

CMS Publishes Final 2012 Medicare Physician Fee Schedule

On November 1, 2011, the Center for Medicare and Medicaid Services (CMS) issued the 2012 Medicare Physician Fee Schedule (MPFS) Final Rule. Overall, neurosurgeons will face an estimated 1 percent pay cut in 2012 (without factoring in the possible 27.4 percent SGR-related cut). The rule also included a number of changes to various Medicare quality-related programs, including PQRS and e-prescribing. Most of the provisions take effect on January 1, 2012 and the complete fee schedule is available on the CMS website at: http://ofr.gov/OFRUpload/OFRData/2011-28597_PI.pdf

Below are some issues of interest to neurosurgeons:

Physician Reimbursement Provisions

Physician Payment Update

Absent Congressional intervention, CMS estimates that the CY 2012 conversion factor will be \$24.6712, which is 27.4% lower than the 2011 conversion factor of \$33.9764. However, over the past 11 years, which one exception, Congress has acted to avoid a negative update.

Resource Based Practice Expense

2012 is the third year of a 4-year transition to the Practice Expense (PE) Relative Value Units (RVUs) calculated using the AMA/Specialty Society Physician Practice Information Survey (PPIS) data. The estimated impact of PE Changes and Multiple Procedure Payment Reductions on neurosurgery is 0 percent and CMS accepted the AMA/Specialty Society Relative Value Update Committee (RUC) recommendations for office-based practice expense inputs for vertebroplasty CPT Codes 22523-22525.

Resource Based Professional Liability RVUs

For new and revised codes, CMS uses a cross-walk methodology to establish the PLI RVUs. In an effort to make the process of PLI RVU assignment more transparent, CMS recently started publishing the codes used for the cross-walk. The next Five Year Review of PLI RVUs will take place in 2015.

Potentially Misvalued Services—High Medicare Expenditure Codes

CMS reaffirmed its commitment to identify codes it considers “misvalued” according to so-called “screens.” In addition, the agency finalized its proposal to eliminate the Five Year Review of work, in favor of the rolling review of codes based on the screens. CMS added a new screen for 2012: “Highest Medicare Expenditure Codes.” These are codes which represent high Medicare expenditures for each specialty, even if not a high percentage of Medicare spending overall, and have not been re-valued since 2006. Neurosurgery codes in this category include:

- CPT Code 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique);*
- CPT Code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar; and*
- CPT Code 22851 *Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure.*

The AANS and CNS will provide the RUC with our “Action Plans” on these codes by December 12, 2011.

Evaluation and Management Codes

In its July 2011 MPFS Proposed Rule, CMS stated its belief that Evaluation and Management Services (E/M) have “evolved dramatically” for primary care specialties since the last RUC review in 2006 and proposed that 91 E/M codes be referred to the RUC to be resurveyed. The AANS and CNS, among

others, objected to this proposal, and as a result, CMS will not ask the RUC to revalue the 91 E/M codes at this time. CMS acknowledged that several on-going initiatives involving primary care such as the CMS Center for Innovation Comprehensive Primary Care Initiative, and care coordination demonstration projects are underway and should be assessed before a wholesale re-review of E/M services.

Site of Service Codes and Codes with "23-hour" Stays

Over the last three years, CMS has identified a number of codes which were originally valued as inpatient procedures that are now more typically done as outpatient procedures. For neurosurgery, these include mostly pain pump and stimulator implantation codes for which patients often stay overnight in the hospital---referred to as "23-hour" stay patients. CMS contends that value of E/M work for codes that fall into the 23-hour stay category should not reflect work that is typically associated with an inpatient service and CMS has upheld this policy in the 2012 physician fee schedule. All of the specialty societies represented at the RUC, including neurosurgery, disagree with CMS and believe the work of the visit is the same whether the facility has designated the bed as inpatient or outpatient. However, CMS continues to insist that the value of the E/M work for these codes be reduced

"Bundled" Codes

CMS continues to recommend that codes that are performed together more than 75 percent be "bundled" into new, all inclusive codes. The following changes for neurosurgical codes based on the bundling policy include:

- For cervical spine fusion, CPT Code 22551, Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2 – the new work value is 25.00 RVUs. This was a slight increase over the 2010 RUC-passed value of 24.50).
- For the new CPT Code 22663, Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and level, CMS accepted the RUC value of 27.75
- The new add-on Code 22634, Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and level; lumbar, each additional interspace and segment (List separately in addition to code for primary procedure), CMS accepted the new work value of 8.16.

Interim Values -- Refinement Panel Process

Values for new and revised codes published in the November notice are considered "interim" for one year to allow for public comment on the values. If CMS receives objections to the "interim" values, the agency uses a process called a "refinement panel" that will review the code values in August. CMS considers the refinement panel's comments and may change the value in the following year. Changes are not retroactive.

CMS had a greater number of requests for refinement in August 2011 because the agency accepted only about half of the RUC-passed values in the 2012 physician fee schedule proposed rule. In the final rule, CMS states that they will "more critically" evaluate requests for refinement and, presumably, not grant all requests. Specialties should specifically state a request that codes be referred to a refinement panel. In addition, CMS requests new supporting information, not previously presented at the RUC, as rationale for the objection to the CMS-proposed value

Neurosurgery requested refinement for 15 codes, the majority of which were identified by CMS as having a site of service change. Presenters at the August 2011 refinement panel were successful in making the case that Vertebroplasty and Kyphoplasty procedures, CPT Codes 22521, 22523, and 22524, were originally valued as outpatient procedures and should not be reduced. CMS accepted this and did not reduce the RUC-passed values of these codes. For the other 12 codes, despite refinement panel recommendations close to the RUC-passed values, CMS maintained their original, lower value (see chart below).

CPT code	Descriptor	RUC Rec Work RVU	CMS Original Rec Work RVU	Refinement Panel Rec Work RVU	CMS Final Rule Work RVU
22521	Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; lumbar	8.65	8.01	8.65	8.65
22523	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	9.26	8.62	9.04	9.04
22524	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar	8.86	8.22	8.54	8.54
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	11.56	10.92	11.56	10.92
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	6.44	6.05	6.44	6.05
62355	Removal of previously implanted intrathecal or epidural catheter	4.35	3.55	4.18	3.55
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump	5.65	5.00	5.48	5.00
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	6.10	5.60	5.95	5.60
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	4.65	3.93	4.40	3.93
63650	Percutaneous implantation of neurostimulator electrode array, epidural	7.20	7.15	7.18	7.15
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	6.05	5.19	5.78	5.19
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	11.56	10.92	11.56	10.92
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	11.19	9.00	11.40	9.00
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	15.00	11.00	15.00	11.00
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	13.00	9.10	13.00	9.10

Multiple Procedure Payment Reduction for advanced imaging

For 2012, CMS will finalize their proposal to apply a 50 percent discount to the professional component of subsequent MRI, CT, and ultrasound procedures. This is similar to the multiple procedure payment reduction policy that currently applies to the technical component of these procedures.

FOR MORE INFORMATION: For questions related to the physician reimbursement elements of the 2012 Medicare Physician Fee Schedule please contact:

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Quality Reporting Provisions

Physician Quality Reporting System (PQRS) Measures

For 2012, PQRS incentive payments will equal 0.5 percent of a physician's estimated Part B allowed charges for all services furnished during the applicable reporting period. CMS retains the 6-month reporting period option (July through December) for the reporting of PQRS measure groups via a registry, but specifies a 12-month reporting period (January through December) for all other reporting options, including claims-based reporting, registry reporting of individual measures, EHR-based reporting, and reporting via the Group Practice Reporting Option (or GPRO, defined as 25 or more eligible professionals who report as a group). The following tables summarize the reporting options for 2012:

Individual Measures Reported by Individuals (i.e., non-GPRO)

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting	At least 3 PQRI measures for 50% of applicable Medicare Part B FFS patients	January 1, 2011– December 31, 2011
Registry-based reporting	At least 3 PQRI measures for 80% of applicable Medicare Part B FFS patients	January 1, 2011 – December 31, 2011
EHR-based reporting	At least 3 PQRI measures for 80% of applicable Medicare Part B FFS patients	January 1, 2011 – December 31, 2011
EHR-based reporting	3 core measures (or up to 3 alternate core measures if none apply) and 3 of 38 alternate measures available under the Medicare EHR incentive program.	January 1, 2011 – December 31, 2011

Measure Groups Measures Reported by Individuals (i.e., non-GPRO)

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting	At least 1 PQRI measure group for at least 30 Medicare patients.	January 1, 2011– December 31, 2011
Claims-based reporting	At least 1 PQRI measure group for at least 50% of applicable Medicare patients (at least 15 patients)	January 1, 2011 – December 31, 2011
Registry-based reporting	At least 1 PQRI measure group for at least 30 Medicare patients.	January 1, 2011 – December 31, 2011
Registry-based reporting	At least 1 PQRI measure group for at least 80% of Medicare patients (at least 15 Medicare patients).	January 1, 2011 – December 31, 2011
Registry-based reporting	At least 1 PQRI measure group for at least 80% of Medicare patients (at least 8 Medicare patients)	July 1, 2011 – December 31, 2011

For 2012, CMS will add over 25 new PQRS measures, many of which are reportable via registry only. New individual measures that may be relevant to neurosurgery include:

- Hypertension: Blood pressure control
- Rate of carotid endarterectomy for asymptomatic patients, without major complications (discharged to home no later than post-operative day #2)
- Seizure Type(s) and Current Seizure Frequency(ies)
- Documentation of Etiology of Epilepsy or Epilepsy Syndrome
- Counseling for Women of Childbearing Potential with Epilepsy

CMS will retain all 14 PQRS measure groups (including Perioperative Care, Back Pain, and Ischemic Vascular Disease), and add 8 new groups, the following of which may apply to neurosurgery:

- Parkinson's:
 - Annual Parkinson's Disease Diagnosis Review
 - Psychiatric Disorders or Disturbances Assessment
 - Cognitive Impairment or Dysfunction Assessment
 - Querying about Sleep Disturbances
 - Parkinson's Disease Rehabilitative Therapy Options
 - Parkinson's Disease Medical and Surgical Treatment Options Reviewed
**Reportable through registries only; measures cannot be reported individually*

- Elevated blood pressure
 - Aspirin or Other Anti-Platelet or Anti-Coagulant Therapy
 - Complete Lipid Profile
 - Urine Protein Test
 - Annual Serum Creatinine Test
 - Diabetes Documentation or Screen Test
 - Counseling for Diet and Physical Activity
 - Blood Pressure Control
 - LDL Control
** Reportable through registries only; measures cannot be reported individually*

- Cardiovascular prevention
 - Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
 - Controlling High Blood Pressure
 - Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
 - Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention
 - IVD: Complete Lipid Profile and LDL Control < 100
 - Preventive Care and Screening: Blood Pressure Measurement

PQRS Registries

CMS retains its long list of requirements that registries must meet to submit PQRS measures data on behalf of physicians, including submission of an acceptable "validation strategy." CMS intends to post these requirements online by November 15, 2011. New registries will be required to self-nominate by January 31, 2012, and CMS plans to finalize the list of eligible 2012 PQRS registries by summer 2012.

HER Data Submission

The final rule also includes a list of requirements that EHR data submission vendors and EHR vendors must meet to submit 2012 PQRS quality measure data. CMS expects to list qualified EHR products by January 2012 and to list the vendors qualified to submit 2012 PQRS EHR measures on behalf of physicians by mid-2012.

Feedback Reports

CMS finalized its proposal to provide interim feedback reports to physicians who use the claims-based reporting option for 2012 and beyond. These reports will be a simplified version of annual feedback reports that CMS currently provides and will be based on claims for the first three months of each program year. The interim feedback reports will be provided to physicians during the summer of each program year. Certified PQRS registries and EHR vendors are also required to provide interim feedback reports, if technically feasible.

As in 2011, a professional may informally challenge a finding that they have failed to meet criteria for satisfactory PQRS reporting. However, CMS now has 90, rather than 60, days to respond to such requests. Review requests can be filed through CMS' newly launched Communications Support Page.

PQRS Penalties

Despite strong opposition from the physician community, CMS finalized its proposal to use 2013 as the reporting period for the 2015 PQRS penalty. Physician or group practices that do not satisfactorily report quality data for the 2013 reporting period will see their 2015 payments reduced by 1.5 percent. CMS felt

it was not operationally feasible to use a later calendar year and still avoid retroactive payments or the reprocessing of claims. However, CMS may consider a shorter reporting period (i.e., less than 12 months) for the 2015 payment adjustment in future rulemaking.

ACO Reporting

Accountable Care Organizations (ACO) participating under the Shared Savings Program will be responsible for reporting and submitting data on behalf of eligible professionals to CMS under the PQRS GPRO. Like other group practices participating in the PQRS, this data will be publicly reported on Physician Compare.

MOC Incentives

An additional 0.5 percent incentive payment is available for years 2011 through 2014 for physicians who participate in the PQRS program and also participate in a MOC program “more frequently than is required to qualify for or maintain board certification status.” CMS will allow each Specialty Board to determine what more frequent participation means for its particular MOC program, although it must include successful completion of at least 1 MOC practice assessment per year, including a survey of patient experience. The MOC program is responsible for reporting to CMS on physicians that have met the “more frequently” requirement. CMS is not, at this time, requesting the results of the patient experience surveys, but may do so for appropriate validation purposes and may do so routinely in future years. The various Boards also may submit MOC program data to the ABMS, which can then submit the information on behalf of the various boards and their member eligible professionals to CMS. MOC programs interested in participating in the 2012 PQRS MOC incentive payment must complete an online self-nomination process by January 31, 2012.

Electronic Prescribing Program

The current schedule for eRx incentives and penalties is as follows:

- Incentive payments for successful e-prescribers:
 - 1.0 percent for 2012;
 - 0.5 percent for 2013
- Penalties for those who do not e-prescribe:
 - 1.0 percent for 2012;
 - 1.5 percent for 2013; and
 - 2.0 percent for 2014

As in 2011, an individual physician is eligible for the incentive payment and subject to the penalty only if at least 10 percent of his or her Medicare Part B allowable charges originate from the CPT codes included in the eRx measure’s denominator (which consists of office-based follow-up visits and new patient encounter codes). Most neurosurgeons will meet this threshold. CMS finalized the following hardship exemptions from the 2013 and 2014 eRx penalties:

- Physicians practicing in a rural area with limited high speed internet access and for areas with limited available pharmacies for e-prescribing (exemption submitted through a G-code).
- Inability to eRx due to local, state or federal laws or regulations that limit or prevent e-prescribing, such as for narcotics (exemption request must be submitted via a web-based tool by June 30, 2012 for the 2013 penalty, and by June 30, 2013 for the 2014 penalty).
- Physicians who prescribe fewer than 100 prescriptions during a 6-month payment adjustment reporting period (exemption requests must be submitted via a web-based tool by June 30, 2012 for the 2013 penalty, and June 30, 2013 for the 2014 penalty).

The reporting options for individuals attempting to qualify for the eRx incentive and avoid the penalty are summarized in the tables below:

Criteria to Qualify for 2012 eRx Incentive (Individual Reporting)

Reporting Period	Reporting Mechanism	Criteria
Jan 1, 2012 – Dec 31, 2012	Claims	eRx for at least 25 unique denominator-eligible visits
Jan 1, 2012 – Dec 31, 2012	Registry	eRx for at least 25 unique denominator-eligible visits
Jan 1, 2012 – Dec 31, 2012	EHR	eRx for at least 25 unique denominator-eligible visits

Criteria to Qualify for 2013 eRx Incentive (Individual Reporting)

Reporting Period	Reporting Mechanism	Criteria
Jan 1, 2013 – Dec 31, 2013	Claims	eRx for at least 25 unique denominator-eligible visits
Jan 1, 2013 – Dec 31, 2013	Registry	eRx for at least 25 unique denominator-eligible visits
Jan 1, 2013 – Dec 31, 2013	EHR	eRx for at least 25 unique denominator-eligible visits

Criteria to Avoid 2013 eRx Penalty (Individual Reporting)

Reporting Period	Reporting Mechanism	Reporting Criteria
12-month (Jan 1, 2011-Dec 31, 2011)	Claims	eRx for at least 25 unique denominator-eligible visits
12-month (Jan 1, 2011-Dec 31, 2011)	Registry	eRx for at least 25 unique denominator-eligible visits
12-month (Jan 1, 2011-Dec 31, 2011)	HER	eRx for at least 25 unique denominator-eligible visits
6-month (Jan 1, 2012-Jun 30, 2012)	Claims	eRx at least 10 times (regardless of whether the encounter is associated with a denominator code)

Criteria to Avoid 2014 eRx Penalty (Individual Reporting)

Reporting Period	Reporting Mechanism	Reporting Criteria
12-month (Jan 1, 2012 - Dec 31, 2012)	Claims	eRx for at least 25 unique denominator-eligible visits (the same criteria as the 2013 eRx incentive)
12-month (Jan 1, 2012 - Dec 31, 2012)	Registry	eRx for at least 25 unique denominator-eligible visits (the same criteria as the 2013 eRx incentive)
12-month (Jan 1, 2012 - Dec 31, 2012)	EHR	eRx for at least 25 unique denominator-eligible visits (the same criteria as the 2013 eRx incentive)
6-month (Jan 1, 2013 - Jun 30, 2013)	Claims	eRx at least 10 times (regardless of whether the encounter is associated with a denominator code)

Medicare EHR Incentive Program

For the 2011 payment year, demonstration of meaningful use of certified EHR technology required, among other things, physician attestation that quality measure results were calculated by the EHR. For 2012 and subsequent payment years, CMS has determined that it is not feasible to report these measures electronically and that physicians may continue to report by attestation.

Physician Compare Website

CMS is developing the Physician Compare Web site in stages:

1. In 2011, the names of those professionals who satisfactorily participated in the 2009 PQRS were posted;
2. From 2011 through 2012, CMS will post the names of professionals who are successful e-prescribers under the 2009 eRx Incentive Program, as well as those who participate in the EHR Incentive Program; and

3. In 2013, CMS will publicly report group practice performance results (i.e., GPRO participants) based on 2012 PQRS data. Group practices must have a minimum sample size of 25 patients and must agree in advance to have their performance results publicly reported as part of their self-nomination to participate in the 2012 PQRS GPRO.

CMS will not make cost and claims data public; only quality data. Physician Compare will also include quality performance data reported by ACOs. In response to concerns about the accuracy of publicly reported data, CMS will work to ensure that information posted to the Physician Compare website is timely and correct.

Value-Based Payment Modifier

The Affordable Care Act (ACA) sets time frames for the development of a budget neutral value modifier that would apply to the payments of certain physicians starting in 2015, and to all physicians by 2017. As required by law, CMS included three items related to the establishment of the value modifier in the 2012 fee schedule: (1) quality and cost measures; (2) the dates for implementation of the value modifier; and (3) the initial performance period for application of the value modifier in 2015.

- **Quality measures:** CMS finalized a list of 44 measures taken from the PQRS and EHR Incentive Programs that represent highly prevalent, high-cost conditions, as well as preventive services. Several of these measures may be relevant to neurosurgery:
 - Ischemic Vascular Disease (IVD): Blood Pressure Management Control
 - IVD: Use of Aspirin or another Antithrombotic
 - IVD: Complete Lipid Profile and LDL Control < 100 mg/dl
 - Low Back Pain: Use of Imaging Studies

CMS does not intend to evaluate individual physicians on each measure, but rather assess physician performance using measures relevant to the care provided. As such, CMS anticipates adding measures for more conditions and specialties in subsequent years, particularly those that focus on outcome, patient experience and rates of potentially preventable hospital admissions. CMS will aim to ensure these measures remain consistent with the PQRS and EHR Incentive Program in future years.

- **Cost measures:** CMS finalizes its proposal to use a total per capita cost measure and per capita cost measures for beneficiaries with four conditions (COPD, heart failure, coronary artery disease and diabetes) for the value modifier. CMS plans to use the next several months to explore ways to develop an episode grouper, composites of cost and quality, and standardized risk adjustment and attribution methodologies that also could be used in the value modifier. CMS will hold listening sessions to gain public input into these issues and ensure transparency.

Despite strong objections, the initial performance period for the value payment modifier will be January 1, 2013 through December 31, 2013.

Physician Resource Use Feedback Program

In preparation for the value-based payment modifier, CMS has been providing feedback reports to select physicians and practice groups regarding relative resource use and quality of care provided to Medicare patients since 2009. For 2012, CMS will take steps to address issues recently identified by the GAO, including the use of methodological approaches that increase the number of physicians eligible to receive a report, such as multiple provider attribution methods and distributing feedback reports that include only resource use information if quality information is unavailable.

FOR MORE INFORMATION: For questions related to the quality provisions of the 2012 Medicare Physician Fee Schedule please contact:

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