Instructions for Utilizing 2018 Fee Schedule Calculator

1. Open the excel sheet
   Step 1. Scroll down to Line 19 and select your payment locality
   Step 2. Scroll down to Line 33 where the gray box begins
   Step 3. Enter the CPT code (with a modifier, if applicable)
   Step 4. If you want to enter more than 1 code, enter the second code below the first, and so forth.
   Step 5. In the gray box, under Units, enter the number of units for each code.

Results;
Each row that contains a code should have values that pop up reflecting:

a. No sequestration, no MPPR
b. No sequestration, with MPPR
c. With sequestration, no MPPR
d. With sequestration, with MPPR

These values can be compared to the 2017 rates, both individually and in aggregate.
The total payment you can expect to receive in 2018 can be found in Column K, Line 15 or 16.
Please see below for a more in-depth explanation.

Column K, Line 15:
• This is the Medicare payment for the codes/units entered in the gray box you would receive in 2018.
  o Note: This value reflects sequestration and the 50% MPPR.

Column K, Line 16:
• This is the Medicare payment with sequestration, but no MPPR that you would receive in 2018.

Column I, Line 15:
• This is the Medicare payment with MPPR but no sequestration

Column I, Line 16:
• This is the Medicare payment without sequestration or MPPR.

Column M/Line 15:
• This is the Medicare payment for the codes/units entered in the gray box you would have received in 2017.
  o Note: This value reflects sequestration and MPPR.

Column N:
• This reflects the percentage difference between 2017 payments and 2018 payments.

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FAQs

1. **What is sequestration?**
   For the Medicare Fee-for-Service program, claims with dates of service or dates of discharge on or after April 1, 2013, will continue to incur a 2% reduction in Medicare payment until further notice. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

   The claims payment adjustment will continue to be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare secondary payer adjustments.

2. **What is the multiple procedure payment reduction (MPPR) policy?**
   Medicare applies a MPPR to the practice expense (PE) payment of select therapy services. The reduction applies to the codes contained on the list of always therapy services, regardless of the type of provider or supplier that furnishes the services. The MPPR is applied to the PE payment when more than 1 unit or procedure is provided to the same patient on the same day.

3. **How does the MPPR policy impact my payments?**
   Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures furnished to the same patient on the same day, full payment is made for work and malpractice and 50% payment is made for the PE for services submitted on either professional or institutional claims.

   To determine which services receive the MPPR, Medicare ranks the services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services.

   For additional information about MPPR, please see [APTA’s FAQs on MPPR](#).

   Please also see CMS’s [Internet Only Manual Publication 100-04, Medicare Claims Processing Manual, Chapter 5, Section 10.7](#).

4. **What are the always therapy codes?**
   Medicare recognizes the services furnished under the outpatient services benefit as either “always” or “sometimes therapy” and publishes this list as an Annual Update on the Therapy Services Billing [page](#). The files on this page contain the list of codes indicating whether they are sometimes or always therapy services.
5. **What are CPT codes?**
The Current Procedural Terminology (CPT) code set is a medical code set maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set is used to bill outpatient and office procedures. These codes are 5 digit codes.

CPT is identified by the Centers for Medicare and Medicaid Service as Level 1 of the Healthcare Common Procedure Coding system. New editions of the code set are released each October.

Physical therapists deliver more than 150 services, which are reflected by CPT codes, many of them beginning with 97... (frequently referred to as the 9700 series).

6. **Why do we need CPT codes?**
For a payer to deliver payment to the provider, the payer must know what skilled service was delivered. This communication is delivered via a claims form with the applicable CPT codes to reflect the services provided. While there are codes for skilled services, there are no CPT codes for equipment, such as a bicycle, for it is the competence/skill of the provider to recognize when equipment is used.

7. **How is a code developed?**
The American Medical Association/ Specialty Society RVS Update Committee (RUC) was formed in 1991 to make recommendations to CMS on the relative values to be assigned to new or revised codes in the Current Procedural Terminology (CPT) book.

The AMA CPT® Editorial Panel is responsible for maintaining the CPT code set. The panel is authorized by the AMA Board of Trustees to revise, update, or modify CPT codes, descriptors, rules and guidelines. The panel is composed of 17 members. The AMA CPT Editorial Panel is tasked with ensuring that CPT codes remain up to date and reflect the latest medical care provided to patients. In order to do this, the panel maintains an open process and *convenes meetings 3 times per year* to solicit the direct input of practicing physicians, medical device manufacturers, developers of the latest diagnostic tests and advisors from over 100 societies representing physicians and other qualified health care professionals.

Supporting the CPT Editorial Panel in its work is a larger body of CPT advisors, the CPT Advisory Committee. The members of this committee are primarily physicians nominated by the national medical specialty societies represented in the AMA House of Delegates. Currently, the advisory committee is limited to national medical specialty societies seated in the AMA House of Delegates and to the AMA Health Care Professionals Advisory Committee (HCPAC), organizations representing limited-license practitioners and other allied health professionals. APTA is a member of the HCPAC.

For more information, please listen to APTA’s Podcast: Coding & CPT: What’s This All About?
[http://www.apta.org/APTAMedia/Podcasts/files/reimbursement_003.mp3](http://www.apta.org/APTAMedia/Podcasts/files/reimbursement_003.mp3)

8. **How is a CPT code valued?**
The RUC process for developing relative value recommendations is as follows:

1. The CPT Editorial Panel’s new or revised codes and CMS and RUC-identified potentially misvalued services are transmitted to the RUC staff, who then prepare a “Level of Interest” form. This form summarizes the panel’s coding actions and specific CMS requests.
2. Members of the RUC Advisory Committee and specialty society staff review the summary and indicate their societies’ level of interest in developing a relative value recommendation. The societies have
several options: (1) they can survey their members to obtain data on the amount of work involved in a service and develop recommendations based on the survey results; (2) they can comment in writing on recommendations developed by other societies; (3) in the case of revised codes, they may decide that the coding change does not require action because it does not significantly alter the nature of the service; or (4) they may take no action because the codes are not used by physicians in their specialty.

3. AMA staff distributes survey instruments for the specialty societies. The survey data may be augmented by analysis of Medicare claims data and information from other studies of the procedure.

4. The specialty RVS committees conduct the surveys, review the results, and prepare their recommendations to the RUC. When two or more societies are involved in developing recommendations, the RUC encourages them to coordinate their survey procedures and develop a consensus recommendation. The written recommendations are disseminated to the RUC before the meeting and consist of physician work, time, and practice expense recommendations.

5. The specialty Advisors present the recommendations at the RUC meeting. The Advisory Committee members’ presentations are followed by a thorough question-and-answer period during which the Advisors must defend every aspect of their proposal(s).

6. The RUC may decide to adopt a specialty society’s recommendation, refer it back to the specialty society, or modify it before submitting it to CMS. Final recommendations to CMS must be adopted by a two-thirds majority of the RUC members. Recommendations that require additional evaluation by the RUC are referred to a Facilitation Committee.

7. The RUC’s recommendations are forwarded to CMS. CMS Medical Officers and Contractor Medical Directors review the RUC’s recommendations.

8. The Medicare Physician Payment Schedule, which includes CMS’s review of the RUC recommendations, is published in late fall on an annual basis.

For additional information: https://www.ama-assn.org/sites/default/files/media-browser/public/rbrvs/ruc-update-booklet_0.pdf

Please also refer to the APTA Podcast: How Codes are Valued for Medicare Payment.
http://www.apta.org/Podcast/2010/7/7/MedicareCodes/

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