



Preliminary Summary of the 2019 Medicare Physician Fee Schedule (PFS) Proposed Rule

On July 12, 2018, the Centers for Medicare and Medicaid Services (CMS) released the [Revisions to Payment Policies under Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements](#) proposed rule with comment period. This is the first year that CMS is combining the Medicare PFS and the Quality Payment Program proposed rules. CMS is requesting comments on the proposed rule by September 10, 2018, and a final rule is expected to be released in November. CMS has published several fact sheets on the rule including a [fact sheet on the PFS proposals for 2019](#). AANS/CNS expert volunteers and staff are continuing to review the rule and will draft responses to these proposals in the coming weeks. Below is a summary of some of the proposals included in the **payment provisions** of the draft regulation. The quality payment program summary will be separately available.



Physician Payment Update

The 2019 Medicare Physician Payment Schedule Conversion Factor is \$36.0463. The 2019 conversion factors reflect a statutory update of .25%, offset by a budget neutrality adjustment of -0.12 percent, resulting in a 0.13 percent update. Per the impact chart, overall, **neurosurgery will see a 1.0% increase in Medicare payments in 2019.**

Practice Expense Relative Values

- **Proposed Additional PE/HR Calculation for Evaluation and Management Services.** CMS determines the proportion of indirect PE allocated to a service by calculating a PE/Hour based upon the mix of specialties that bill for a service. Because such a broad range of specialties bill E/M services, CMS' proposal to change the structure of E/M visit into one single visit level and payment rate would have a large effect on the PE/Hour for many specialties. To address this issue CMS is proposing to create a single PE/Hour value for E/M visits of \$136.34, based on an average of the PE/HR across all specialties that bill E/M codes, weighted by the volume of those specialties' allowed charges for E/M services.
- **Codes with Duplicative "Visit Supply Packages".** CMS identified CPT codes reported with an office E/M code more than 50 percent of the time in the nonfacility setting for which the practice expense (PE) calculation has more "minimum multi-specialty visit packs" than corresponding post-operative visits included in the code's global period. Each "visit pack" includes items that would be typical for all specialties for an E/M: one patient gown, 7 feet of exam table paper, one pillow case, two pairs non-sterile gloves and one thermometer cover. If the number of visit packs exceeds the number of visits in the global period, CMS has concluded that either the inclusion of office E/M services was not accounted for in the code's global period when these codes were initially reviewed by the RUC PE Subcommittee, or that the RUC PE Subcommittee initially approved a minimum multi-specialty visit supply pack for these codes without considering the resulting overlap of supplies. The RUC regarded these overlapping supply packs as a duplication,

due to the fact that the quantity of the visit packs exceeded the number of postoperative visits, and requested that CMS adjust the number of visit packs accordingly.

Included on the list is CPT code 22310, Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing. The code has a neurosurgery Medicare volume of 9.59%. CMS has reduced the number of “visit packs” for that code from 2.5 to 1.5, to match the post-op visits in the global surgical period. In addition, for CPT Code 62252, Reprogramming of programmable cerebrospinal shunt, with a neurosurgery volume of 63.45%, CMS has reduced the number of visit supply packs from 1 to 0, as the code is an XXX code (for XXX, global surgical rules do not apply and the code may be reported on the same day as a surgical service).

Professional Liability Insurance (PLI) Relative Values

In CY 2017, CMS finalized the 8th geographic practice cost index (GPCI) review, which included updated malpractice (MP) premium data. In the CY 2018 MPFS they proposed to use the data to update malpractice RVUs. Under that proposal, neurosurgery was expected to see a negative 1% decrease and AANS, CNS, the American College of Surgeons and others urged CMS not to implement the proposal and provided comments on a number of flaws in CMS’ methodology. For the CY 2019 MPFS, CMS has not proposed changes but has stated that they are required by law to review, and if necessary, adjust the MP RVUs by CY 2020. They are soliciting feedback for the next MP RVU update on how the agency might improve the way that specialties in the state-level insurance rate data are crosswalked to CMS specialty codes which are used to develop the specialty-level risk factors and the MP RVUs. One of the concerns in the flawed CY 2018 proposal was that non-MD providers were crosswalked to the lowest level physician risk factor. Due to the growing percentage of non-MD providers billing Medicare, this overstatement of their risk factor has a significant impact. For 2019, neurosurgery, along with cardiothoracic surgery — specialties with high professional liability costs — are proposed to receive positive impacts to payments related to their insurance costs.

Global Surgery Data Collection

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to implement a process to collect data on postoperative visits and use these data to assess the accuracy of global surgical package valuation. Beginning July 1, 2017, CMS required groups with 10 or more practitioners in nine states to use the no-pay CPT code 99024 to report postoperative visits for specified procedures. Of practitioners that met the criteria for reporting, only 45 percent participated — this varied substantially by specialty. Among procedures performed by “robust reporters” of 99024, only 16 percent of 10-day global services and 87 percent of 90-day global services had one or more matched visits reported (volume-weighted).

- Neurosurgery had 614 practitioners eligible to report, and 512 (83%) neurosurgeons submitted one or more CPT code 99024 claims between July 1st, 2017 and December 31st.
- For 10-day global codes, neurosurgeons reported 99024 on 241 (21%) out of 1,148 services.
- For 90-day codes, neurosurgeons reported 990924 on 5,256 procedures (75%) out of 6,993 services provided.

The Agency is soliciting comments pertaining to increased compliance and also whether visits are typically being performed in the 10-day global period. Also, they are soliciting comment on whether they should mandate the usage of modifiers -54 “for surgical care only” and -55 “post-operative management only”, regardless of whether the transfer of care is formalized.

RUC Recommendations

CMS announced proposed work relative values for nearly 200 CPT codes reviewed by the AMA/Specialty Society RVS Update Committee. CMS proposed to accept 71 percent of the RUC recommendations and 81 percent of the RUC's Health Care Professional Advisory Committee recommendations for CPT 2019.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

CMS seeks to expand access to medical care using telecommunications technology by proposing to cover a number of new services. CMS asks for comment on the description, coverage and valuation of three new CMS created HCPCS codes including:

- brief, non-face-to-face appointments via communications technology (virtual check-ins);
- evaluation of patient submitted photos; and
- the foregoing codes bundled together for use by federally qualified health centers and rural health clinics.

In addition, CMS proposes to value new CPT codes for Interprofessional Internet Consultation (CPT codes 994X6, 994X0), while also proposing to unbundle and cover existing CPT codes (99446, 99447, 99448, and 99449).

Also, CMS proposes modifications to existing regulations required by the recent passage of the Bipartisan Budget Act of 2018 mandating expanded coverage of telehealth (two-way audio, visual real time communication between physician and patient). CMS proposes to expand coverage of telehealth services and modify or remove limitations relating to geography and patient setting for certain telehealth services, including:

- end-stage renal disease home dialysis evaluation;
- diagnosis, evaluation, and treatment of an acute stroke; and
- services furnished by certain practitioners in certain accountable care organizations.

To implement these requirements, CMS has proposed to create a new modifier that would be used to identify acute stroke telehealth services. The practitioner and, as appropriate, the originating site, would append this modifier when clinically appropriate to the HCPCS code when billing for an acute stroke telehealth service or an originating site facility fee, respectively. Practitioners would be responsible for assessing whether it would be clinically appropriate to use this modifier with codes from the Medicare telehealth list. By billing with this modifier, practitioners would be indicating that the codes billed were used to furnish telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke. CMS contends that the adoption of a service level modifier is the least administratively burdensome means of implementing this provision for practitioners, while also allowing CMS to easily track and analyze utilization of these services.

CMS also proposes to expand telehealth coverage for prolonged preventive services (but coverage would still be subject to statutory geographic and originating site restrictions).

Potentially Misvalued Service

CMS mentions in background information that they had agreed that CPT code 27279 sacroiliac joint fusion was potentially misvalued in 2017. However, this code was considered at the April 2018 RUC meeting and, therefore, will be discussed in the CY 2020 MPFS proposed rule, not in this CY 2019 MPFS proposed rule.

Evaluation and Management (E/M) Proposals for 2019

- **Documentation Changes for Office/Other Outpatient/Home Visits.** Physicians will be allowed to choose method of documentation, among the following options:
 1. 1995 or 1997 Evaluation and Management Guidelines for history, physical exam and medical decision making (current framework for documentation);
 2. Medical decision making only; or
 3. Physician time spent face-to-face with patients

CMS will only require documentation to support the medical necessity of the visit and to support a level 2 CPT visit code, although the agency assumes that some physicians will continue to document and report among the five levels of codes for other reasons (e.g., medical malpractice risk management, etc.)

In order to report an established office visit to Medicare, physicians need to document medical necessity and then one of the following:

1. Two of the three components: (1) problem-focused history that does not include a review of systems or a past, family or social history; (2) a limited examination of the affected body area or organ system; and (3) straightforward medical decision making measured by minimal problems, data review and risk; or
2. Straightforward medical decision making measured by minimal problems, data review and risk; or
3. Time personally spent by billing practitioner face-to-face with the patient. CMS is soliciting comment on what time should be required if this is the documentation selection (two options mentioned, 10 minutes (CPT defined typical time) or 16 minutes (weighted average of all established office visits).

CMS is seeking comment on other documentation systems (eg, Marshfield clinic). Comments are also sought on the impact of these proposals on clinical workflows and EHR systems. In addition, physicians will no longer be required to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated. CMS is seeking comment if this should be expanded to medical decision-making. CMS will eliminate re-entry of information regarding chief complaint and history that is already recorded by ancillary staff or the beneficiary. The practitioner must only document that they reviewed and verified the information.

- **Condensing Visit Payment Amounts.** CMS calls the system of 10 visits for new and established office visits “outdated” and proposes to retain the codes but simplify the payment for applying a single payment rate for level 2 through 5 office visits.

CPT Code New Office Visits	CY 2018 Non-Facility Payment Rate	CY 2019 Proposed Non-Facility Payment Rate
99201	\$45	\$44
99202	\$76	\$135
99203	\$110	
99204	\$167	
99205	\$211	

CPT Code Est. Office Visits	CY 2018 Non-Facility Payment Rate	CY 2019 Proposed Non-Facility Payment Rate
99211	\$22	\$24
99212	\$45	\$93
99213	\$74	
99214	\$109	
99215	\$148	

CMS asserts that this changes will have little net impact on neurosurgical payments, a finding confirmed by modeling done by the American Medical Association (AMA). Members of the AANS/CNS Coding and Reimbursement Committee are analyzing this shifts. While these changes only relate to the office visit codes, we are also carefully considering the implications for these changes for other E/M services, including those provided in the in-patient setting, as well as the potential for revaluing the 10- and 90-day global surgery codes.

CMS modifies the practice expense methodology to compute a PE RVU for the new blended E/M payment rate by blending the PE/Hour across all specialties that bill E/M codes, weighted by the volume of those specialties' allowed E/M services.

- **Other Coding/Payment Proposals Related to E/M.** CMS proposes to reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit. The policy is not consistent with current valuation of procedures commonly performed with office visits, as duplicative resources have already been removed from the underlying procedure. It appears that CMS proposes this policy to offset payment increases to dermatology and other specialties that often report lower level office visit codes in conjunction with minor procedures.
- **New Add-on Codes.** CMS will add \$5 to each office visit performed for primary care purposes (definition to be determined via comment process) via a new code GPC1X *Visit complexity inherent to evaluation and management associated with primary medical care services.*

CMS also identified several specialties that often report higher level office visits and noted the potential reduction in payment. To offset this loss, CMS proposes to add \$14 to each office visits performed by the specialties listed below via a new code GCG0X *Visit complexity inherent to evaluation and management associated with:*

- Allergy/Immunology
- Cardiology
- Endocrinology
- Hematology/Oncology
- Interventional Pain Management-Centered Care
- Neurology
- Obstetrics/Gynecology
- Otolaryngology
- Rheumatology
- Urology

- **New prolonged service code.** A new code will be implemented to add-on to any office visit lasting more than 30 minutes beyond the office visit (i.e., hour long visits in total). The code GPRO1 *Prolonged evaluation and management or psychotherapy services(s) (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)* will have a payment rate of \$67.

Example: A neurologist currently reporting a 99205 and spending more than 60 minutes with a patient would be paid \$211. Under the proposed new method, the neurologist would report 99202-99205, depending on their documentation selection, \$134 + GCG0X, \$14 + GPRO1, \$67, for a combined payment of \$215.

- **Implementation Date and Future Proposals.** The proposed implementation date is Jan. 1, 2019. CMS is seeking comment on whether the implementation should be delayed to Jan. 1, 2020. CMS will consider changes to Emergency Department Visits (CPT codes 99281-99285) and other E/M code sets in the future and seeks additional comment on these code families. In addition to implementation of a number of digital medicine/telehealth new payment opportunities, CMS calls for comments on additional codes and payment related to care coordination services.

Appropriate Use Criteria (AUC)

The AUC program requires ordering providers to consult with applicable AUC through a qualified clinical decision support mechanism for applicable imaging services. CMS previously delayed implementation of this program by including a voluntary reporting period, which started in July 2018 and runs through December 2019. In 2020, the AUC program period will begin with an educational and operations testing period, during which CMS will continue to pay claims whether or not they correctly include AUC information. Additionally, in this proposed rule, CMS proposes to:

- Expand the definition of an applicable setting to include independent diagnostic testing facilities;
- Create significant hardship exceptions from the AUC requirements that are specific to the AUC program and independent of other Medicare programs;
- Establish the coding methods, to include G-codes and modifiers, to report the required AUC information on Medicare claims; and
- Allow non-physicians, under the direction of an ordering professional, to consult with AUC when the consultation is not performed personally by the ordering professional.

CMS clarified that the AUC consultation information must be reported on all claims for an applicable imaging service (e.g., if separate, both the technical and professional claim must include the AUC information). CMS also invites comments on how to identify potential outliers that will be subject to prior authorization.

Teaching Physician Documentation Requirements for E/M Services

CMS proposes revising federal regulations by allowing the presence of the teaching physician during evaluation and management services to be demonstrated by the notes in the medical records made by a physician, resident, or nurse. CMS also proposes revising federal regulations to provide that the medical record must document the extent of the teaching physician's participation in the review and direction of services furnished to each beneficiary, and that the extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by a physician, resident, or nurse.

The proposed rule may be contrary to CMS guidance dated May 31, 2018, regarding [E/M Documentation Provided by Students](#). The May 2018 CMS guidance document allows teaching

physicians to use medical student documentation, including history, physical exam and/or medical student decision making provided that he/she personally performs or re-performs the physical exam and medical decision making of the evaluation and management service and verifies the student's documentation. CMS' proposed rule does not incorporate the policy outlined in the May 2018 CMS guidance document related to E/M documentation provided by students.

Neurosurgery-Specific Coding Changes

- Neurostimulator Services.** CMS has proposed to reduce the RUC-passed values for five neurostimulator programming codes. Although these codes are not typically reported by neurosurgeons, the AANS and CNS CPT and RUC advisors and **Joshua Rosenow, MD**, who was asked to participate as an expert on neurostimulator procedures, participated in the development of the codes to assure that other neurostimulator codes were not inappropriately and unnecessarily revised as part of the proposal. The codes were first identified for review in October of 2013 under the High Volume Growth screen. To justify the reductions, CMS objected to the reference codes selected by the RUC as rationale for their valuation and CMS proposed other codes as cross-walks. See from Table 13:

CPT Code	Descriptor	Current Work RVU	RUC-passed Work RVU	CMS Proposed Work RVU
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve neurostimulator pulse generator/transmitter, without programming.	0.45	0.45	0.35
95X83	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	New	0.95	0.73
95X84	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive	New	1.19	0.97

CPT Code	Descriptor	Current Work RVU	RUC-passed Work RVU	CMS Proposed Work RVU
	neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional			
95X85	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator /transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional	New	1.25	0.91
95X86	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional	New	1.00	0.80

Please direct any Questions, Comments, and Clarifications to:

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