

CMS's 2018 Medicare Physician Fee Schedule Proposed Rule Would Slash Non-Excepted Provider-Based Department Payments

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The Centers for Medicare & Medicaid Services (CMS) released its 2018 Medicare Physician Fee Schedule proposed rule on July 13, 2017. The proposed rule, among other things, proposes to cut Medicare payments for services provided at non-excepted, off-campus provider-based departments from 50% to 25% of the Outpatient Prospective Payment System (OPPS) rate for the 2018 calendar year.

Currently, non-excepted, off-campus provider-based departments are paid for certain items and services under the Medicare Physician Fee Schedule at a payment rate equal to 50% of the OPPS payment rate for the applicable item or service. The current payment rate has only been in place since January. CMS said in the proposed rule that it viewed the 2017 rates as “transitional policy,” but few people in the industry were likely expecting to see such a significant decrease in payment so soon. CMS openly admits, however, that it is working with a limited set of payment data since it does not have claims data from calendar year 2017 and that additional analysis is needed. CMS said it welcomes stakeholder input with regard to its initial analysis and the proposal to pay for the applicable services at 25% of the OPPS. In fact, CMS specifically requested comment on whether it should adopt a different payment rate, such as 40% of the OPPS, that would represent a middle ground between the current rates and the proposed rate. If finalized, the payment cut would further disincentive hospitals from opening or operating new (i.e., non-excepted) off-campus provider-based locations.

Some of the key additional changes proposed by CMS in the 1,000+ page proposed rule include:

- Medicare Telehealth Services. CMS is proposing to add several codes to the list of

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covered 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).

- Retroactive PQRS and Value Modifier Adjustments. CMS is also proposing to reduce or eliminate certain financial penalties for performance in 2016 under the Physician Quality Reporting System (PQRS) and the Value Modifier program. Under PQRS, for example, CMS says it wants to retroactively reduce the number of metrics that physicians had to report on in PQRS from nine to six measures. For the Value Modifier, CMS proposes to reduce the automatic downward adjustment for not meeting minimum quality reporting requirements from negative four percent to negative two percent for groups of ten or more clinicians and from negative two percent to negative one percent for physician and non-physician solo practitioners and groups of two to nine clinicians.
- Evaluation and Management Comment Solicitation. CMS is seeking comment from stakeholders on specific changes it should undertake to “update the guidelines, to reduce the associated burden, and to better align” Evaluation and Management coding and documentation with the current practice of medicine.

The advanced copy of the Proposed Rule is available [here](#). The official version of the Proposed Rule is scheduled for publication in the Federal Register on July 21, 2017. Comments on the Proposed Rule are due by September 11, 2017.