ACR Preliminary Summary of Radiology Provisions in the 2018 MPFS Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2018 Medicare Physician Fee Schedule (MPFS) proposed rule on Thursday, July 13. Upon initial review, the ACR is pleased with several provisions within the rule. CMS has proposed to move forward with implementation of appropriate use criteria (AUC)/clinical decision support (CDS) for all advanced diagnostic imaging services on January 1, 2019. The ACR applauds CMS for moving forward with implementation of this important program.

Additionally, CMS has not proposed to move forward with a 50 percent cut to the technical component of mammography services which was discussed in the 2017 MPFS rulemaking process, choosing instead to maintain the current values as per the ACR's recommendation.

Conversion Factor and CMS Overall Impact Estimates

CMS estimates a CY 2018 conversion factor of $35.9903, which reflects the 0.5 percent update specified by the Medicare Access and CHIP Reauthorization Act, a budget neutrality adjustment, and a target recapture amount mandated by the Protecting Access to Medicare Act of 2014. Overall, this is a slight increase from the current conversion factor of $35.8887.

CMS estimates an overall impact of the MPFS proposed changes to radiology to be a 1 percent decrease, while interventional radiology would see an aggregate decrease of 1 percent and nuclear medicine a 0 percent change if the provisions within the proposed rule are finalized. Radiation oncology and radiation therapy centers are looking at an overall impact of a 1 percent increase.

Appropriate Use Criteria/Clinical Decision Support

On the topic of AUC, many medical specialty societies have expressed concern to CMS about their readiness for a January 1, 2018 implementation date and have urged the Agency to delay until after implementation of the Quality Payment Program (QPP). The ACR understands that referring physicians may need additional time to prepare and are pleased with the CMS proposal to implement the program on January 1, 2019.

Due to the complex nature of the AUC program, CMS is proposing an "educational and operations testing period" of one year that would begin on January 1, 2019. During this period, ordering professionals would consult AUC and furnishing providers would report AUC consultation information on the claim, but CMS would continue to pay claims whether or not the correct information is included. The Agency notes that this educational period would allow professionals to actively participate in the program while avoiding claims denials during the learning curve. It also gives CMS an opportunity to make any needed claims processing adjustments before payments are impacted.

In addition, CMS expects a voluntary reporting period to be available around July 2018. The timing of this opportunity for voluntary reporting is dependent on the readiness of the Medicare claims system to accept and process claims that include AUC consultation information. This is

consistent with the proposal in the recently released QPP proposed rule to give Merit Based Incentive Payment System (MIPS) credit to ordering professionals for consulting AUC using a qualified CDSM as a high-weight improvement activity for the performance period beginning January 1, 2018

CMS announced the list of qualified clinical decision support mechanisms (CDSMs) and new qualified provider led entities (PLEs) on their website. The ACR is pleased that the National Decision Support Company ACR Select program is among the list of qualified CDSMs and we note that this is the only qualified mechanism that currently includes a free web-based portal option for providers.

Finally, the Agency proposed specific claims processing instructions for the AUC program, namely establishing a series of Healthcare Common Procedure Coding System (HCPCS) level 3 codes. These G-codes would describe the specific CDSMs that were used by the ordering professional and there would be one code for each CDSM.

Mammography with Computer Aided Detection (CAD)

Three new mammography codes were developed to be implemented in 2017 which bundle mammography with CAD when performed. In the 2017 MPFS final rule, CMS stated that due to Medicare claims system processing issues, they would not be able to process claims using the new Current Procedural Terminology (CPT®) codes. Since the new codes are parallel in nature to the existing G-codes, CMS operationalized the new coding rules, including the new code descriptors through the use of the G-codes. CMS anticipated being able to adopt the new CPT coding for 2018. While the 2018 MPFS proposed rule does not specifically address mammography within the text, Addendum B of the rule includes the new category I CPT codes for mammography and not the G-codes.

With regard to valuation, in the CY 2017 rulemaking cycle, CMS made a slight increase to the professional component of mammography and maintained the 2016 payment rates for the technical component rather than implementing drastic cuts to the practice expense relative value units (RVUs). Again, CMS does not address this issue within the text of the 2018 proposed rule, however, the values listed for mammography in Addendum B remain essentially the same. The ACR met with CMS staff in March and urged them to maintain the existing payment rates indefinitely and as such, we are pleased with the values included in the proposed rule.

Computed Radiology/Digital Radiology (CR/DR)

The Consolidated Appropriations Act of 2016 mandates a 7 percent payment reduction for the TC of imaging services for X-rays taken using computed radiography technology furnished during CYs 2018-2022 and a 10 percent reduction for CY 2023 and beyond. To implement this mandate, CMS is proposing to establish a new modifier to be used on claims for these services beginning on January 1, 2018.

The modifier would be required on claims for the technical component of the X-ray service, including when the service is billed globally because the MPFS payment adjustment is made to

the technical component regardless of whether it is billed globally, or billed separately using the –TC modifier. The modifier must be used to report the specific services that are subject to the payment reduction and accurate use is subject to audit.

Additional Information

In addition to the payment and policy proposals, CMS also released a Request for Information (RFI) to welcome feedback on positive solutions to better achieve transparency, flexibility, program simplification, and innovation for the Medicare program.

CMS has posted a press release on their website. ACR staff will review the entire MPFS proposed rule in the coming weeks and will provide a comprehensive summary of the rule. The ACR will also submit comments to CMS by the comment period deadline in September.

Please contact Katie Keysor at kkeysor@acr.org with any questions.