Updates to the Medicare Physician Fee Schedule for 2018

By: Kate Thomas

Some questions have come up regarding the billing of sinusoidal vertical axis rotational chair testing, 92546. In the November/December 2017 *Audiology Today* article, "Billing and Coding the Vestibular Evaluation," it was recommended billing one unit per plane of testing. By definition, vertical axis rotation is evaluation of the horizontal plane only. Billing CPT code 92546 only applies to horizontal plane testing and the audiologist should not use this code to bill for additional axes.

It is important to check with your third-party payers on billing multiple units for 92546, as there may be variation in coding guidance based upon the payer. Medicare only allows the billing of one unit of 92546 per encounter. *CPT Assistant* has also published guidance advising that this code is intended to be billed once per encounter. As with all your billing and coding, make sure you check with your patient's third-party payer prior to providing services.

On November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) final rule for 2018.The final rule addresses adjustments to the MPFS and other Medicare Part B payment policies, including changes in valuation for services and overall payment updates.

The changes finalized in the MPFS final rule officially took effect on January 1, 2018. The Academy has prepared a list of payment rates by CPT code for audiology procedures covered under the fee schedule. This list is available on the Academy's website, search key words "Final Rule Changes to 2018 Medicare Physician Fee Schedule." The Academy has also prepared an analysis of the final rule below, and will continue to provide additional information and updates on the Reimbursement page of the Academy's website.

CMS Finalizes Conversion Factor of $35.99 for CY 2018

For Calendar Year (CY) 2018, CMS determined the MPFS conversion factor to be $35.99. 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. The conversion factor for CY 2018 represents a slight increase over the conversion factor for CY 2017, which was $35.89.

Valuation of Specific Services

For CY 2018, CMS is finalizing the values for individual services that generally reflect the expert recommendations from the American Medical Association (AMA)—Relative Value Scale Update Committee (RUC) without as many refinements as CMS has proposed in past years. The Academy addressed the valuation process in our MPFS proposed rule comments. Those comments are available on the Academy's website under "Reimbursement."

Notably, CMS also encourages the RUC to heed public comments requesting a more open valuation process and for broader medical representation across specialties on the panel. It is unclear if such comments will have an effect on the RUC, which has long been considered a private and closed process.

Professional Liability Insurance

CMS finalized its proposal to utilize the RUC and specialty recommendations related to expected specialties for low-volume codes, a change advocated by the AMA RUC and supported by the Academy. CMS did not finalize its proposal to use updated premium data in

computing the professional liability insurance relative values. CMS has stated that they will work to address the limitations with the premium data prior to updating this information in 2020.

Payment Rates for Non-excepted Items and Non-excepted Off-Campus Providers

In CY 2017, CMS finalized the MPFS as the applicable payment system for certain items and services furnished by certain off-campus hospital outpatient provider-based departments. For CY 2018, CMS is finalizing a 20 percent reduction to the current MPFS payment rates for these items and services. CMS currently pays for these services under the MPFS based on a percentage of the Hospital Outpatient Prospective Patient System (OPPS) payment rate. Specifically, the final policy will change the MPFS payment rates for these services from 50 percent of the OPPS payment rate to 40 percent of the OPPS rate.

Physician Quality Reporting System

CMS is finalizing a change to the current policy that requires reporting of nine measures across three National Quality Strategy domains to only require reporting of six measures.

MACRA Patient Relationship Categories and Codes

CMS is finalizing their proposal to use the Level II HCPCS modifiers found in TABLE 1 as the patient relationship codes. CMS will add these codes to the operational list of patient relationship categories available at www.cms.hhs.gov/medhcpcsgeninfo.

NO.	HCPCS MODIFIER	PATIENT RELATIONSHIP CATEGORY
1x	X1	Continuous/broad services
2x	X2	Continuous/focused services
3x	X3	Episodic/broad services
4x	X4	Episodic/focused services
5x	X5	Only as ordered by another clinician

TABLE 1. Patient Relationship HCPCS Modifiers and Categories

CMS is also finalizing their proposal that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include the applicable patient relationship modifier, as well as the NPI of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

Audiologists are not considered applicable practitioners at this time. For 2018, an applicable practitioner is defined as a physician assistant, nurse practitioner, clinical nurse specialist, and a certified registered nurse anesthetist. The secretary of HHS has the authority to expand the list of applicable practitioners to include other providers, such as audiologists, in 2019.

In the final rule, CMS is finalizing that HCPCS modifiers may be voluntarily reported, and the use and selection of the modifiers will not be a condition of payment. CMS has stated that voluntary reporting will allow the agency to collect more information about the patient relationship codes, and provide more opportunities for education and outreach to clinicians. This will inform their overall ability to refine the codes in the future.

The Academy is closely monitoring this issue. We have advocated to CMS that when HHS determines audiologists are applicable practitioners (likely 2019), the Agency extend the same opportunities for voluntary reporting, flexibility, and education and clinician outreach.

OPPS and QPP Final Rules for 2018

In addition to the MPFS final rule, CMS released the OPPS and Quality Payment Program (QPP) final rules for CY 2018. Those rules also took effect on January 1, 2018. The Academy has an analysis of both of those final rules available on the Reimbursement page of our website, including a listing of all OPPS 2018 Ambulatory Payment Classifications for audiology codes.

Additional Information

The Academy continues to monitor CMS Medicare Part B policies, provide commentary, and meet with CMS at Agency headquarters as necessary to advocate for the profession of audiology. Look for updates in the *Audiology Weekly* e-newsletter.

Kate Thomas is the senior director of advocacy and reimbursement for the American Academy of Audiology.