CMS released CY2018 Medicare Physician Fee Schedule (MPFS) Final Rule that includes policy and payment changes for services provided to Medicare beneficiaries in 2018. The MPFS final rule will appear in the November 15, 2017 Federal Register, it may be downloaded [here](https://www.federalregister.gov/public-inspection/current).

**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.
* **Changes in Valuation for Specific Services:** CMS reviews the resource inputs for several hundred codes under the annual process referred to as the potentially misvalued code initiative. Recommendations from the American Medical Association-Relative Value Scale Update Committee (RUC) are critically important to this work. For CY 2018, CMS is finalizing the values for individual services that generally reflect the expert recommendations from the RUC without as many refinements as CMS made in recent years.

We are pleased that CMS has accepted the RUC recommendation to increase the wRVUs for CPT code 93306 from 1.30 to 1.50 wRVUs. Additionally, CMS will maintain the current wRVUs values for remaining transthoracic and stress echocardiography services. Ensuring adequate reimbursement levels for echocardiography services on behalf of our ASE provider members ultimately helps provide patient access to this important technology. The attached table summarizes codes of interest to ASE members.

* **Payment Rates for Nonexcepted Off-campus Provider-Based Hospital Departments Paid Under the PFS:** 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.
* **Appropriate Use Criteria for Advanced Diagnostic Imaging:** CMS is finalizing a start date for the Medicare Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging. The program will begin in a manner that allows practitioners more time to focus on and adjust to the Quality Payment Program before being required to participate in the AUC program. The Medicare AUC program will begin with an educational and operations testing year in 2020, which means physicians would be required to start using AUCs and reporting this information on their claims. During this first year, CMS is proposing to pay claims for advanced diagnostic imaging services regardless of whether they correctly contain information on the required AUC consultation. This allows both clinicians and the agency to prepare for this new program.

Physicians may begin exploring these mechanisms well in advance of the start of the Medicare AUC program through the voluntary participation period that will begin mid-2018 and run through 2019. During this time CMS will collect limited information on Medicare claims to identify advanced imaging services for which consultation with appropriate use criteria took place. Additionally, by having qualified clinical decision support mechanisms available (some of which are free of charge) clinicians may use one of these mechanisms to earn credit under the Merit-Based Incentive Payment System as an improvement activity. This improvement activity was included in the 2018 Quality Payment Program final rule.

* **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.
* **Equipment for Scope Systems:** CMS will not implement its proposals to change its pricing methodology for scope systems. CMS had proposed to create and price single scope equipment codes for each of the five categories previously identified, including transesophageal echocardiography, and add 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. However, the agency is now asking for additional stakeholder feedback before addressing these issues in a future rulemaking period.
* **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.
* **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.

* **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.