

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

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2018 Medicare Physician Fee Schedule (MPFS) final rule on November 2nd. Upon initial review, the ACR is pleased with several provisions within the rule. While CMS has adjusted its proposal to move forward with implementation of appropriate use criteria (AUC)/clinical decision support (CDS) for all advanced diagnostic imaging services on January 1, 2019 to January 1, 2020, the ACR is pleased that CMS is taking time to adjust the claims processing instructions to make the process less burdensome for physicians. The ACR applauds CMS for moving forward with implementation of this important program.

Conversion Factor and CMS Overall Impact Estimates

CMS estimates a CY 2018 conversion factor of \$35.9996, 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, interventional radiology and nuclear medicine to be a neutral 0 percent change while radiation oncology and radiation therapy centers will see an overall impact of a 1 percent increase. The proposed rule included an estimated 6 percent decrease in reimbursement for Independent Diagnostic Testing Facilities due to practice expense relative value unit (RVU) changes to codes outside of the radiology code set. The estimated impact to IDTFs in the final rule is a 4 percent reduction.

Appropriate Use Criteria/Clinical Decision Support

On the topic of AUC, many medical specialty societies expressed concern to CMS in their proposed rule comments about their readiness for a January 1, 2019 implementation date and urged the Agency to delay until after implementation of the Quality Payment Program (QPP). The ACR expressed concern with the Agency's proposal to establish a complex series of Healthcare Common Procedure Coding System (HCPCS) level 3 G-codes and modifiers to be used to implement the program. The ACR advocated for the use of a unique consultation identifier for reporting, which is a much simpler and less burdensome approach for providers.

As a result of comments received, CMS decided to delay implementation of the AUC program until January 1, 2020, in order to allow time to determine the best way to use the unique consultation identifier for reporting and for providers to prepare for implementation. Due to the complex nature of the AUC program, CMS finalized an "educational and operations testing period" of one year that will begin on January 1, 2020. During this period, ordering professionals will be required to consult AUC and furnishing providers will report AUC consultation information on the claim, but CMS will continue to pay claims whether or not the correct information is included. The Agency notes that this educational period will allow professionals to actively participate in the program while avoiding claims denials during the testing period. It also gives CMS an opportunity to make any needed claims processing adjustments before payments are impacted.

In addition, CMS expects to move forward with a voluntary reporting period to be available from July 2018 through December 31, 2019. This voluntary reporting period was extended for an additional 12 months in comparison to provisions included in the CY 2018 MPFS Proposed Rule. 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 a provision in the QPP final 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.

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 final 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 rule making, 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 final 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 establishing a new modifier “FY” to be used on claims for these services beginning on January 1, 2018.

The modifier will 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.

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

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 Hospital Outpatient Prospective Payment System (OPPS) beginning January 1, 2017. For CY 2017, CMS pays for these items and services under the MPFS at a rate of 50 percent of the OPPS rate. For CY 2018, CMS is finalizing a reduction to the current MPFS payment rates for these items and services from 50 percent of the OPPS payment rate to 40 percent of the OPPS rate. This is an increase from the proposed 25 percent reimbursement rate.

Additional Information

CMS has posted a [press release](#) on their website. ACR staff will review the entire MPFS final rule in the coming weeks and will provide a comprehensive summary of the rule.

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