

2014 Medicare Physician Fee Schedule Proposed Rule Reimbursement Provisions

The 2014 Medicare Physician Fee Schedule (MPFS) Notice of Proposed Rulemaking (NPRM) was published in the *Federal Register* on July 19, 2013. Most policies are open to comment until September 6, 2013 and scheduled to take effect on January 1, 2014. Total payments under the 2014 MPFS will be approximately \$87 billion. ***The overall impact of the changes for neurosurgery, not taking into consideration a change in the conversion factor, is predicted to be a 1 percent increase.*** The MPFS Proposed Rule is available at: <http://1.usa.gov/17FW9KW>. Below are some payment issues of interest to neurosurgeons:

Payment Update

In March 2013, CMS estimated that the statutory formula used to determine the MPFS Conversion Factor (CF) would result in a CY 2014 CF of \$25.7109, which represents a change of -24.4 percent from the 2013 conversion factor of \$34.0320. However, over the past 12 years, with one exception, Congress has acted to avoid a negative update.

Resource Based Practice Expenses

CY 2014 is the second year of full implementation of Practice Expense (PE) Relative Value Units (RVUs) calculated using the AMA/Specialty Society Physician Practice Information Survey (PPIS) data, with a few exceptions required by statute or due to data limitations. ***The estimated impact of PE changes for neurosurgery in CY 2014 is -1.0 percent.***

- **Direct inputs for Stereotactic Radiosurgery (SRS).** Since 2001, Medicare has used HCPCS G-codes, in addition to the CPT codes, for stereotactic radiosurgery (SRS) to distinguish robotic and non-robotic methods of delivery. CMS has determined that most services currently furnished with linac-based SRS technology, including services currently billed using the non-robotic codes, incorporate some type of robotic feature. Therefore, CMS believes that it is no longer necessary to continue to distinguish robotic versus non-robotic linac-based SRS through the HCPCS G-codes. For purposes of the hospital outpatient prospective payment system (OPPS), CMS is proposing to replace the existing four SRS HCPCS G-codes G0173 (Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session), G0251 (Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment), G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment), and G0340 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment), with the SRS CPT codes 77372 (Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based) and 77373 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions) that do not distinguish between robotic and non-robotic methods of delivery.

Two of the four current SRS G-codes are paid in the nonfacility setting through the MPFS. These two codes, G0339 and G0340, describe robotic SRS treatment delivery and are contractor-priced. CPT codes 77372 and 77373, which describe SRS treatment delivery without regard to the method of delivery, are currently paid in the nonfacility setting based on resource-based RVUs developed through the standard PE methodology. If the CY 2014 OPPS proposal is implemented, it would appear that there would no longer be a need for G-codes to describe robotic SRS treatment and delivery. Prior to eliminating the contractor-priced G-codes and using the existing CPT code for PFS payment of services previously reported using G-codes, CMS asserts that it

would be appropriate to ensure that the direct PE inputs used to develop PE RVUs for CPT codes 77372 and 77373 accurately reflect the typical resources used in furnishing the services that would be reported in the non-facility setting in the absence of the robotic G-codes. Therefore, for CY 2014, we are not proposing to replace the contractor-priced G-codes for MPFS payment. CMS is seeking comment from the public and stakeholders, including the RUC, regarding whether or not the direct PE inputs for CPT codes 77372 and 77373 would continue to accurately estimate the resources used in furnishing typical SRS delivery were there no coding distinction between robotic and non-robotic methods of delivery.

- Non-facility PE Payment.** CMS is proposing to limit the nonfacility (office) PE RVUs for individual codes so that the total nonfacility MPFS payment amount would not exceed the total combined amount Medicare would pay for the same code in the facility setting. That is, if the nonfacility (office) PE RVUs for a code would result in a higher payment than the corresponding Medicare Hospital Outpatient Prospective Payment System (OPPS) or Ambulatory Surgery Center payment rate and MPFS facility PE RVUs (when applicable) for the same code, CMS would reduce the nonfacility (office) PE RVU rate so that the total nonfacility (office) payment does not exceed the total Medicare payment made for the service in the facility setting.
- Collection of Data on Services Furnished in Off-Campus Hospital Provider Based Departments.** CMS seeks to understand the impact on the MPFS and on beneficiaries of the trend for hospitals to acquire physician practices. They have considered asking hospitals to break out the cost and charges for their provider-based departments in their Medicare hospital cost report. CMS is asking for public comment on the best way to collect information on the frequency, type, and payment for services furnished in off-campus provider-based departments of hospitals.
- 2014 Pre-service Clinical Labor time reductions.** CMS accepted the RUC recommendation to reduce pre-service clinical labor time for 48 codes with a 000 day global period. The codes were Harvard valued coded that had not been previously reviewed by the RUC. In general, the RUC has recommended that codes with 000 day global period include a maximum of 30 minutes of clinical labor time in the pre-service period in the facility setting. The new, reduced, clinical labor time will be used in the calculation of CY 2014 direct PE for these codes. Procedure of interest to neurosurgery are listed below:

2014 Pre-service Clinical Labor reductions

CPT Code	Short Descriptor	Current CL Pre-Service Minutes	Proposed CL Pre-service Minutes (RUC Recommendations)	2012 Medicare Percent of code Volume Performed by NS	Medicare Volume 2012
61000	Remove cranial cavity fluid	60	15	30%	10
61001	Remove cranial cavity fluid	60	15	100%	1
61020	Remove cranial cavity fluid	60	15	41.05%	475
61026	Injection into brain canal	60	15	15.91%	679
61050	Remove brain canal fluid	60	15	4.07%	123
61055	Injection into brain canal	60	15	17.40%	707
61070	Brain canal shunt procedure	60	15	26.29%	4397
62268	Drain spinal cord cyst	36	30	5.88%	187

Resource Based Professional Liability RVUs

For CY 2014, CMS will continue to use its current “cross-walk” approach for determining RVUs for professional liability. CMS will publish a list of new and revised codes and the crosswalks used in determining their PLI RVUs in the 2014 MPFS Final Rule expected on or before November 1, 2013. These values will be considered interim and subject to public comment. The next Five Year Review of PLI RVUs will take place in 2015.

Potentially Misvalued Services

- **CMS Studies on RVU Validation.** In response to a requirement in the Affordable Care Act (ACA) for formal validation of RVUs, CMS has entered into two contracts with outside entities to develop validation models for RVUs. During a 2-year project, the RAND Corporation will use available data to build a validation model to predict work RVUs and the individual components of work RVUs, time and intensity. The RAND study will focus on the statistical methodologies and approach used to develop the initial work RVUs and to identify potentially misvalued procedures under current CMS and AMA RUC processes. RAND will use a representative set of CMS-provided codes to test the model and will consult with a technical expert panel.

The second CMS contract is with the Urban Institute. This project will focus on data from several practices for services selected by the contractor in order to develop time estimates. CMS states that “objective time estimates” will be compared to the current time values used in the MPFS. The project team will then convene groups of physicians from a range of specialties to review the new time data and their potential implications for work and the ratio of work to time.

- **HHS ASPE Contracts.** In addition to the CMS studies described above, the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services (HHS) has contracted a completely separate study to survey 5 specialties (radiology, cardiology, orthopaedic surgery, ophthalmology and family medicine) to measure physician time for 25 services. The services do not include procedures typically performed by neurosurgeons. These data will then be compared to current time in the MPFS. The contract awards \$493,626 to Social and Scientific Systems and the Urban Institute to survey time only for this small number of codes and does not appear to be coordinated with the CMS studies described above.
- **CMD Review.** CPT Code 22035, *Closed treatment of vertebral process fracture(s)*, is included on the list of codes identified by Medicare Carrier Medical Directors (CMDs) for review. CMS doubts that a 90-day global surgical package is appropriate for the procedure that is performed in settings other than the inpatient setting 33 percent of the time.
- **Global Surgical Package Post-Operative Work.** In the CY 2013 NPRM, CMS sought comments on methods of obtaining accurate data on Evaluation and Management (E/M) services in the global surgical package. The RUC commented that the physician time shown in a chart the FY 2013 NPRM had incorrectly reported the time for visits in the global period for 117 codes. In the CY 2014 NPRM, CMS agreed with the RUC and has changed their records to reflect the correct physician time.

Expanding of Multiple Procedure Payment Reduction Policy

CMS has not proposed changes to the Multiple Procedure Payment Reduction (MPPR) policy for 2014. However, CMS states that they are continuing to consider expanding the MPPR based on efficiencies when multiple procedures are furnished together.

Geographic Practice Cost Indices (GPCIs)

The current 1.0 “floor” for the work Geographic Practice Cost Indices (GPCI) will expire on December 31, 2013. CMS has reviewed several reports issued by the Institute of Medicine (IOM) regarding the GPCIs. CMS is proposing new GPCIs using updated data and changing the weights assigned to

each GPCI (work, PE and malpractice) consistent with the recommendations of the Medicare Economic Index (MEI) Technical Advisor Panel (see below) to increase the weight of work and reduce the weight of practice expense in the GPCI formula. These new GPICs would be phased in over CY 2014 and CY 2015. The proposed GPICs reflect the elimination of the work “floor” and as a result 51 localities will have a work GPCI below 1.

Medicare Economic Index (MEI)

CMS is proposing revisions to the calculation of the MEI, which is the price index used to update physician payments for inflation. The changes are in response to recommendations by a Technical Advisory Panel that met during CY 2012. Application of the MEI along with the SGR determines the total amount of payment made each year under the MPFS. The NPRM includes proposed changes in the RVU and GPCI weights assigned to work and practice expense so that the weights in the payment calculation would continue to mirror those in the MEI if the proposed MEI revisions are adopted. The proposal would re-distribute some payment to work from practice expense.

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

Currently, Medicare only pays for primary care management services as part of a face-to-face visit. In the 2014 proposed rule, CMS proposes separate payment for complex chronic care management services beginning in 2015. In the 2014 MPFS NPRM, CMS proposes to pay for non-face-to-face complex chronic care management services for Medicare beneficiaries who have multiple, significant chronic conditions (two or more). Complex chronic care management services include regular physician development and revision of a plan of care, communication with other treating health professionals, and medication management. Medicare will make separate payment to physicians through two G-codes for establishing of a plan of care and furnishing care management over 90-day periods. To be eligible for these services, CMS proposes that beneficiaries also must have had an Annual Wellness Visit (or an Initial Preventive Physical Examination, if applicable) to establish a plan of care. CMS also propose that a single practitioner furnish these services and that they must have the beneficiary’s consent to receiving these services over a one-year period.

Medicare Coverage of Items and Services in FDA Investigational Device Exemption (IDE) Clinical Studies -- Revision of Medicare Coverage

Currently Medicare covers the cost of routine services for devices that are described as experimental/investigational devices but not devices (Category A) used in an IDE study and for routine services and for devices described as nonexperimental/investigational devices (Category B). Determinations of which IDE are eligible for Medicare payment has been made at the local carrier level. CMS is proposing that the decision be made at CMS centrally to prevent different practices or duplicative practices from contractor to contractor. They are specifically requesting public comment on the proposal to have a centralized, national, single entity making the IDE coverage decision. For IDE studies to qualify, they would have to meet a series of conditions including addressing use in the Medicare-aged population, timing of public release of data, and registering the trial on ClinicalTrials.gov.

2014 Medicare Hospital Outpatient Prospective Payment System/Ambulatory Surgery Center Proposed Rule

On July 19, 2013, CMS also published the Calendar Year (CY) 2014 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates Notice of Proposed Rulemaking (NPRM) in the *Federal Register*. CMS anticipates that payments under the OPPS, including beneficiary cost-sharing, will be approximately

\$50.4 billion for CY 2014 (an increase of 9.5 percent over CY 2013). Similarly, CMS anticipates total payments to ASCs, including beneficiary cost-sharing, for CY 2014 will be approximately \$3.98 billion (an increase of 3.51 percent over CY 2013). A copy of the NPRM is available at: <http://1.usa.gov/1bRnmX>. Comments are due on September 6, 2013.

ASC Provisions

- **ASC Conversion Factor.** For CY 2014 CMS proposes to adjust the CY 2013 ASC conversion factor (\$42.917) by the wage adjustment for budget neutrality of 1.0004 in addition to update factor of 0.9 percent, which results in a proposed CY 2014 ASC conversion factor of \$43.321 for ASCs meeting the quality reporting requirements.
- **Bundling of Services.** In addition, CMS is proposing that certain ancillary or adjunctive services that would be packaged under the OPSS for CY 2014 also would be packaged under the ASC payment system for CY 2014. Payments to ASCs that fail to meet ASC Quality Reporting Program requirements would be reduced by two percent.

Proposed Changes to the OPSS

- **Bundling of Services.** CMS proposes to expand the categories of interrelated items and services that are bundled into a single payment by adding an additional 7 categories. The list of OPSS packaged items and services will expand to include: 1. Drugs, biological and radiopharmaceuticals that function as supplies in a diagnostic test or procedure; 2. Drugs and biologicals that function as supplies or devices in a surgical procedure; 3. Laboratory tests; 4. procedures described by add-on codes; 5. Ancillary services (status indicator "X"); 6. Diagnostic tests on the bypass list; and 7. Device removal procedures.
- **Establishing Comprehensive APCs.** CMS proposes to create 29 comprehensive APCs relating to costly device-dependent services. The comprehensive APCs will treat all individually reported codes as representing components of the comprehensive services, resulting in a single prospective payment. Currently, in certain instances CMS provides more than one APC payment if more than one procedure is performed in the outpatient hospital setting. For example, if a lead and neurostimulator are placed during the same operative session, in the past more than one APC payment may have been paid. However, for CY 2014, CMS is proposing to establish "comprehensive APCs" for certain services, which provide only a single payment to the hospital based on the cost of all individually reported codes that represent the delivery of a primary service as well as all adjunct services provided to support that delivery.
- **Single Level of Payment for Outpatient Visits.** CMS proposes to replace the current five levels of outpatient visit codes with a single HCPCS code for each unique type of hospital visit. Thus, there would be a single HCPCS code based on the mean total costs of Level 1 through Level 5 visit codes – one for clinic visits and one for each type of emergency department visit (24 hour and non-24 hour).
- **Stereotactic Radiosurgery (SRS) Services (APCs 0066 and 0067).** Since 2001, CMS has distinguished the various methods of delivery of stereotactic radiosurgery (SRS) with HCPCS G-codes. SRS includes two different radiation source types, Cobalt-60 and linear accelerator (linac). Among the linac-based SRS devices, the HCPCS G-codes distinguish between robotic and nonrobotic. In 2007 new CPT codes were established for SRS, and at that time, CMS recognized one of the three new CPT codes for SRS for separate payment under the OPSS, but did not replace all of the HCPCS G-codes for SRS with the new CPT codes because they believed that the distinctions reflected in the HCPCS G-codes should be maintained for APC assignment purposes. Specifically, in 2007 CMS replaced HCPCS code G0243 (Multisource photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions) with CPT code 77371 because this CPT code corresponded

directly to procedures for HCPCS code G0243. Since 2007, HCPCS G-codes G0173, G0251, G0339, G0340, and CPT code 77371 have been the codes used in the OPPTS to describe SRS treatment delivery procedures. However, SRS techniques and equipment have evolved and advanced over time. In light of these considerations, CMS has reexamined the HCPCS G-codes and CPT codes for SRS with the intent of identifying the codes that would best capture the significant differences between the various procedures while eliminating unnecessary complexity, redundancy, and outdated distinctions that no longer represent meaningful distinctions, given current technology and clinical practice. CMS believes most current linac-based SRS technology incorporates some type of robotic feature. Therefore, CMS has decided it is no longer necessary to continue to distinguish robotic versus nonrobotic linac-based SRS through the HCPCS G-codes. For CY 2014, CMS proposes to replace the existing four SRS HCPCS G-codes G0173, G0251, G0339, and G0340, with the SRS CPT codes 77372 and 77373. CMS contends that utilizing all of the CPT codes for SRS (77371, 77372, and 77373) will more accurately capture the most significant distinctions between the various SRS procedures that are currently used today, namely: (1) Cobalt-60 versus linac; and (2) single session cranial treatment versus fractionated treatments.

Under the SRS proposal, CMS plans to restore the superior payment for gamma knife, while at the same time complying with legislation that called for equal payment by equating linac and gamma knife in the cases where both are used only once in a full course of treatment. Based on the proposal, multisession linac goes from \$3300 to \$2400 and gamma knife goes to \$8576.28 (last year it was \$7910, but Sec. 634 took it down to \$3300 on April 1, 2013)

- **OPPTS/ASC Cap facility payment cap.** CMS proposes to limit payment for practice expense or facility payment for 211 procedures to the lower of OPPTS/ASC or non-facility (office) PE RVUs. Their rationale is that the payment should be the same regardless of setting. Vertebroplasty and Kyphoplasty CPT Codes 22520 through 22525 are on the list of codes. For radiology specialties that own their facility in which they perform these procedures, the setting is considered a non-facility setting or office. The amount they are paid for the non-facility PE will be capped at the OPPTS/APC rate.