

Summary of 2010 Medicare Physician Fee Schedule

On October 30, 2009, the Centers for Medicare and Medicaid Services released the Medicare Physician Fee Schedule (MPFS) final rule for Calendar Year (CY) 2010. The rule was printed in the *Federal Register* on November 25, 2009: <http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf>. Below are highlights of provisions affecting neurosurgeons.

2010 Payment Update Factor

The update to the physician fee schedule Conversion Factor is -21.2 percent for CY 2010, the preliminary estimate for the sustainable growth rate for CY 2010 is -8.8 percent and the Conversion Factor for CY 2010 is \$28.4061, down from \$36.0666 in CY 2009. It is important to keep in mind that Congress will likely act to change these numbers.

Payment for Stereotactic Radiosurgery

The 2010 MPFS Final Rule includes the results of the August 2009 Refinement Panel review of Stereotactic Radiosurgery work RVUs. In the 2009 MPFS final rule, CMS significantly reduced the AMA Relative Value Update Committee (RUC) passed values for new codes replacing SRS Code 61793. Representatives from the AANS/CNS Coding and Reimbursement Committee successfully made the case for increasing these values. The results announced in the 2010 Final Rule are below in the last column:

CPT Code	Description	RUC Proposed Work RVUs	CMS Approved Work RVUs	2010 CMS Approved Work RVUs
61800	Application of stereotactic headframe for stereotactic radiosurgery	2.25	2.25	2.25
61796	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); 1 simple cranial lesion	<u>15.50</u>	<u>10.79</u>	<u>13.83</u>
61797	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, simple	3.48	3.48	3.48
61798	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one complex cranial lesion	<u>19.75</u>	<u>10.79</u>	<u>19.75</u>
61799	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, complex	4.81	4.81	4.81
63620	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one spinal lesion	<u>15.50</u>	<u>10.79</u>	<u>15.50</u>
63621	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional spinal lesion	4.00	4.00	4.00

Impact of RVU Changes on Neurosurgery

In terms of RVU changes, neurosurgery experiences a 1% reduction due to work RVU changes (largely due to the elimination of consultation services), a increase of 2% for Practice Expense (PE) when the fully transitioned use of updated practice expense survey data is complete (although no increase will be realized during the first year of the transition to the PE data), and no increase from the changes in Malpractice RVUs. Again, it is important to remember that this is only the RVU changes and does not take in to account the final Conversion Factor.

Neurosurgical Code Specific Reimbursement

For illustration purposes, below is a chart representing common neurosurgical procedures and their 2009 rates and 2010 rates based on RVU changes only. **NOTE:** To illustrate the impact of these changes, the 2009 conversion factor is applied to the proposed 2010 total RVUs. Also note, that 2009 rate for 99243, the mid-level office consult code, is compared to the proposed 2010 rate for a 99203, the mid-level office visit/new patient code. This is done to illustrate the difference in reimbursement if CMS eliminates payment for consultation codes.

CPT Code	Procedure Description	2009	2010*
22554	Ant cerv fusion	\$1,200	\$1,236
22612	Lumbar post-lat fusion	1,485	1,563
22630	PLIF	1,433	1,505
22842	Lumbar pedicle screws	750	764
22845	Ant cerv instrumentation	719	734
22851	Intervert biomech device	399	409
35301	Carotid endarterectomy	1,068	1,120
61107	Twist drill- ventric	302	311
61154	Burr hole for SDH	1,145	1,225
61312	Crani for subdural	1,876	2,033
61313	Crani for ICH	1,798	1,930
61510	Craniotomy for tumor	1,993	2,122
61512	Crani for meningioma	2,356	2,492
61697	Brain aneurysm repair -- carotid (complex)	3,808	4,137
61698	Brain aneurysm repair – vert. basilar (complex)	4,082	4,551
61700	Craniotomy for aneurysm (simple)	3,211	3,348
61751	Stereotactic biopsy	1,250	1,352
61795	Intraop frameless stereotaxis	233	216
61796	Stereotactic Radiosurgery cranial (simple)	732	764
61798	Stereotactic Radiosurgery cranial (complex)	732	764
61800	Stereotactic Radiosurgery head frame placement	142	146
62223	VP shunt	945	1,019
62230	Shunt revision	763	816
62362	Programmable pump implant	385	411
63030	Lumbar discectomy	892	940
63042	Recurrent lumbar disc	1,222	1,272
63047	Lumbar laminectomy	1,015	1,070

CPT Code	Procedure Description	2009	2010*
63075	Ant cerv discectomy	1,284	1,341
63081	Ant cerv corpectomy	1,645	1,737
63620	Stereotactic Radiosurgery spine	732	764
63650	Perc epidural dorsal column stim	379	281
64718	Ulnar nerve transposition	517	561
64721	Carpal tunnel	377	401
99243	Office Consultation (will become Office Visit 99203)	125	103
	National Conversion Factor	\$36.07	\$36.07

* 2010 Fee is based on final Work, transitional PE and MP RVUs and the 2009 conversion factor is used for illustration purposes only. Until Congress acts, we do not know what the 2010 conversion factor will be, although we can be fairly certain that we will not get the scheduled 21.2% cut. Figures are rounded to nearest dollar.

Drugs Administered Incident to Physician Services

In the final rule, CMS said it will go ahead with removing physician-administered drugs from the definition of “physician services” for purposes of computing the physician update formula – both retroactively and in the future, as proposed. Organized medicine has long advocated for this, however, the previous administration repeatedly refused to do so claiming it had no legal authority to make such a change. This move will trim the costs of SGR reform considerably and restore \$122 billion to funding for physician services over 10 years. While this decision will not affect payments for services during CY 2010, CMS projects it will have a positive effect on future payment updates

Practice Expense RVUs

CMS proposed to update the practice expense (PE) relative value units (RVUs) substituting outdated PE data with the new AMA PE data. The AANS and CNS and 72 other specialty societies had contributed \$25,000 to help underwrite the cost of a new PE survey, and over 100 neurosurgeons provided data to the AMA in this process (we had a 100% participation rate). In the final rule, CMS states that it will go ahead and use this new survey as proposed, but will provide a four year transition. Below is a table that highlights the differences between the current (old data) and new PE per hour rates in the MPFS final rule for neurosurgery and several other specialties.

Specialty	Current Indirect PE/HR	Final Rule Indirect PE/HR	Current Indirect %	Final Rule Indirect %	Impact of all PE RVU Changes Transition/Fully Implemented
Neurosurgery	\$89.64	\$115.76	86%	87%	0% / 2%
All Physicians	\$59.04	\$86.36	67%	74%	0% / 0%
Family Medicine	\$52.79	\$90.15	62%	76%	2% / 5%
Internal Medicine	\$49.60	\$84.03	69%	76%	2% / 5%
Orthopaedic Surgery	\$98.56	\$131.40	72%	81%	1% / 3%
Cardiology	\$131.02	\$88.04	56%	65%	-8% / -13%

In addition to updating the PE data, CMS will go forward with its proposal to change the utilization rate assumption for diagnostic imaging equipment such as CT and MRI from the current 50% utilization rate to 90% utilization rate for equipment costing over \$1 million. The proposed rule would have applied this

assumption to therapeutic equipment as well, but the final rule does not. This provision will affect neurosurgeons who own and operate their own in-office imaging equipment, but overall has a negligible impact on neurosurgery.

Malpractice RVUs

CMS will finalize its proposed changes to their methodology for calculating malpractice (MP) RVUs by using more recent data, including premium data for all physician specialties (rather than just the top 20 Medicare physician specialties), and establishing resource-based PLI relative values for services with technical components. CMS has agreed to use the dominant specialty for procedures with a Medicare frequency of less than 100 times per year, as proposed. However, for rare situations for very low volume codes in which the dominant specialty data did not seem to make sense and may be attributable to miscoding, CMS did not accept the RUC recommendation that a “common sense” consensus about the dominant specialty be used. For example, Medicare data shows that for CPT Code 61708 *Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial electrothrombosis*, the dominant specialties are Radiation Oncology and Diagnostic Radiology. The RUC had asked that neurosurgery be considered the dominant specialty for this procedure but CMS disagreed. However, as is stated above, the overall impact of CMS changes to PLI RVUs for neurosurgery is no change.

Elimination of Payment for Consultation Codes

In the final rule, CMS states its intention to eliminate payment for consultation services in the office and hospital setting, as proposed. CMS will create a modifier to identify the admitting physician from other specialty physicians in the hospital setting. CMS will also create new HPCPS G-codes for reporting consultation services for telehealth services. However, CMS agreed with AANS and CNS and other specialty societies that the evaluation and management (E/M) work included in the global surgical fees should be increased to correspond with the increase in E/M codes

Potentially Misvalued Services

CMS notes that it will continue to work with the RUC to identify misvalued services and will focus these efforts by reviewing site-of-service changes, reviewing codes with high intra-service work per unit of time (IWPUT), the fastest growing procedure codes, reviewing Harvard-valued codes that have not been reevaluated, reviewing services often billed together and the possibility of expanding the multiple procedure payment reduction policy to additional nonsurgical procedures.

- **Bundling Codes** – Despite significant opposition expressed in comments to the proposed rule, CMS still plans to continue its analysis of codes billed together and reduce the “screen” from billed together 90% of the time to codes that are furnished together more than 75% of the time. For codes that are furnished together more than 75% of the time, CMS will ask the RUC to consider requiring specialty societies to create bundled codes.
- **Site of Service Shift** – CMS will not go forward in CY 2010 with plans to further devalue codes where there have been shifts in site-of-service to eliminate work values associated with pre-service, post-service, hospital days, and discharge day management services. Although CMS has agreed to maintain the RUC-passed work RVUs for these codes for 2010, they state that they continue to prefer the “building block” methodology in which the hospital visit values are stripped out of the code to determine the value, resisting arguments that some of these codes were historically undervalued relative to other codes in the MPFS. The proposed and final work values for some of the codes of concern to neurosurgery are below.

CPT Code	Descriptor	Pre-AMA RUC Eval. Work RVU	2009 AMA RUC Recommended Work RVU	2010 CMS Proposed Work RVU	FINAL RULE Work RVU
62263	Epidural lysis mult sessions	6.41	6.41	6.04	6.54
62350	Implant spinal canal cath	8.04	6.00	1.29	6.05
63650	Implant neuroelectrodes	7.57	7.15	4.18	7.20
63685	Insrt/redo spine n generator	7.87	6.00	4.27	6.05
64708	Revise arm/leg nerve	6.22	6.22	7.36	6.36
64831	Repair of digit nerve	10.23	9.00	9.74	9.16

23-Hour Stay Rule

CMS will not go forward with its proposal to change its policy regarding billing an E&M code with a 23-hour stay in the outpatient setting and will work with CPT and the RUC to address their concerns about the appropriate method to account for post-service time spent with the patient.

Expert Panel to Review RUC Decisions

CMS said they will take into consideration all comments about whether or not to establish a group of experts (aka the “shadow RUC”) to review RUC recommendations as recommended by MedPAC and will propose no new policy at this time. Any change in the CMS methodology to review RUC recommendations would be published in future rulemaking and would allow for additional public input. It should be noted, however, that a proposal to establish a so-called expert panel to review reimbursement for physician services is included in both the House and Senate healthcare reform proposals.

Five Year Review of the Fee Schedule for Work and PLI RVUs

CMS is required to conduct a comprehensive review of the relative values in the MPFS at least every five years. As expected, the 2010 MPFS Final Rule lays out the agency’s plan for the 2010 Five Year Review of the Fee Schedule Work RVUs and asks the public to submit recommendations for codes to be reviewed. Unlike in past years, CMS specifically states that “For the fourth Five-Year Review of work RVUs, we will no longer consider the existence of a possible rank order anomaly to be the primary basis for undertaking the review of a code.” In addition to the five year review of work, CMS states “ in this rule, we are implementing the second review and update of malpractice RVUs.” The next five year review of practice expense will take place in 2014.

Quality Issues

Physician Resource Use Measurement and Reporting Program

Per the Medicare Improvements for Patients and Providers Act, or MIPPA, CMS is required to provide physicians with confidential feedback reports on their resource use. The regulation spells out the details how they will proceed in providing cost of service data, etc. The agency would use 3 years of claims data for developing resource use measures. Fortunately, there are no neurosurgery-specific conditions for which CMS will collect resource use data **at this time**.

Value Based Purchasing

CMS is required to develop a plan to submit to Congress by May 2010 on how Medicare can move to a value based purchasing system of payment. Value-based purchasing uses payment incentives and

transparency to increase the value of care by rewarding providers for higher quality and more efficient services and for publicly reporting performance information. The Agency is still developing this plan and is seeking further input on aspects of the plan. It is too early to tell whether this will be beneficial or detrimental for neurosurgeons – but probably a little of both.

Physician Quality Improvement Initiative

Under MIPPA, Medicare will pay physicians who successfully participate in PQRI 2010 incentive payments equal to 2% of estimated allowed charges for the reporting period. For 2010, CMS is proposing that an eligible professional may choose to report data on PQRI quality measures through claims, to a qualified registry (it is still PQRI quality measures, however), or through a qualified EHR product. Ultimately, CMS is trying to reduce its reliance on claims-based reporting and move to reporting through clinical data registries. There are detailed specifications for who qualifies as a “qualified registry” in the regulation. One requires that the registry have a “validation strategy” that ensures participants have accurately reported their data. The regulation spells out in detail the various individual measures and measure groups on which neurosurgeons can report.

E-Prescribing Incentives

Per MIPPA, eligible professionals who successfully participate in the e-Rx program will receive a 2% bonus. Based on an analysis done by the AMA, neurosurgeons now appear to be eligible for this program.

For More Information:

Questions related to the reimbursement section of the MPFS should be directed to:

Cathy Hill, Senior Manager for Regulatory Affairs
AANS/CNS Washington Office
202-446-2026
chill@neurosurgery.org

Questions related to the quality section of the MPFS should be directed to:

Rachel Groman, Senior Manager for Quality Improvement
AANS/CNS Washington Office
202-446-2030
rgroman@neurosurgery.org