

Summary of the 2019 Medicare Physician Fee Schedule (PFS) Final Rule — Payment Provisions

On November 1, 2018, the Centers for Medicare & 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](#) final rule with comment period which was published in the November 23, 2018, *Federal Register*. This is the first year that CMS combined the Medicare PFS and the Quality Payment Program (QPP) proposed rules. CMS has published several fact sheets on the rule, including a [fact sheet](#) on payment changes for 2019. Below is a summary of some of the proposals included in the **payment provisions** of the final regulation. The quality payment program summary is separately available.



Physician Payment Update

The Calendar Year (CY) 2019 conversion factor is \$36.04, a 0.11 percent increase over the CY 2018 conversion factor of \$35.99. The final rule contains several specialty impact tables, but overall, **neurosurgery experiences no change in Medicare payments in CY 2019**. However, CMS estimates that if they had implemented the Evaluation and Management (E/M) proposals in 2019 rather than putting them off until 2021, the impact on neurosurgery would have been -1 percent in CY 2019. In the proposed rule, CMS had stated that the E/M changes would be minimal or possibly slightly positive, a supposition met with skepticism by neurosurgery.

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 visits into a single visit level and payment rate would have a large effect on the PE/Hour for many specialties. To address this issue, CMS proposed the creation of 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. **However, after reviewing comments received, CMS will not finalize the proposal for a single PE/Hour value for E/M visits.**
- **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 pillowcase, 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 the RUC PE Subcommittee initially reviewed these codes, 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 because of 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). **CMS will finalize their proposal to adjust the number of visit packages to the number of visits.**

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% change and the AANS, the 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 solicited 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-physician providers were crosswalked to the lowest level physician risk factor. Due to the growing percentage of non-physician 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 payment impacts to their insurance-related costs. **In the final rule, CMS stated that it received “a few comments” on this topic and that it will consider the input in future rulemaking and for the required CY 2020 update. As recommended by the RUC and other commenters, CMS added approximately 30 codes to the low volume services to the list of codes for anticipated specialty assignment. Disappointingly, in the Addendum for the CY 2019 Malpractice Risk Factors and Premium Amounts by Specialty, CMS continues to crosswalk non-MD/DO specialties to the lowest MD/DO risk factor specialty of Allergy Medicine.**

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 codes. 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 1 and December 31, 2017.
- 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.

In the proposed rule, the agency solicited comments about increased compliance and also whether visits are typically being performed in the 10-day global period. Also, they asked for comments on whether they should mandate the use of modifiers -54 “for surgical care only” and -55 “post-operative management only,” regardless of whether the transfer of care is formalized. **In the final rule, CMS did not make any changes to the global surgery policy and said they would consider stakeholder comments and whether to propose action at a future date. The agency did agree to additional education for those providers in the nine states required to report CPT code 99024.**

RUC Recommendations

In the proposed rule, CMS announced issued 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. CMS finalized most of these proposed changes.

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. In the proposed rule, CMS asked 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 preceding codes bundled together for use by federally qualified health centers and rural health clinics.

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

Finally, CMS proposed 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 proposed 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 track and analyze utilization of these services easily. **CMS will finalize its plan to adopt a modifier for acute stroke services. Also, the agency will finalize policies to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation or treatment of symptoms of an acute stroke.**

The SUPPORT Act Interim Final Rule and Request for Information

On Oct. 24, 2018, the president signed comprehensive legislation to address the opioid epidemic. **In the final rule, CMS states that they have reviewed the new law, the "Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act" and the Agency has issued an interim final rule to address some of the regulatory aspects.** CMS proposes to add the home of an individual as a permissible originating site for telehealth services furnished on or after July 1, 2019, to individuals with a substance use disorder diagnosis for purposes of treatment of a substance abuse disorder or a co-occurring mental health disorder and also to remove the telehealth geographic requirements for these services. Also, CMS requested information on the new January 1, 2020, Medicare benefit category for "Certain Services Furnished by Opioid Treatment Programs (OTP)." CMS is looking for input on services furnished by OTPs, payment for these services and additional conditions for Medicare participation for OTPs that would be useful for future rulemaking. CMS also stated that its guidance on implementing the SUPPORT Act provisions related to RHCs/FQHCs "will be forthcoming." The majority of the provisions in the final rule are not subject to comment. However, for items such as this in which CMS has specifically requested comment, the deadline is Dec. 31, 2018.

Potentially Misvalued Services

CMS mentions in the background information of the proposed rule that the agency 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, the value will be included in the CY 2020 MPFS proposed rule, not in this CY 2019 MPFS proposed or final rule. **In the final rule, CMS included a list of seven potentially misvalued services; none are commonly performed by neurosurgeons.**

Evaluation and Management (E/M) Proposals for 2019

CMS had proposed sweeping new E/M policy and payment changes for Calendar Year 2019. **In the final rule, CMS stated for 2019 they will finalize a few policies intended to reduce evaluation and management (E/M) documentation burden.** For example, physicians may choose to document only the history and exam components that have changed since the last visit for established patients. For both new and established patients, physicians will not be required to re-document the chief complaint or history that has already been documented. **In response to strong objections from many specialty societies including the AANS and the CNS, CMS did not immediately finalize changes to the valuation of E/M codes. Rather, the agency postponed these changes to 2021,** at which point CMS plans to collapse E/M office/outpatient visit levels 2, 3 and 4 into a single payment rate and will allow for E/M documentation based on medical decision making or time spent providing a service or on the current 1995/1997 guidelines. Below are some details on the CMS proposed and final rules for E/M policy and payment.

- **Documentation Changes for Office/Other Outpatient/Home Visits.** CMS had proposed that physicians be allowed to choose the 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 had also proposed only requiring 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.)

To report an established office visit to Medicare, CMS had proposed that 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 were mentioned, 10 minutes (CPT defined typical time) or 16 minutes (weighted average of all established office visits).

CMS sought comment on other documentation systems (e.g., Marshfield clinic). Comments were also sought on the impact of these proposals on clinical workflows and EHR systems. Also, CMS proposed that 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 sought comment on whether this should be expanded to medical decision-making. CMS proposed to 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. **In the final rule, CMS confirmed that physicians would be able to choose whether to document via (1) the existing 1995 or 1997 guidelines; (2) medical decision making; or (3) by time (although this would be delayed to CY 2021).**

- **Condensing Visit Payment Amounts.** In the proposed rule, CMS called the system of 10 visits for new and established office visits “outdated” and proposed 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 had asserted that this changes would have little net impact on neurosurgical payments. While these changes only relate to the office visit codes, the AANS and the CNS are also carefully considering the implications for these changes for other E/M services, including those provided in the inpatient setting, as well as the potential for revaluing the 10- and 90-day global surgery codes.

In the final rule, CMS modified its proposed policy to collapse office/outpatient E/M visit Levels 2 – 4 into a single payment level. Physicians would still submit claims for visit levels 2 – 4, but because 2 – 4 receive the same payment level, only documentation needed to obtain a Level 2 is required (when documenting by current guidelines of MDM only).

CPT Code New Office Visits	Current \$	Revised Payment Amount
99201	\$45	\$45
99202	\$76	\$130
99203	\$110	
99204	\$167	
99205	\$211	\$211

CPT Code Est. Office Visits	Current \$	Revised Payment Amount
99211	\$22	\$22
99212	\$45	\$90
99213	\$74	
99214	\$109	
99215	\$148	\$148

CMS has provided a new [chart](#) to reflect the final rule changes to E/M services, which reflects the above changes and those related to the add-on codes, discussed below.

- **Other Coding/Payment Proposals Related to E/M.** CMS proposed 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 proposed policy was not consistent with the current valuation of procedures commonly performed with office visits, as duplicative resources have already been removed from the underlying

procedure. It appears that CMS proposed this policy to offset payment increases to dermatology and other specialties that often report lower level office visit codes in conjunction with minor procedures. **Ultimately, CMS did not finalize its proposal to apply the Multiple Procedure Payment Reduction (MPPR) policy to E/M visits billed on the same day as a global procedure.**

- **New Add-on Codes.** CMS proposed to 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 proposed 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

For CY 2021, CMS will finalize the proposed add-on code for visit complexity inherent to non-procedural specialty care using the input values, as proposed. The agency noted that before implementing this in CY 2021, it could consider, through rulemaking, the code, and its valuation, in the context of any potential changes to CPT codes and/or recommendations offered by stakeholders, including the RUC, as part of the annual process for valuing PFS services.

- **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.

For CY 2021, CMS will finalize the proposed add-on code for prolonged services. Again, CMS has noted that the agency could consider, through rulemaking, the code, and its valuation in the context of any potential changes to CPT codes and/or recommendations offered by stakeholders, including the RUC, as part of the annual process for valuing PFS services. **The CPT/RUC Workgroup on E/M coding is considering such as proposal as part of its larger code change application, which is expected to be submitted for consideration at the February 2019 CPT meeting.**

- **Practice expense methodology.** CMS modified 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. **CMS will not finalize the proposal for a single PE/Hour value for E/M visits.**

- **Teaching Physician Documentation Requirements for E/M Services.** For CY 2019, **CMS has finalized its plan to revise federal regulations to allow the presence of the teaching physician during E/M services to be demonstrated by the notes in the medical records made by a physician, resident or nurse.** CMS also finalized its proposal to revise 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 notes may demonstrate the extent of the teaching physician's participation in the medical records made by a physician, resident, or nurse.

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 final rule, CMS finalized the following proposals:**

- To expand the definition of an applicable setting to include independent diagnostic testing facilities;
- To create significant hardship exceptions from the AUC requirements that are specific to the AUC program and independent of other Medicare programs;
- To establish the coding methods, to include G-codes and modifiers, to report the required AUC information on Medicare claims;
- To allow "clinical staff," under the direction of an ordering professional, to consult with AUC when the consultation is not performed personally by the ordering professional; and
- To clarify that AUC consultation information must be reported on all claims for an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (i.e., on any claim for an outpatient advanced diagnostic imaging service, including those billed and paid under the PFS, OPPOS or ASC payment system). As such, claims from both furnishing professionals *and* facilities must include AUC consultation information. In other words, this information should be included on the practitioner's claims for the professional component and the provider's or supplier's claim for the facility portion or technical component of the imaging service.

Neurosurgery-Specific Coding Changes

- **Neurostimulator Services.** CMS had proposed to reduce the RUC-passed values for five neurostimulator programming codes. Although these codes are not typically reported by neurosurgeons, the AANS and the CNS CPT and RUC advisors, as well as **Joshua Rosenow, MD, FAANS** — 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 a rationale for their valuation and the agency proposed other codes as cross-walks. **CMS confirmed their intent to finalize the proposed reductions and did not change the proposed values in the final rule.**

CPT Code	Descriptor	Current Work RVU	RUC-passed Work RVU	CMS Proposed/Final 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 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	New	1.19	0.97
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

CPT Code	Descriptor	Current Work RVU	RUC-passed Work RVU	CMS Proposed/Final Work RVU
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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