2018 Medicare Physician Fee Schedule and CPT® Code Changes Impacting PM&R Practice

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Coding Changes and Payment Updates

Several changes to payment policy, coding, and reimbursement took effect on January 1, 2018. Many of these changes are due to the 2018 Medicare Physician Fee Schedule (MPFS), published by the Centers for Medicare & Medicaid Services (CMS) in November 2017. The fee schedule, updated annually, includes payment policy and reimbursement information for all codes billed to Medicare Part B. Additional changes are due to revisions found in the 2018 edition of the American Medical Association's (AMA's) Current Procedural Terminology (CPT) Codebook. The following is a summary of the coding and reimbursement changes affecting physiatrists starting January 1, 2018. The 2018 conversion factor, which is used to determine payment for Medicare services, is set at $35.99, an increase of approximately $0.10. Note that the total payment listed in this article is for the non-facility setting. Also note that payment is specific to Medicare Part B; commercial payer rates will differ.

Cognitive Assessment and Care Plan Services

CPT has added a new code and relevant guidelines to describe cognitive assessment and care plan services. The descriptor for this code includes many detailed required elements. For this content, please consult the 2018 CPT Codebook. This code can only be billed once per 180 days for any given patient.

CODE	DESCRIPTOR	WORK RVU	WORK PAYMENT	TOTAL RVU	TOTAL PAYMENT
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements*...Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver. *For detailed elements see 2018 CPT codebook.	3.44	$123.81	6.72	$241.85

Suprascapular Nerve Injection

The AMA Relative Value Scale Update Committee (RUC) reviewed code 64418 for suprascapular nerve injection in April 2016 and finalized a reduced work RVU for the code. The new work RVU and payment will take effect in 2018.

CODE	DESCRIPTOR	WORK RVU	WORK PAYMENT	TOTAL RVU	TOTAL PAYMENT
64418	Injection, anesthetic agent; suprascapular nerve	1.10	$39.59	3.34	$120.21

Neurostimulators

Several changes were made to the neurostimulator code section.

Code 64550 was updated to specify that a TENS unit is an example of an appropriate device when billing this code. Payment for this code did not change from the 2017 rates.

CODE	DESCRIPTOR	WORK RVU	WORK PAYMENT	TOTAL RVU	TOTAL PAYMENT
64550	Application of surface (transcutaneous) neurostimulator (e.g., TENS unit)	0.18	$6.48	0.51	$18.35

Codes 64553 and 64555 were reviewed by the AMA RUC in January 2017. The values for these 2 codes were extremely outdated and did not reflect the significantly-different way these services are now performed. Work values for these codes more than doubled from the 2017 rates and practice expenses increased substantially as well.

CODE	DESCRIPTOR	WORK RVU	WORK PAYMENT	TOTAL RVU	TOTAL PAYMENT
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve	6.13	$220.62	32.14	$1,156.70
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	5.76	$207.30	34.35	$1,236.26

Visit **www.aapmr.org/reimbursement** for more information.
If you have comments or questions, please email us at **codingquestions@aapmr.org**.

Ultrasound of Extremity

AMA CPT updated the ultrasound of extremity (76881 and 76882) code descriptors to include additional detail, particularly for the limited code (76882). These changes were editorial, meaning that there was no change to the intended use of the codes. Practice expense reimbursement for these codes has changed for 2018. Practice expense for the complete code (76881) has decreased to account for a change in the typical specialty performing the procedure. The service is no longer expected to be typically performed using a dedicated ultrasound room or PACS workstation. This decrease is the first step in a multi-year decrease in practice expense for this code. Practice expense for the limited code has increased to account for the fact that the service was now determined to be performed typically with a PACS workstation. No changes were made to the payment for physician work for these 2 codes.

CODE	DESCRIPTOR	WORK RVU	WORK PAYMENT	TOTAL RVU	TOTAL PAYMENT
76881	Ultrasound, complete joint (i.e., joint space and periarticular soft-tissue structures), real-time with image documentation	0.63	$22.67	2.89	$104.01
76882	Ultrasound, limited, joint or other nonvascular extremity structure(s) (e.g., joint space, peri-articular tendon(s), muscle(s), nerve(s), other soft-tissue structure(s), or soft-tissue mass(es), real-time with image documentation	0.49	$17.64	1.64	$59.02

Orthotic Management and Training and Prosthetic Training

AMA CPT revised 2 codes in this section (97760 and 97761) and added 1 code (97763) to update this section to current practice. Values for the 2 previously existing codes have increased slightly over their 2017 rates.

CODE	DESCRIPTOR	WORK RVU	WORK PAYMENT	TOTAL RVU	TOTAL PAYMENT
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	0.50	$18.00	1.33	$47.87
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	0.50	$18.00	1.15	$41.39
97763	Orthotic(s)/prosthetic(s) management and/or trunk, subsequent orthotic(s)/ prosthetic(s) encounter, each 15 minutes	0.48	$17.28	1.37	$49.31

Remote Monitoring

CMS finalized separate payment for remote monitoring service 99091. This code was established by AMA CPT several years ago, however CMS chose not to reimburse for it until this year. The code requires a minimum of 30 minutes of time.

CODE	DESCRIPTOR	WORK RVU	WORK PAYMENT	TOTAL RVU	TOTAL PAYMENT
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time	1.10	$39.59	1.63	$58.66

Medicare Physician Fee Schedule Updates

The 2018 Medicare Physician Fee Schedule includes important changes to policy effective January 1, 2018 and beyond.

Telehealth

In its recent rulemaking, CMS took several steps to expand telehealth coverage. CMS approved adding new codes to the list of services that can be provided as telemedicine. These services include, among others, CPT codes 96160 and 96161 for Health Risk Assessment and HCPCS code G0506 for Care Planning for Chronic Care Management. Further, as described above, CMS approved separate payment for remote monitoring services using code 99091. CMS acknowledged that payment for 99091 is a temporary solution for coverage of remote monitoring, as AMA CPT is working on developing new codes for these services. Additionally, CMS finalized a proposal to eliminate the GT modifier, which was previously used to designate services provided via telemedicine. Providers can now simply use the telemedicine place of service code (POS 02) when offering telemedicine services.

Evaluation and Management Services—Comment Solicitation

In its 2018 proposed rule, CMS asked stakeholders to submit comments regarding the guidelines of the evaluation and management code set. CMS particularly highlighted the complexity of documentation requirements and arguably outdated nature as justifications for future revisions.

CMS received numerous comments on this topic, including comments from AAPM&R, which were submitted on September 11, 2017 and can be found at **www.aapmr.org/reimbursement**. Based on feedback submitted by stakeholders, CMS is considering mechanisms for a collaborated effort in the future. While no changes were made this year, your Academy will continue to monitor this important issue in future CMS rulemaking.

Patient Relationship Category Modifiers

CMS finalized its proposal to move forward with the use of Level II HCPCS modifiers to be used on claims to indicate patient relationship categories. Modifiers were established for 5 patient relationship categories:

1. continuous/broad services
2. continuous/focused services
3. episodic/broad services
4. episodic/focused services
5. only as ordered by another clinician

Definitions of the categories can be found on the CMS website. Reporting of the patient relationship category modifiers is *voluntary* this year. CMS will propose making the modifiers mandatory in future rulemaking. ❖