American Association of Neurological Surgeons

Congress of Neurological Surgeons

Medicare Physician Fee Schedule Final Rule Summary

On Nov. 1, 2019, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) Medicare Physician Fee Schedule (MPFS) Final Rule. According to CMS, in CY 2020, overall payments to neurosurgery will not change. Below is a summary of key payment provisions, noting whether CMS agreed with the AANS/CNS comments submitted on Sept. 13, 2019. The CY 2020 provisions are final, but CMS will accept comments through Dec. 31, 2019, on the evaluation and management (E/M) office/outpatient visit code issues scheduled for implementation in CY 2021. More details are provided in a CMS factsheet and press release and below in the following sections:

Evaluation and Management Office/Outpatient Visit Valuation and Global Surgical Codes

CMS accepted the structure and AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) values for evaluation and management (E/M) office/outpatient visits. The new values, which go into effect in 2021, are as follows:

CPT Code	2019 Work RVU	2021 Work RVU
New Patient		
99201	0.48	N/A
99202	0.93	0.93
99203	1.42	1.60
99204	2.43	2.60
99205	3.17	3.50
Established Patient		
99211	0.18	0.18
99212	0.48	0.70
99213	0.97	1.30
99214	1.50	1.92
99215	2.11	2.80
Prolonged Services Add-on		
99XXX	NA	0.61

New Add-on Code

CMS will implement a new add-on code to the new E/M office visit codes, GPC1X, to capture the complexity of ongoing care to an established patient with a single, serious, or complex chronic condition. The AANS and the CNS had opposed this, as the rationale is unclear, the work associated

with the code is not well defined, and the estimated negative impact on specialists that do not report the code is excessive. CMS assumes that the code will be reported with 100 percent of E/M office/outpatient codes for the specialties most expected to use the code, including emergency medicine, family practice, internal medicine, general practice and 19 other subspecialties. CMS has asked the RUC to review the valuation of the code, and the RUC has indicated an intention to do so in January 2020.

Global Surgery Code Values

CMS failed to incorporate proportionate increases in the 10- and 90-day global surgical services to account for increased E/M office/outpatient visit work. The AANS and the CNS had urged CMS to reconsider this decision and to adjust the global codes, but in the final rule, CMS stated that it would not adopt changes to global surgery codes as the agency is continuing to evaluate the data provided as part of its global surgery data collection project.

CMS acknowledged several comments about the RAND reports on global surgical services, but reiterated its support for the basic conclusion that, "a small share of expected post-operative visits for procedures with 10-day global periods, and less than half of expected post-operative visits for procedures with 90-day global periods, appear to actually occur." The agency stated that RAND will issue a report later this year to address methodological concerns submitted by commenters on the proposed rule.

In refusing to increase the global surgery codes, CMS ignored the recommendations of organized medicine and members of the U.S. House and Senate.

CMS Valuation of Specific Codes

Regarding neurosurgery-specific codes, CMS took the following actions:

- The agency ***reduced*** the RUC-passed values for CPT code 22310, *Closed Treatment Vertebral Fracture*, from 3.89 work RVUs to 3.45.
- CMS ***reduced*** the RUC-passed work values for *Lumbar Puncture* codes as follows:
  - CPT codes 62270, *Spinal puncture, lumbar, diagnostic*, from 1.37 to 1.22;
  - 62328, *Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance*, from 1.95 to 1.73;
  - 62272, *Spinal puncture, lumbar, therapeutic*, from 1.35 to 1.22; and
  - 62329, *Spinal puncture, lumbar, therapeutic, with fluoroscopic or CT guidance*, from 2.25 to 2.03.
- CMS finalized work RVUs of 12.13 for CPT code 27279, *Arthrodesis Sacroiliac Joint, Percutaneous or Minimally Invasive*, rather than increase the value to match the 20.00 work RVUs for *Arthrodesis Sacroiliac Joint, Open* procedure, as some industry commenters had suggested. Neurosurgery did not support parity with the open code, and the agency proposed value is closer to the AANS and the CNS' recommendation of 11.00 RUVs.

Malpractice (MP) RVUs

In response to comments from the AANS, the CNS and others, CMS did not finalize its proposal to combine major and minor surgery premiums to create the surgery service risk groups or to re-define major and minor surgery. The AANS and the CNS had expressed concerns regarding the CMS proposal and noted significant resulting errors for neurosurgery. The AANS and the CNS strongly objected to the imputation of neurosurgery PLI premiums from neurology that resulted in glaring inaccuracies for neurosurgery. In the final rule, CMS acknowledged our concerns and noted a revision in the data based on the decision described above. Further details are included in the final contractor's report, which is included as supplementary information to the fee schedule.

While CMS has improved data collection for non-physician provider (NPP) groups, over the objection of the AANS and the CNS, for those NNP groups for which they do not have premium data, the agency will continue to crosswalk these NPP group to the lowest physician risk factor specialty — allergy and immunology — which grossly overstates the non-physician specialties' risk factors. As the percentage of non-physician providers billing Medicare for services increases, this distortion becomes increasingly problematic. Fortunately, CMS continues to accept the RUC specialty designation "overrides" for very low volume services to prevent significant variation in year-to-year MP RVUs.

Finally, CMS finalized its proposal to align the update of MP RVUs with the geographic practice cost index (GPCI) RVU updates and, therefore, will update MP RVUs every three years going forward.

Practice Expense (PE) Issues

CMS finalized its proposal to increase direct PE inputs for CPT code 22310, *Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing,* as the AANS/CNS comments supported. The agency disagreed with refinement recommendations from the AANS, the CNS and others regarding direct PE inputs for 11 of the 16 *Somatic Nerve Injection* and CMS finalized the reduction of clinical labor time for patient education from 3 to 2 minutes.

Impact Tables

Based on the changes in the final rule, the impacts on neurosurgical payments are estimated as follows:

2020 Impact on Total Allowed Charges by Specialty (from Table 119)

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Neurosurgery	$807	0%	0%	-1%	0

Finalized E/M Payment and Coding Policies (from Table 120)

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Neurosurgery	$802	-3%	-1%	-2%	-6%

E/M Payment and Coding Policies w/out Add-on Codes

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Neurosurgery	$802	-2%	0	-1%	-3%

Quality Payment Program: Merit-Based Incentive Payment System (MIPS)

CMS made several changes to the Quality Payment Program (QPP), making it more difficult for neurosurgeons to comply with the program. Click here for the final rule QPP Executive Summary and here for QPP final rule FAQs. Some changes in the final rule include:

- The overall MIPS **performance threshold**, which is the minimum number of points needed to avoid a penalty, increased from 30 points to 45 points. CMS also raised the exceptional performance threshold from 70 to 85 points. These changes will make it more challenging for

neurosurgeons to avoid a penalty and qualify for the exceptional performance bonus. The maximum penalty under MIPS increases from -7% to -9% in 2022 based on 2020 performance.

- The Quality category's **data completeness threshold** has increased, so clinicians will now have to report each quality measure for 70% of all applicable patients, rather than 60%.

- CMS removed the following two measures from the MIPS **Neurosurgical Specialty set** since they are considered duplicative of other measures:
  - #345: Rate of Asymptomatic Patients Undergoing Carotid Artery Stenting Who Are Stroke Free or Discharged Alive
  - #346: Rate of Asymptomatic Patients Undergoing Carotid Endarterectomy Who Are Stroke Free or Discharged Alive

- CMS added ten **new episode-based cost measures**, including a measure that evaluates costs related to "Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels," which was developed with input from the AANS and the CNS.

- Revised versions of the existing **Medicare Spending Per Beneficiary** (MSPB) and **Total Per Capita Cost measures**, which aim to improve attribution, were finalized. As requested by the AANS and the CNS, CMS opted not to increase the weight of the Cost category, as originally proposed, due to limited feedback on both new and existing cost measures.

- Making it more challenging for a group practice to comply with the **Improvements Activity** category, CMS will now require that at least 50% of the clinicians in the practice perform the same activity for the group to get credit. Currently, only a single clinician needs to participate in an activity for the group to get credit.

- CMS made it easier for group practices to meet the definition of "hospital-based" and to qualify for an automatic exemption from the **Promoting Interoperability** category reporting requirements. Instead of 100% of clinicians, more than 75% of the clinicians in a group must be "hospital-based" for the entire group to be excluded from this category.

- CMS finalized more stringent and impractical requirements for **Qualified Clinical Data Registries** (QCDR) over the next two years, which contributed to neurosurgery's decision to not offer a QCDR for 2020 (though the new American Spine Registry will serve as a QCDR).

- Finally, CMS is finalizing its MIPS **Value Pathways** (MVPs) participation framework that begins in the 2021 performance year. MVPs will move us away from siloed activities and measures toward a set of measures options that are more relevant to a clinician's scope of practice and more meaningful to patient care. The agency will begin to implement the MIPS Value Pathways (MVPs) framework gradually, beginning in the 2021 performance year. Over the coming months, CMS will continue to collaborate with stakeholders to create and implement the MVPs framework using an incremental approach. The AANS and the CNS registered concerns about the applicability of this program to specialties.

For More Information

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