CMS released the 2018 Physician Fee Schedule Final Rule last week. The following is a summary of the AHRA-related policies.

1. Appropriate Use Criteria Delayed Until 2020

CMS had already proposed to delay the start of Appropriate Use Criteria (AUC) in the proposed rule until January 1, 2019. AHRA supported this proposed delay in our comments and we thanked CMS for allowing the industry the time to work through the operational and technical challenges AUC poses.

In the final rule, CMS proposed to "further delay the effective date for the AUC consultation and reporting requirements to January 1, 2020." CMS also finalized a voluntary period for early adopters to begin reporting AUC information. This voluntary period will begin in July 2018 and go through December 2019. Furthermore, the first year of the program (2020) will begin with an "educational operations testing period" whereby CMS will continue to pay claims whether or not they correctly include AUC information.

Under this new timeline, CMS will not deny a claim for incorrect AUC information until January 1, 2021.

2. Educational Operations Testing Period Specifics Remain Unclear

CMS first proposed an educational and operations testing period in 2019. AHRA supported this concept but asked CMS to clarify exactly what they expected during this period. Specifically, AHRA wanted to know if claims with *no* AUC consultation information would suffice during the educational period. Or, if CMS expected *some* AUC consultation information on the claim, that they would simply not verify for accuracy.

In the final rule CMS simply states that they "will not deny claims that fail to properly include AUC consultation information" during the educational and operations testing period. CMS notes that they will "communicate additional details and expectations for AUC consultation and reporting during the educational and operations testing period through future rulemaking."

3. Who Must Consult the AUC?

In our comments on the proposed rule, AHRA reiterated that our understanding of the AUC program, based on the clear intent of the law, was that ordering professionals must consult the AUC through qualified Clinical Decision Support Mechanism (CDSM) *personally*. We noted that there were some entities who thought otherwise and asked CMS to unequivocally state that ordering professionals *themselves*, must consult AUC on applicable imaging orders.

While CMS clearly noted our comment, they did not unequivocally clarify who must use a CDSM to consult an AUC. CMS wrote that:

> …commenters opposed allowing consultation by anyone other than the ordering professional, which they understand as the clear requirement…and are concerned that other types of individuals and stakeholders are preparing to circumvent this requirement by performing consultations on behalf of ordering professionals.
>
> **Response:** Section 1834(q)(4)(A)(i) of the Act requires an ordering professional to consult with a qualified CDSM. We appreciate the varying opinions presented by stakeholders and the number of commenters who raised these questions. We will consider developing policy to address this issue.

In other words, CMS reiterates the statutory language but does not color in the exact policy. Thus leaving the issue unsettled until CMS decides to develop a comprehensive policy.

4. Reporting AUC Information on Claims

AHRA expressed significant concerns about the proposed "G-code plus modifier" approach to reporting AUC information on claims. Instead of this method, we advocated that CMS use the "unique consultation identifier" generated by the CDSM to report AUC information on claims. We suggested that CMS create a working group with AUC stakeholders to develop a solution that works for CMS and the imaging community.

We reiterated these concerns and made the case for a "unique consultation identifier" during a call with the CMS AUC/CDSM team in September.

Thankfully, CMS listened to our concerns and decided to abandon this "G-code plus modifier" approach in favor of a "unique consultation identifier" approach. CMS wrote that:

> In response to these comments we will not move forward with the G-code and modifier combinations for reporting which CDSM is consulted, adherence, non-adherence or situations where AUC are not applicable. We will further explore and pursue use of the unique consultation identifier for reporting on Medicare claims. However, in order to use such an identifier we must work with stakeholders to develop a standard taxonomy. We expect to conduct stakeholder outreach during 2018 so that such standardization can be accomplished and will discuss such changes in future rulemaking ahead of the 2020 consulting and reporting effective date.

We think that this decision will go a long way in reducing the administrative burden the AUC/CDSM requirement places on imaging centers. The AHRA Regulatory Affairs Team will be sure to provide stakeholder feedback as CMS develops this standard

taxonomy. Our goal is to create an effective AUC reporting mechanism with minimal administrative burden.

5. Clarification on AUC Exemption for Emergencies

AHRA asked CMS to clarify that all patients that present in an emergency department (ED) be exempt from AUC requirements. We noted that the definition for "emergency medical condition" used in rule is not as comprehensive as we would like because it is primarily used to determine if an ED turned away a patient in need of emergency medical care.

CMS did not respond to this particular comment but AHRA will continue to seek clarification on this issue.

6. Estimate of Cost of AUC Implementation

In our comments on the proposed rule, AHRA noted that OMB only considered the burden of AUC implementation for ordering providers. We requested that the OMB reconsider their determination that the operational aspects of AUC reporting do not qualify for review.

The OMB did not specifically address our concerns but noted that "because [CMS] has not yet proposed a mechanism or calculation for outlier ordering professional identification and prior authorization, we are unable to quantify that impact at this time."

AHRA will be sure to communicate our concerns to the OMB should they ignore the operational costs in their estimate once the mechanism is finalized.

7. Site Neutral (Nonexcepted) Payment Rate Set at 40%

In their proposed rule, CMS considered adopting a low rate (25% of OPPS) for nonexcepted services. This adjustment is called the "PFS relativity adjuster." We strongly disagreed with the methodology CMS used to justify a 25% PFS relativity adjuster for all nonexcepted services. We noted that in many instances, the 25% PFS relativity adjuster would drop reimbursement far below the costs of furnishing that service.

We argued that this would cause nonexcepted Hospital Outpatient Departments to either no longer offer these services or convert to freestanding centers that can bill using the Physician Fee Schedule. This policy is supposed to promote payment equity between sites, not promote one site over another.

CMS decided to back off their proposal of 25%, and instead finalized a PFS Relativity Adjuster of 40% for CY 2018. CMS offers the following rationale as to how they settled on a 40% PFS Relativity Adjuster:

> In the CY 2018 PFS proposed rule, we sought comment on whether a different PFS Relativity Adjuster, such as 40 percent, would reflect a middle ground between the CY 2017 PFS Relativity Adjuster of 50 percent, selected to ensure adequate payment to hospitals, and our proposed CY 2018 PFS Relativity Adjuster of 25 percent, selected to ensure that hospitals are not paid more than others would be paid through the PFS nonfacility rate. Since, as we acknowledged in response to public comments, we are unable at this time to fully calculate the effects of packaging under the OPPS, we believe that a 40 percent PFS Relativity Adjuster, which is an upward adjustment to the 35 percent calculation described above, is appropriate. We are, therefore, finalizing a PFS Relativity Adjuster of 40 percent for CY 2018.

While 40% is certainly better than the proposed 25%, it is still a cut from the CY 2017 PFS relativity adjuster of 50%.

8. Payment Incentive for Transition from Traditional X-Ray Imaging to Digital Radiography

CMS finalized that modifier FY must be used on claims for X-rays taken using computed radiography/cassette-based technology and billed on the physician fee schedule. The presence of this modifier will result in a 7 percent reduction for CY 2018 through CY 2022 and a 10 percent reduction for CY 2023 and beyond. The modifier should be included on the technical component or global bill.

Here are some general provisions that may also be of interest:

Update to the MPFS Conversion Factor (CF)

For 2018, CMS is finalizing a 0.41 percent increase to the MPFS Conversion Factor (CF). The 2018 CF will be $35.99, up from $35.89 in 2017. This update reflects the 0.50 percent update established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience (ABLE) Act of 2014.

Updating Evaluation and Management Coding Guidelines

In the proposed rule, CMS stated that it is considering revising the Evaluation and Management (E/M) coding guidelines. CMS solicited input from stakeholders on how to best go about updating these guidelines. CMS is not moving forward yet with a revision to the guidelines but hopes to do so in the near future after reviewing the stakeholder feedback it received in more detail.

Changes to 2016 Quality Reporting

CMS is finalizing its proposal to reduce the number of measures necessary for satisfactory reporting for the Physician Quality Reporting System, Value Modifier and EHR Meaningful Use (MU) programs. Eligible providers only need to report on six measures with no domain or cross-cutting measure requirements to satisfy the reporting requirements for PQRS and MU. The PQRS and VM feedback reports that clinicians received assumed this proposal would be finalized. Therefore, the information in the feedback reports reflects this final policy.

Medicare Telehealth Services

For CY 2018, CMS is finalizing the addition of several codes to the list of telehealth services, including:

- HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility);
- CPT code 90785 (Interactive Complexity);
- CPT codes 96160 and 96161 (Health Risk Assessment);
- HCPCS code G0506 (Care Planning for Chronic Care Management); and
- CPT codes 90839 and 90840 (Psychotherapy for Crisis).

Additionally, CMS is finalizing its proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners. CMS is also finalizing payment for CPT code 99091, which covers remote patient monitoring.

Patient Relationship Codes

As part of the transition towards value-based payments, CMS was required by Congress to develop patient relationship categories and codes that 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. The categories include different relationships of the clinician to the patient and reflect various types of responsibility for and frequency of furnishing care.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to begin collecting these codes on claims in 2018. CMS is finalizing its proposed list of five Level II HCPCS modifiers which will serve as the patient relationship category codes. However, reporting these codes on claims will be voluntary in 2018. These codes will not impact reimbursement.