Calendar Year 2018 Medicare Physician Fee Schedule Proposed Rule

August 2017
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Overview

• The Centers for Medicare and Medicaid Services (CMS) published the calendar year (CY) 2018 Medicare Physician Fee Schedule Proposed Rule on July 13, 2017

• Comments on the Proposed Rule are due by 5 p.m. EST on September 11, 2017
Key issues addressed in the Proposed Rule

- Comment solicitation on payment for biosimilar biological products
- PFS conversion factor update
- Drug administration services
- Care management services
Current biosimilar reimbursement

- Medicare Part B reimbursement for biosimilars

100% of the ASP of the biosimilar product + 6% of the ASP of the reference product = Biosimilar Payment Amount

- All biosimilars of the same reference product are grouped in the same billing code and subject to the same blended payment amount
- Payment amount for the reference product is not affected by this policy

42 U.S.C. § 1395w–3a(b)(8); 80 Fed. Reg, 70,886,71,096–101
Comment solicitation on coding and payment for biosimilars

• How has the payment policy affected the biosimilar market since implementation on January 1, 2016?
  • Economic data, research articles, and market analyses

• Should biosimilars sharing a common reference product be coded and paid separately?
  • If and how should payment reflect the reference product’s and/or biosimilar’s indications?

• Other novel ideas to foster a “competitive marketplace, increase patient access, and drive cost savings”?

82 Fed. Reg. at 34,090–91
PFS conversion factor would be $35.99 in CY 2018

• CMS proposes to slightly increase the conversion factor from $35.89 to $35.99
• Update reflects:
  • +.50% increase required by MACRA
  • -.19% required for CMS to meet the misvalued code target
  • -.03% budget neutrality adjustment
• Before budget neutrality adjustment, proposed rate increase is +.31%

82 Fed. Reg. at 34,176–77
Reimbursement for drugs set at default rate of ASP plus 6%

- Drugs and biologicals would continue to be reimbursed at the statutory default rate of **ASP plus 6%**
  - With sequestration still in effect, this amount is effectively ASP plus 4.3%

2 U.S.C. § 901a(6)(B)
List of “potentially misvalued” codes includes some drug administration codes

**CY 2018 Proposed “Potentially Misvalued” Drug Administration Codes**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>96401</td>
<td>Chemo administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic</td>
</tr>
<tr>
<td>96402</td>
<td>Chemo administration, subcutaneous or intramuscular; hormonal anti-neoplastic</td>
</tr>
<tr>
<td>96409</td>
<td>Chemo administration, intravenous push, single or initial substance/drug</td>
</tr>
<tr>
<td>96411</td>
<td>IV push, each additional chemo substance/drug</td>
</tr>
</tbody>
</table>

82 Fed. Reg. at 34,007
Drug administration coding and payment

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
<th>2017 Final Rates¹</th>
<th>2018 Proposed Rates²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Hydration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96360</td>
<td>IV infusion, hydration, 31 minutes to 1 hour</td>
<td>58.50</td>
<td>47.51</td>
</tr>
<tr>
<td>96361</td>
<td>IV infusion, hydration; each additional hour</td>
<td>15.43</td>
<td>14.04</td>
</tr>
<tr>
<td></td>
<td><strong>Therapeutic, Prophylactic, and Diagnostic Infusions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96365</td>
<td>IV infusion, for therapy/prophylaxis/diagnostic, initial, up to 1 hr</td>
<td>69.98</td>
<td>73.06</td>
</tr>
<tr>
<td>96366</td>
<td>IV infusion for therapy/prophylaxis/diagnosis; each additional hour</td>
<td>19.02</td>
<td>22.31</td>
</tr>
<tr>
<td></td>
<td><strong>Chemotherapy &amp; complex drug/biologic infusions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96413</td>
<td>Chemo administration, intravenous infusion; up to 1 hour, single or initial substance or drug</td>
<td>139.61</td>
<td>143.60</td>
</tr>
<tr>
<td>96415</td>
<td>Chemo administration, intravenous infusion; each additional hour</td>
<td>28.71</td>
<td>30.95</td>
</tr>
<tr>
<td></td>
<td><strong>Injections</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic, prophylactic or diagnostic injection, sc or im</td>
<td>25.84</td>
<td>20.87</td>
</tr>
<tr>
<td>96401</td>
<td>Chemo administration, subcutaneous or intramuscular, non-hormonal anti-neoplastic</td>
<td>75.37</td>
<td>80.62</td>
</tr>
<tr>
<td>96402</td>
<td>Chemo administration, subcutaneous or intramuscular, hormonal anti-neoplastic</td>
<td>33.02</td>
<td>29.15</td>
</tr>
<tr>
<td></td>
<td><strong>Other chemotherapy administration codes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96425</td>
<td>Chemo initiation of prolonged infusion (&gt;8 hrs) requiring use of a portable/implantable pump</td>
<td>185.54</td>
<td>185.35</td>
</tr>
</tbody>
</table>

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¹ NOTE: All reimbursement is presented as national rates, without application of geographic adjustment factors (GPCI). Actual provider payment rates will vary according to the geographic location of the practice. The rates displayed have not been adjusted for any impact of sequestration.

² The "2017 Final Rates" are calculated using: 1) the Final CY 2017 conversion factor (CF) of 35.8887; and 2) final total RVUs, comprised of: work RVU (wRVU), non-facility (NF) Practice Expense RVU (pRVU), and malpractice RVU (mRVU) weights, as published in CMS-1654-F. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Final Rule, 81 Fed. Reg. 80170 (Nov. 15, 2016) and Addendum B, both available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html
Calculated dollar amounts reflect national rates before geographic adjustment.

² The "2018 Proposed Rates" are calculated using: 1) the proposed 2018 conversion factor (CF) of 35.9903; and 2) proposed total RVUs, comprised of: work RVU (wRVU), non-facility (NF) Practice Expense RVU (pRVU), and malpractice RVU (mRVU) weights, as published in CMS-1676-F. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Proposed Rule, displayed July 13, 2017; and Addendum B, both available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html
Calculated dollar amounts reflect national rates before geographic adjustment.
Proposed revisions to payment adjustments under physician quality programs

- Physician Quality Reporting System (PQRS) and Value-Based Modifier (Value Modifier) payment adjustments will be replaced by the Merit-Based Incentive Payment System (MIPS) beginning January 1, 2019
- CMS will still apply payment adjustments in CY 2018 based on data already submitted for CY 2016 under these programs
- Proposed changes include:

<table>
<thead>
<tr>
<th>PQRS</th>
<th>Value Modifier</th>
</tr>
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<tbody>
<tr>
<td>6 reporting measures required instead of 9 reporting measures</td>
<td>Quality reporting penalty would decrease from -4% to -2% for groups of 10 or more clinicians</td>
</tr>
<tr>
<td>No domain requirements instead of reporting across 3 domains</td>
<td>Maximum upward adjustment would decrease from +4% to +2%</td>
</tr>
</tbody>
</table>

82 Fed. Reg. at 34,099; 34,125
Proposed new telehealth codes

To improve patient access and ease administrative burdens for practitioners, CMS proposes to add a number of new codes to the list of telehealth services, including codes for:

- Care planning for chronic care management (HCPCS code G0506);
- Health risk assessments (CPT codes 96160 and 96161);
- Psychotherapy for crisis (CPT codes 90839 and 90840); and
- Interactive complexity related to psychotherapy services (CPT codes 90839 and 90840)

82 Fed. Reg. at 33,974–75
Payment for primary care services and care management

- CMS seeks comment on:
  - Ways to reduce reporting burden for care management services
  - Updates to reporting guidelines for Evaluation and Management (E/M) visits
- Proposes new codes for chronic care management (CCM) and psychiatric collaborative care model (CoCM) for rural health clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

82 Fed. Reg. at 34,079–80
Comments requested on how to improve PFS and OPPS

• In both PFS and OPPS Proposed Rules, CMS seeks stakeholder ideas on ways to:
  • Increase transparency;
  • Flexibility;
  • program simplification; and
  • Innovation

• Examples include:
  • Recommendations regarding payment system re-design;
  • Elimination or streamlining of reporting requirements;
  • Operational flexibility;
  • Data sharing to facilitate patient-centered care; and
  • How to generally simplify rules for beneficiaries, clinicians, providers, and suppliers

82 Fed. Reg. at 34,172–73
Commenting on the Proposed Rule

Submit comments electronically using file code CMS-1676-P at www.regulations.gov or mail comments to:

Regular Mail
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
P.O. Box 8013
Baltimore, MD 21244-1850

Express or Overnight Mail
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Public comments are due by no later than 5:00 p.m. on September 11, 2017

82 Fed. Reg. at 33,950