



CMS Issues 2013 Medicare Physician Fee Schedule Proposed Rule

On July 6, 2013, the Centers for Medicare and Medicaid Services (CMS) issued the 2013 Medicare Physician Fee Schedule (MPFS) Proposed Rule. The official document will be published in the July 30, 2012 *Federal Register* and the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) will submit comments on several important aspects of this proposal. Following the comment period, the final fee schedule regulation will take effect on January 1, 2013. **Overall, neurosurgical reimbursement is expected to drop by 1 percent in 2013.** It should be noted, however, that this payment reduction **does not** include any cuts related to Medicare's sustainable growth rate (SGR) system. Absent Congressional action, SGR-related cuts are estimated to be 27 percent.

The proposal contains several provisions related to payment policies that are of interest to neurosurgery. In addition, the regulation proposes changes to several of the quality reporting initiatives that are associated with MPFS payments, including the Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, and Medicare's Physician Compare tool. Finally, the proposed rule includes recommendations for developing and implementing the physician value-based payment modifier, which is required by the Affordable Care Act (ACA). This new Value Modifier is "budget neutral" and will adjust payment rates to physicians based on the quality and cost of care they furnish to beneficiaries enrolled in traditional Medicare fee-for-service.

Highlighted below are the key payment and quality issues of interest to neurosurgeons. To review the entire proposed rule, visit the CMS website at: <http://go.cms.gov/MWzRq>.

PAYMENT POLICY PROVISIONS

Payment Update

Absent Congressional intervention, CMS estimates that the CY 2013 conversion factor will be \$24.7124, a 27 percent reduction from the 2012 conversion factor of \$34.0376. Since the inception of the SGR, however, Congress has, with one exception, acted to prevent any SGR payment cuts. The AANS and CNS therefore anticipate that Congress will yet again provide short-term relief to prevent these cuts.

Resource Based Practice Expense

- ❖ Calendar year 2013 is the first year when updated practice expense (PE) relative value units (RVUs) will be fully implemented. The new values are required by law and are calculated using the AMA/Specialty Society Physician Practice Information Survey (PPIS) data. Several years ago, the AANS and CNS participated in this data collection effort so the new values reflect neurosurgical practice expenses.
- ❖ One code -- spinal cord stimulation trial procedures (CPT 63650) -- requires valuation and CMS has requested recommendations from the AMA/Specialty Society Relative Value Update Committee (RUC). The AANS and CNS will review this service and make recommendations to the RUC at its October 2012 meeting.

- ❖ The estimated impact of PE changes for neurosurgery is zero.

Potentially Misvalued Services

- ❖ The ACA requires CMS to establish a formal process for validating the RUCs recommendations to ensure that services are appropriately valued under the MPFS. In response, CMS is planning to enter into a contract to “explore a model for the validation of physician work under the [physician fee schedule], both for new and existing services” and will reveal the details in a separate proposed rule later this year.
- ❖ Based on recent reports released by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) regarding the evaluation and management (E/M) care provided during the global surgical period, CMS believes that E/M work is overstated in the current global surgical services. CMS intends to gather more information on the valuation of E/M work in the global period for surgical procedures and is soliciting input on possible methods for a “claims-based data collection approach that would include reporting E/M services furnished as part of a global surgical package, as well as other valid, reliable, generalizable, and robust data to help identify the number and level of E/M services typically furnished in the global surgical period for specific procedures.”
- ❖ CMS has identified 16 “Harvard-valued Codes” (codes never reviewed by the RUC) with annual allowed charges of great than \$10 million. Only one code of interest to neurosurgery -- 64450 Injection, anesthetic agent; other peripheral nerve or branch – is under review. The code is rarely reported by neurosurgeons, however.
- ❖ CMS has identified 7 codes for which there is physician time in the CMS physician time file but no physician work. Included on the list is CPT code 22841 -- Internal spinal fixation by wiring of spinous processes – which is listed separately in addition to the primary procedure code. CMS proposes to remove the 5 minute physician time for this code and states there will be little or no impact on PE RVUs.

Expanding of Multiple Procedure Payment Reduction Policy

CMS proposes several expansions to its Multiple Procedure Payment Reduction (MPPR) policy including the application of the MPPR to the professional component of certain diagnostic imaging services when two or more physicians in the same group practice furnish services “to the same patient, in the same session, on the same day.”

Care Coordination for Post-Discharge Transition and Advance Primary Care Practices

- ❖ Beginning in CY 2013, CMS proposes to create and pay for a new “G Code” to describe “non-face-to-face work” performed by physicians for coordinating care for their patients who have returned to the community following a hospital stay (in-patient hospital, skilled nursing facility, outpatient observation, etc.). The code would be different from, and in addition to, current hospital discharge management codes typically reported by the physician who has treated patient while in the facility. CMS anticipates that the code would be reported by primary care physicians who already have a relationship with the patient. The creation and payment of the new code accounts for the projected one percent reduction in payment to neurosurgeons.
- ❖ CMS is also considering enhanced payment for primary care services furnished in an “advance primary care practice environment” (e.g., medical home). CMS has asked for recommendations regarding the process for establishing and verifying such practices and suggestions on the way in which the practices should be evaluated.

Certified Registered Nurse Anesthetists and Chronic Pain Management Services

Certified Registered Nurse Anesthetists (CRNAs) have been permitted to bill Medicare directly for certain services since 1989. In some states, CRNAs provide chronic pain management services that are separate from a surgical procedure and Medicare carriers differ as to whether these services fall under the “anesthesia services and related care” policy for which payment is permitted. CMS proposes to add the following language to its carrier manual: “Anesthesia and related care includes medical and surgical services that are related to anesthesia and that a CRNA is legally authorized to perform by the State in which the services are furnished.” The AANS and CNS are concerned that this language may pave the way for non-physicians to perform invasive pain management services outside the oversight of a supervising physician.

More Information: For questions regarding the physician payment sections of the proposed fee schedule rule, please contact Cathy Hill, AANS/CNS Senior Manager for Regulatory Affairs, at chill@neurosurgery.org.

QUALITY POLICY PROVISIONS

Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) is a pay-for-reporting program that uses a combination of incentive payments and downward payment adjustments to promote reporting of quality information by eligible professionals (EPs). For 2012-2014, bonus payments will be reduced from 1.0 to 0.5 percent. Physicians will have an opportunity to earn an additional 0.5% incentive through 2014 by participating in a qualified Maintenance of Certification (MOC) program. Beginning in 2015, a 1.5 percent payment cut will be levied on physicians who do not satisfactorily report data on quality measures for covered services. **Note that physicians must successfully participate in PQRS in 2013 to avoid payment adjustments in 2015.**

Proposed PQRS Measures

- ❖ For 2013 and 2014, CMS proposes to include a total of 264 individual measures that physicians can choose from for purposes of participating in the PQRS. In addition, CMS is proposing to include 26 measure groups for reporting. Table 30 of the rule lists 13 new PQRS individual measures for 2013 and several of these may be relevant to neurosurgery, including:
 - Stroke and Stroke Rehabilitation: Tissues Plasminogen Activator (t-PA) considered (Paired Measure)
 - Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Administration initiated (Paired Measure)
 - Participation by a Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality Measures (Must include at least 2 NQF approved measures)*

Table 31 in the proposed rule lists 14 measures used for 2012 PQRS that CMS proposes to retire for 2013 PQRS. Two retired measures of relevance to neurosurgery are:

- Stroke and Stroke Rehabilitation Computed (CT) or Magnetic Resonance Imaging (MRI) Reports
 - Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy
- ❖ The AANS and CNS intend to submit an application to CMS to seek approval for the National Neurosurgery Outcomes Database (N²QOD) to become a PQRS certified registry for 2013. In addition, neurosurgery is developing a neurosurgery-specific measure group for use in the PQRS program.

Individual Physician PQRS Measure Reporting

- ❖ In terms of reporting PQRS measures for the 2013 and 2014 PQRS incentive program, CMS is proposing criteria similar that which is in place for 2012.¹ The proposed rule does make some notable changes, however, including:
 - New criteria for PQRS reporting using the electronic health record-based reporting mechanism, which would better align the PQRS program with the clinical quality measure (CQM) component of meaningful use contained in Medicare's EHR Incentive Program.
 - Decrease the minimum threshold of patients on which physicians are required to report using measures groups via a registry from 30 to 20. In addition, the measure group can be reported on non-Medicare patients as long as the majority reported are for Medicare patients.
- ❖ In order to assist physicians with avoiding the payment cuts in 2015 and 2016, CMS has proposed allowing physicians to report one PQRS measure or measures group during the payment adjustment period. For 2015, the payment adjustment period is Jan. 1-Dec. 31, 2013 and for 2016 it is Jan. 1-Dec. 31, 2014. ***Note this is a significantly lower bar than the current incentive program so it only applies to avoiding the payment adjustment and not the PQRS incentive.***
- ❖ Physicians may elect to use the proposed administrative claims-based reporting option for proposed set of administrative claims-based measures. CMS has not been clear on how they will calculate the claims based reporting option which will determine whether it is a feasible alternative option for neurosurgery.

Group Practice PQRS Measure Reporting

Physicians can also report PQRS measures as a group practice under the Group Practice Reporting Option (GPRO).

- ❖ CMS is proposing to expand the definition of group practice to include groups of 2-24 eligible professionals.
- ❖ In terms of reporting PQRS measures for groups, CMS will have two group reporting options depending on practice size:
 - CMS is proposing to expand the use of the claims, registry, and EHR-based reporting mechanisms to groups of 2-99 EPs.
 - CMS is maintaining the Group Practice Reporting Option (GPRO) for groups of 25 or more eligible professionals. Practices participating in GPRO will report PQRS measures through the GPRO web-interface. In addition, practices participating in GPRO only have the option of reporting PQRS GPRO measures, which is a defined set of PQRS measures.
- ❖ With regard to PQRS reporting for 2015 and 2016, CMS is proposing to allow group practices to elect to use the proposed administrative claims-based reporting option.
- ❖ For physicians participating in a Medicare Shared Savings Program (e.g., accountable care organization), CMS is proposing to align quality measure reporting for purposes of avoiding the 2015 PQRS pay cut. On behalf of its physicians, an ACO must report on all measures included in GPRO, which is consistent with the quality measures ACOs must report on.

¹ PQRS criteria for 2012 is available on CMS' website at: www.cms.gov/pqrs

Electronic Prescribing Incentive Program

The requirements for the 2013 eRx incentive and 2014 eRx payment adjustment were established in the CY 2012 MPFS final rule.² For 2013, CMS is proposing the following:

- ❖ Two additional significant hardship exemptions for physicians participating in the EHR Incentive Program, including:
 - Eligible Professionals or Group Practices Who Achieve Meaningful Use During Certain 2013 and 2014 eRx Payment Adjustment Reporting Periods
 - Eligible Professionals or Group Practices Who Demonstrate Intent to Participate in the EHR Incentive Program and Adoption of Certified EHR Technology
- ❖ An informal review process. In cases where the eligible professional or group practice did successfully report for the 2013 incentive, CMS will provide the appropriate incentive payment. When the EP or group practice meets the criteria for being a successful electronic prescriber for purposes of the 2014 payment adjustment, CMS would stop application of the 2014 pay cut and reprocess all claims that had been adjusted.

Physician Compare Website

The proposed rule outlines the next phase of the plan to publicly report physician performance information on Physician Compare.³ Starting with measures submitted in 2013, CMS proposes to post quality measure performance rates submitted by group practices participating in the PQRS GPRO and ACOs participating under the Medicare Shared Saving Program. In addition, when feasible, but no earlier than 2014, CMS proposes to report composite measures that reflect group performance across several related areas. The next step will likely involve publicly reporting performance rates on quality measures included in the 2015 PQRS and value based payment modifier for individual physicians.

Value Based Payment Modifier

As noted above, the ACA requires the Secretary of HHS to establish a value-based payment modifier. This new Value Modifier is “budget neutral” and will adjust payment rates to physicians based on the quality and cost of care they furnish to beneficiaries enrolled in traditional Medicare fee-for-service. Initially, the payment adjustment will range from a low of -1.5 percent to a high of +2 percent. Under the law, the Value Modifier will go into effect on Jan. 1, 2015, although initially it will only apply to groups of 25 or more eligible professionals. The Value Modifier will apply to all physicians treating Medicare patients by Jan. 1, 2017.

- ❖ Physician groups subject to the modifier can avoid all negative adjustments simply by participating in PQRS. In this case, physicians will receive neither a value-bonus nor pay cut under this new program. Physicians can, however, elect to be paid according to the measured cost and quality of services provided in 2013 and 2014. Any payment adjustment will be applied to 2015 and 2016 Medicare payments, respectively.
- ❖ In the first phase of implementation, CMS is proposing that groups of physicians with 25 or more eligible professionals would be included in the Value Modifier framework. These groups would have options, depending upon whether they satisfactorily report under the PQRS, regarding how their Value Modifier would be calculated for CY 2015 payment. For more detailed information on calculation and payment adjustment, see CMS Fact Sheet on Value-based Payment Modifier: <http://go.cms.gov/Mkfprc>.

² Requirements for the current e-Rx incentive program are available on CMS' website at: <http://go.cms.gov/Ns2y6c>

³ To review your information, neurosurgeons can visit the Physicians Compare website at: <http://1.usa.gov/cO8F7V>.

Physician Feedback Reports

Since 2010, CMS has provided confidential Physician Feedback reports to certain physicians and groups of physicians. The reports quantify and compare the quality of care furnished and costs among physicians and physician group practices, relative to the performance of their peers. Starting in 2013, CMS anticipates using these reports to inform groups of physicians about their Value Modifier score. In March 2012, CMS disseminated feedback reports to individual Medicare fee-for-service physicians in Iowa, Kansas, Missouri, and Nebraska. The individual physician reports, in summary, showed that approximately 20 percent of beneficiaries received care from multiple physicians. When beneficiaries received care from multiple physicians there was not one physician solely directing the care of each patient. These beneficiaries were also the highest cost and risk.

CMS intends to include episode-based cost measures for several conditions in the Physician Feedback reports. CMS is studying how “episode groupers” -- which connect all claims for a beneficiary during a certain timeframe -- may be used in the reports and will seek input from stakeholders on the development and use of episode groupers before phasing these measures into the Value Modifier. While it is too soon to tell, it appears that the only episode grouper measures applicable to neurosurgical care may be for imaging and stroke. More information on this will be forthcoming to AANS and CNS measures once CMS makes final decisions.

More Information: For questions regarding the quality sections of the proposed fee schedule rule, please contact Koryn Rubin, AANS/CNS Senior Manager for Quality Improvement at krubin@neurosurgery.org.

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