessed as a group rather than individually, allowing smaller practices to pool their resources and earn a potentially higher payment adjustment. Note that a "small" practice for Virtual Groups means 10 or fewer providers while "small" for the small practice bonus means 15 or fewer providers.

6. More Part B providers are exempt from MIPS. The MIPS program comes with a "low-volume" threshold below which providers were exempt from having to participate in the program. For an individual provider, this threshold *was* set at $30,000 or less in total annual Part B charges or seeing 100 or fewer Medicare beneficiaries per year. This threshold is increasing substantially in the QPP final rule: For 2018, a provider who bills $90,000 or less in Part B charges a year, or who sees 200 or fewer beneficiaries per year, will be exempt from MIPS.

7. Cost performance will count in 2018. The Cost performance category, which replaces the value modifier program, will account for 10% of your MIPS composite score in 2018, up from 0% in 2017. You will still receive a breakdown of your Cost performance in 2017 when CMS releases its MIPS report card early next year, but it won't affect your payment adjustment. For 2018, it will. Even so, you won't be able to do too much about it, as the methodology isn't changing much in the near-term from that used in the value-modifier (see related story on QRURs and cost measurement, pg. 8).

More guidance to come

Look for a complete guide to MIPS in 2018 in the next issue of *The Business of Medicine*. We will cover what the higher 15-point score threshold means for minimum participation (just to avoid a negative payment update in 2020), whether exemptions apply to you under the final rule, and strategies to boost your MIPS score if your practice intends to dive into the program.

REVENUE CYCLE MANAGEMENT

Your 2016 QRUR will be the last you ever receive

You should now have access to your 2016 annual Quality and Resource Use Report (QRUR), which describes your practice's cost performance in 2016 and your payment adjustment for 2018 under the Value-Based Payment Modifier (VBM) program. This will be the last QRUR you receive because the VBM program will go away in 2018, replaced by the Cost performance category of the Merit-based Incentive Payment System (MIPS).

The Cost performance category will account for 10% of your overall MIPS score during the 2018 measurement year (see related story, pg. 6), which will be used to set your MIPS payment adjustment in 2020. **Remember:** To access your QRUR, you will need to log into the CMS Enterprise Portal at https://portal.cms.gov/wps/portal/unauthportal/home/.

The QRUR determines your 2018 value modifier based on quality and cost. In the case of Colorado ENT & Allergy in Colorado Springs, the group was determined to have shown "high" quality and "average" cost in 2016, says Kevin Watson, administrator. This resulted in a +1.0x adjustment factor for 2018, which is the same adjustment factor his practice received in 2016 based on their 2014 performance. In 2016, that adjustment factor resulted in a Part B payment boost of approximately 16%, and Watson expects a similar bonus in 2018.

Because the value modifier is based on quality and cost data that CMS automatically calculates, and because those variables do not factor in provider specialty, Watson argues that practices can do little to boost their QRUR ratings.

In the case of many specialties such as ENT or orthopedic surgery, many QRUR measures could be affected by variables that these specialists would have little control over. To measure cost, CMS assigns individuals Part B beneficiaries to providers based on whichever provider performed the majority of E/M services to each beneficiary each year. Thus if a specialist happens to perform the majority of a beneficiary's E/M services in a year, he or she is on the hook for all of that beneficiary's healthcare costs, even for conditions that are not managed by his or her specialty. This includes conditions such as coronary artery disease, diabetes, and hypertension, as well as any hospital admissions regardless of the reason.

Otolaryngologists are in a similar boat, Watson says. "CMS understands that this is not equitable to some specialties," he says. "They admit it; they say they have to start somewhere. I guess we'll see what happens with the cost component of MIPS once it comes online."

Looking forward to MIPS

In the QRUR, a copy of which was obtained by *The Business of Medicine*, CMS advises practices to prepare for MIPS. "2018 will be the final year that Medicare will apply the Value Modifier to clinician payments for services billed under the Medicare Physician Fee Schedule," the agency states. "In 2019, the Quality Payment Program (QPP) payment adjustment will be based on the 2017 performance year."

Thus the bonus payments for recent years and going forward break down as follows:

- 2016: Based on the various CMS quality reporting programs, including EHR meaningful use, the Physician Quality Reporting System (PQRS), and the value modifier (VBM) from 2014.
- 2017: Same as above, except based on 2015 data.

HHS unveils strategic plan for 2018 and beyond

Every four years, HHS releases a strategic plan for the next four, a document intended to give a high-level overview of the agency's overall direction and priorities. The latest draft plan for 2018-2022 was released with little fanfare for public comment (the comment period closed at the end of last month).

Unlike in previous years, this latest plan hints at a more conservative-leaning policy bent, emphasizing less government intervention and a bigger role for the market. The draft plan also adds potentially controversial, explicitly anti-abortion language, such as "HHS accomplishes its mission through programs and initiatives that cover a wide spectrum of activities, serving and protecting Americans at every stage of life, beginning at conception."

A sampling of the draft's policy priorities includes:

- **Promote use of "high-quality, lower-cost healthcare providers,** such as community health workers, dental therapists, and community organizations"
- **Improve return on investment** of federal healthcare spending by "encouraging development of payment models that reward value over volume"
- **Expand opportunities for CMS alternative payment models** "to incentivize value-based care options"
- **Support consumer choice** by promoting a range of individual health insurance plans and payment options, "including faith-based options, with different benefit and cost-sharing structures"
- **Use public-private partnerships** "to prevent and detect fraud and other inappropriate payments across the healthcare industry by sharing fraud-related information and data, promoting best practices, and educating partners"

While industry stakeholders applauded the plan's focus on reducing costs of care, supporting evidence-based decision-making, and targeting of specific health crises (infectious disease and opioid abuse), the agency's embrace of faith-based initiatives and overtly religious definitions for life and conception have proven controversial. HHS is expected to release a final version of its strategic plan, in which it will respond to public comments received, by the end of the year.

- 2018: Same as above, except based on 2016 data.
- 2019: MIPS consolidates all of the previous quality reporting programs. A single MIPS composite score will determine Part B payment adjustment based on 2017 performance under the four MIPS components (quality, EHR meaningful use, clinical practice improvement, and cost).
- 2020: Same as above, with MIPS payment adjustment based on 2018 MIPS performance.

CODING

Look for big changes to ENT procedure coding in 2018

Endoscopy codes will see some of the biggest changes of all procedure codes next year under Medicare's 2018 Physician Fee Schedule (PFS) final rule. Below are the highlights.

- **Brand-new endoscopy codes.** CMS is introducing five new nasal/sinus endoscopy codes that each represent a bundle of services frequently reported together. These services only had placeholder CPT codes assigned in the proposed rule, but in the final rule they are as follows (including finalized values for work relative value units or wRVUs).
- **31241** (nasal/sinus endoscopy, surgical; with ligation of Sphenopalatine artery), 8.00 wRVUs.
- **31253** (nasal/sinus endoscopy, surgical with ethmoidectomy; total, including frontal sinus exploration with removal of tissue when performed): 9.00 wRVUs.
- **31257** (nasal/sinus endoscopy, surgical with ethmoidectomy; total, including sphenoidotomy): 8.00 wRVUs.
- **31259** (nasal/sinus endoscopy, surgical with ethmoidectomy; total, including sphenoidotomy, with removal of tissue from the sphenoid sinus): 8.48 wRVUs. This is a new code representing a combination of the services previously described by codes **31255** and **31288**.
- **31298** (nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia). 4.50 wRVUs. This

represents a combination of codes **31296** and **31297**.

- **Cuts to existing endoscopy codes.** The wRVUs for 10 endoscopy codes will be slashed in 2018 based on recommendations made by the AMA's Relative Value Update Committee (RUC).

- **31254** (nasal/sinus endoscopy, surgical; with ethmoidectomy, partial, anterior): 4.27 wRVUs, down from 4.64
- **31255** (nasal/sinus endoscopy, surgical; with ethmoidectomy, total, anterior and posterior): 5.75 wRVUs, down from 6.95.
- **31256** (nasal/sinus endoscopy, surgical, with maxillary antrostomy): 3.11 wRVUs down from 3.29.
- **31267** (nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus): 4.68 wRVUs down from 5.45.
- **31276** (nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus): 6.75 wRVUs down from 8.84.
- **31287** (nasal/sinus endoscopy, surgical, with sphenoidotomy): 3.50 wRVUs down from 3.91.
- **31288** (nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus): 4.10 wRVUs down from 4.57.
- **31295** (nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium, transnasal or via canine fossa): 2.70 wRVUs, unchanged.
- **31296**, (nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium): 3.10 wRVUs down from 3.29.
- **31297**, (nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium): 2.44 wRVUs down from 2.64.

New DoctorsManagement clients

Client	Services provided
Dermatology group, TN	Monthly practice management
Medical clinic, CA	Practice assessment
Solo practitioner, FL	Practice startup and ongoing management
Podiatry group, FL	Practice manager search
Indian health services, MI	Practice assessment
Dermatology group, MN	Post-bill audit
Physician group, OH	Coding audit
Rheumatology group, OH	Coding audit
Urgent care group, CA	Coding audit
Rheumatology practice, Washington D.C.	Coding audit
Vascular group, MD	Government audit
Diagnostic group, NC	Compliance research
Solo practitioner, TN	Payer contract negotiations
Solo practitioner	OIG compliance plan development
ENT group, AL	New provider enrollment
Optometry/ophthalmology group, CA	Credentialing services for 63 providers
Diagnostic group, NC	Credentialing research
University health system, FL	On-site education
Family practice, AR	On-site education