CMS Publishes Final 2016 Medicare Payment Schedules

On Nov. 16, 2015, the Centers for Medicare & Medicaid Services (CMS) released two separate Medicare payment rules that will impact physician reimbursement and quality reporting in 2016. The first is the 2016 Medicare Physician Fee Schedule (MPFS) Final Rule, which updates payment policies, rates, and quality provisions for services furnished under the fee schedule on or after January 1, 2016. Overall, neurosurgical reimbursement under the MPFS is expected to ***decrease by about three-percent*** in 2016 due to changes in relative values and the Medicare sequester cuts. CMS also released its 2016 Hospital Outpatient Prospective Payment System and Ambulatory Surgery Center Final Rule, which updates Medicare payment policies and rates, as well as quality reporting mandates, for hospital outpatient department and ambulatory surgical center services.

Highlighted below are the key payment and quality issues of interest to neurosurgeons.

Physician Payment Provisions

Payment Update

CMS estimates a 2016 conversion factor of $35.8279. The reductions are primarily attributed to a change in methodology for malpractice relative value units, cuts related to so-called "misvalued" services spending and the budget sequester.

Professional Liability Insurance (PLI) Relative Value Units (RVUs)

For 2016, CMS finalized its new PLI methodology. The AANS and CNS expressed concern about the projected one-percent decrease in payments for neurosurgery due to these changes since the reported eight-percent decrease in neurosurgical malpractice premiums contained in the CMS contractor's data does not reflect the experience of our neurosurgeons. We further questioned the sample size used and the methods by which practicing neurosurgeons were identified for inclusion, and asked for great transparency going forward.

- **Proposed Annual Update of PLI RVUs.** CMS will now begin conducting annual PLI RVU updates to reflect changes in the mix of practitioners providing services, and to adjust PLI RVUs for risk. Under this approach, specialty-specific risk factors would continue to be updated every five years using updated premium data and would remain unchanged between the five-year reviews. However, in an effort to ensure that PLI RVUs are as current as possible, CMS would recalibrate all PLI RVUs on an annual basis to reflect the specialty mix based upon updated Medicare claims data. As the specialty with the highest professional liability insurance premiums, neurosurgery supported using the most current PLI premium information available.
- **PLI Determination for Low Volume Codes.** CMS agreed to continue to maintain code-specific overrides for codes for which claims data are inconsistent with the specialty that would reasonably be expected to furnish the services. In addition, in an effort to increase transparency, CMS has posted a public use file containing the overrides. The AANS and CNS agreed with the agency's decision to maintain code-specific "overrides" when the claims data are inconsistent with a specialty that could be reasonably expected to furnish the service and had asked that the agency publish the list of codes for which it has decided to "override" the dominant specialty in order allow stakeholders adequate opportunity for review and comment.

Misvalued Services

CMS implemented several policies regarding misvalued codes.

- **Validating RVUs of Potentially Misvalued Codes—High Expenditure Codes.** CMS agreed to remove ZZZ add-on codes from the high expenditure screen and not require a review at this time. The AANS and CNS had strongly opposed CMS' intention to revalue the ZZZ add-on codes, which included spine procedures reported with CPT codes 22614, 22840, 22842, and 22845.
- **Improving the Valuation and Coding of the Global Surgery Package.** CMS is required by law to evaluate the accuracy of the 10- and 90-day global surgery codes. The AANS and CNS strongly supported legislation to prevent CMS from eliminating the 10- and 90-day global periods and have asked CMS to work with the AMA/Specialty Society Relative Value Update Committee (RUC) and specialty societies to meet this requirement. CMS has agreed to wider stakeholder involvement as it conducts this review, and will convene open forums or "town hall" meetings as they develop a proposal for the 2017 fee schedule.
- **Elimination of the Refinement Process.** CMS reversed its proposed plan and agreed to preserve the refinement panel process. In addition, for 2017 and forward, CMS will publish virtually all of the next year's fee schedule values in the proposed fee schedule rule. This should eliminate the current situation, which can lead to a year of inappropriately reduced values. The AANS and CNS supported this policy.
- **Target for Relative Value Adjustment for Misvalued Services.** The agency finalized its plan to include not only codes captured by the "screens" for misvalued procedures, but also any associated family codes simultaneously pulled in for review in the calculation of savings resulting from the misvalued code review. In other words, CMS will credit the savings from "family" codes and screened codes. The AANS and CNS had agreed that savings from all codes valued as a result of the misvalued services screens should be credited toward the savings target.
- **Phase-in of significant RVU Reductions.** As required by law, CMS finalized its plan regarding a phase-in for codes experiencing a great than 20 percent reduction in value. CMS will phase in 19-percent of the reduction in the first year, and the remainder of the reduction in the second year. The AANS and CNS supported the requirement that significant reductions should be phased-in over a two-year period to allow physicians to plan for, and adjust to, these changes. However, we urged CMS to reconsider its proposal to adopt a 19 percent reduction as the maximum one-year reduction and to phase-in any remaining reduction in the second year of the phase-in period. Instead, we supported a 50 percent phase-in approach, whereby one-half of the reduction would be applied in each of the two years, making the "hit" lower in the first year.

Medicare Private Contracting/Opt-out

CMS is implementing a process making it easier for physicians to maintain their Medicare opt-out status. The AANS and CNS are long-time proponents of private contracting for Medicare patients and supported this provision allowing physicians to opt-out of Medicare without the requirement to file an affidavit every two years to remain in an opt-out status.

CMS Response to RUC-passed Values for New and Revised Codes

The following values have been assigned to new and revised codes:

- For the new **code 61645**, Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s), the RUC-passed work value of 17.00 was reduced to 15.00
- For the new **code 61650**, Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory, the RUC-passed work value of 12.00 was reduced to 10.00
- For the new **code 61651**, Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to the primary code), the RUC-passed work value of 5.50 was reduced to 4.25

The CMS rationale to reduce the RUC-recommended work relative values for the new codes is flawed. The AANS and CNS met with CMS staff on Dec. 4, 2015 and submitted additional comments objecting to these reductions. Additionally, we coordinated a multispecialty comment letter and will participate in a refinement panel sometime in March 2016.

Physician Quality Provisions

Overall, CMS opted to maintain most features of the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and Medicare's Physician Compare Website for 2016. Beginning in 2017, these programs will be consolidated into a new Merit-Based Incentive Payment System (MIPS). MIPS, which was authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), aims to streamline current physician quality reporting programs into a single system that will provide Medicare payment adjustments to physicians starting in 2019 based on 2017 reporting. Under the new MIPS system, CMS is authorized to adjust physician payments based on a composite performance score that takes into account quality and resource measurement, meaningful use of EHR, and participation in clinical practice improvement activities.

In 2016, prior to implementation of MIPS, neurosurgeons must continue to satisfy the criteria of existing quality mandates. Medicare payments at risk in 2018 as a result of these programs are highlighted below:

Program	Reporting Year	Payment Year	Medicare Payment at Risk
PQRS	2016	2018	-2.0%
Value Modifier	2016	2018	Up to -4.0%
EHR Incentive Program	2016	2018	-4.0%
TOTAL			**Up to 10%**

2016 Physician Quality Reporting System (PQRS)

Physicians who fail to satisfy PQRS reporting requirements in 2016 will be subject to a -2.0 percent Medicare payment adjustment in 2018, as well as additional penalties associated related to the VM, as discussed below.

- **PQRS Reporting Options.** CMS maintained all current options and requirements for individual-level reporting of quality measures in 2016 through claims, EHRs, qualified registries, and qualified clinical data registries (QCDRs). CMS made some minor changes to the options available to those electing to participate in the PQRS via the Group Practice Reporting Option (GPRO). Most notably, group practices will be allowed to report via QCDRs for the first time in 2016.

  QCDRs are a relatively new reporting mechanism by which physicians can avoid PQRS penalties by reporting on specialty society-developed measures not included in the traditional PQRS measure set via a clinical data registry. Despite organized neurosurgery's repeated requests for CMS to allow QCDRs to determine the most appropriate and statistically valid reporting samples, CMS will continue to require that EPs participating via QCDR report on 50 percent of all applicable patients (i.e., Medicare and non-Medicare) for each of the nine measures submitted to CMS. Neurosurgery's National Neurosurgery Quality and Outcomes Database (N^2QOD) was approved as a QCDR for 2015 and expects to be qualified again in 2016. Currently, the N^2QOD focuses only on spine care, but additional practice modules will be offered in the future.

- **PQRS Measures.** CMS added multiple measures to the traditional PQRS measure set for 2016. Listed below are some new measures that might apply to a neurosurgical practice. Neurosurgeons are encouraged to consult the complete list of PQRS measures available for 2016 to determine which measures are most appropriate for their practice:

  - Chronic Opioid Therapy (COT) Follow-up Evaluation [registry only]
  - Clinical Outcome Post-Endovascular Stroke Treatment [registry only]
  - Documentation of Signed Opioid Treatment Agreement [registry only]

- Door to Puncture Time for Endovascular Stroke Treatment [registry only]
- Evaluation or Interview for Risk of Opioid Misuse [registry only]
- Overuse Of Neuroimaging for Patients with Primary Headache And a Normal Neurological Examination [claims, registry]
- Imaging in Adult Emergency Department (ED) Patients with Minor Head Injury [claims, registry]
- Imaging in Pediatric ED Patients Aged 2 through 17 years with Minor Head Injury [claims, registry]
- Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy: [claims, registry]

Note, CMS retired certain measures for 2016 that neurosurgeons may previously have used, including:

- Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older
- Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge

Physician Value-Based Payment Modifier (VM)

The VM provides differential payments under the MPFS based on the quality and cost of care provided to Medicare patients. The VM is applied at the Taxpayer Identification Number (TIN) level and applies to all physicians and certain non-physicians billing under the TIN who are subject to the VM during the payment year. Similar to the PQRS, most VM policies will remain the same for 2016.

- **Payment Adjustments.** The VM will apply to all physicians and select non-physicians in 2018, based on 2016 quality and cost performance.
  - Maximum upward payment adjustments for the 2018 VM, based on 2016 quality/cost performance, are:
    - For groups with 10 or more EPs: +4.0 times the adjustment factor (to be determined after the conclusion of the performance period)
    - For groups with 2-9 EPs and solo practitioners: +2.0 times the adjustment factor
  - Maximum downward payment adjustments for the 2018 VM, based on 2016 quality/cost performance, are:
    - For groups with 10 or more EPs: -4.0 percent
    - For groups with 2-9 EPs and solo practitioners: -2.0 percent

  Failure to satisfy PQRS requirements will result in an automatic -4.0 percent penalty for groups with 10 or more eligible participants (EPs) and a -2.0 percent penalty for groups with 2-9 EPs and solo practitioners. These cuts will be applied ***in addition to*** the PQRS penalty.

- **VM Quality and Cost Measures.** Despite widespread ongoing concerns, CMS did not make any changes to the set of quality or cost measures used to calculate the VM. CMS did increase the minimum number of attributed episodes needed for the Medicare Spending Per Beneficiary (MSPB) measure to count towards a TIN's cost composite score from 20 to 125. Although the AANS and CNS requested an even higher threshold, it supports this change since it will minimize the inappropriate application of this flawed measure.

  CMS also finalized its proposal that a group or solo practitioner subject to the VM will automatically receive an "average" cost composite score if there is not at least one cost measure that meets the minimum number of cases required for inclusion in the calculation of the cost composite. The other cost measures used to calculate the VM have a minimum case requirement of 20 patients. CMS had previously adopted a similar policy for quality measures.

Physician Compare

Under the Affordable Care Act (ACA), CMS is required to make publicly available through its Physician Compare website information on physician performance that provides comparable information on quality and patient experience measures. As part of its phased approach to public reporting, CMS intends to make all individual and group practice PQRS measure data that meet certain minimum requirements available for public

reporting in late 2016. This would include QCDR data. However, QCDRs can choose whether to provide data directly to CMS for public reporting on Physician Compare or to publicly report data on their own website and allow CMS to provide links to that site via Physician Compare. Additional details include:

- ❖ CMS will only publicly report on measure data that meets the following minimum requirements: non-first year measures; measures that prove to be valid, reliable, and accurate; measures that resonate with consumers through field testing; and measures meet a minimum sample size of 20 patients. CMS maintained this sample size requirement despite requests to raise it.
- ❖ CMS will not provide a green checkmark on Physician Compare physician profile pages to identify professionals who received an upward payment adjustment as a result of the VM. However, CMS will include in a publicly accessible downloadable database the 2018 VM tiers for 2016 cost and quality performance, noting if a group practice or EP is high, low, or neutral on cost and quality performance. The database will also include a notation of the payment adjustment received based on the cost and quality tiers and an indication if the group practice or individual EP was eligible, but did not report quality measures to CMS.
- ❖ As mandated under MACRA, CMS will include utilization data in the Physician Compare downloadable database.
- ❖ CMS will publicly report a measure-level benchmark for group practice and individual PQRS measures using the ABC methodology.™ The benchmark will be based on the PQRS performance rates most recently available and stratified by reporting mechanism for both group practice and individual-level measures. CMS also intends to translate this benchmark into a 5-star physician rating system. QCDRs will continue to have the flexibility to develop their own benchmark methodology and submit their methodology and benchmark rates to Physician Compare for public reporting.

Hospital Outpatient/Ambulatory Surgery Center Payment Provisions

Spine Codes Removed from Medicare Inpatient Only List

CMS has removed four spine codes from the Medicare Inpatient Only List; however, it did not add these procedures to the Ambulatory Surgery Center (ASC) list. The codes are:

- CPT Code 20936, Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from the same incision;
- CPT Code 20937, Autograft for spine surgery only (includes harvesting the graft); morselized through separate skin or fascial incision);
- CPT Code 20938, Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision); and
- CPT Code 22552, Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace

Despite recommendations from the AANS and CNS, CMS will **not** add the following codes to the ASC list; keeping them on the Inpatient Only List:

- CPT Code 22840, Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure);
- CPT Code 22842, Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure); and
- CPT Code 22845, Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)

Short Inpatient Stays

CMS will modify its current "rare and unusual" exception policy for inpatient hospital stays for cases expected to last fewer than "two-midnights." CMS will allow for Medicare Part A payment on a case-by-case basis if the admitting physician confirms that an impatient stay is clinically necessary and documents patient-specific circumstances. The modification represents some additional flexibility, but AANS and CNS continue to oppose the two-midnight policy.

Stereotactic Radiosurgery

CMS will require the use of the HCPCS modifier J-1 when billing for services related to single session stereotactic radiosurgery (SRS), which will allow CMS to clearly identify the services that are included in the bundled facility payment.

Hospital Outpatient/Ambulatory Surgery Center Quality Provisions

Hospital Outpatient Quality Reporting (OQR) Program

Outpatient hospitals are subject to a two-percent reduction in their outpatient department payment for failure to meet requirements for the Hospital OQR Program. CMS finalized its decision to remove one measure from the program titled, OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache, since the measure does not align with the most updated clinical guidelines.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Ambulatory surgical centers are subject to a two-percent reduction in the ASC payment update for failure to successfully participate in the ASCQR Program. CMS did not propose to add any new measures to this program, leaving the 2018 ASCQR Program measure set — 12 measures (11 required and one voluntary). Several policy changes also were finalized to align the Hospital OQR Program with the ASCQR Program.

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More Information

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