CMS Issues 2017 Proposed Physician Fee Schedule: What Spine Surgeons Should Know

[CMS-1654-P] - Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

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Comment Deadline

CMS is accepting comments on the proposed rule until September 6, 2016 at Regulations.gov. CMS will issue the final rule by November 1, 2016.

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Overview

On July 7, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that updates payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2017. The PFS pays for services furnished by physicians and other practitioners in all sites of service. These services include but are not limited to visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services. CMS will accept comments on the proposed rule until September 6, 2016, and will issue the final rule by November 1, 2016.

To set payment rates, CMS evaluates three components of medical services/procedures: physician work, practice expense, and malpractice expense. Each component is assigned a value also known as a relative value unit (RVU). The work RVU, practice expense RVU, and malpractice RVU are each multiplied by geographic practice cost indices (GPCI), added together, and then multiplied by a conversion factor that is updated annually. The 2017 proposed conversion factor is $35.7751 (the 2016 final conversion factor was $35.8043).

Payment = [(Work RVU x GPCI) + (Practice Expense RVU x GPCI) + (Malpractice RVU x GPCI)] x Conversion Factor

Spine Codes

As part of the proposed rule, CMS issues proposed values for new codes and codes deemed misvalued. Please see the spine code spreadsheet for a comparison of RVUs and reimbursements from the 2016 final rule to the 2017 proposed rule. Highlighted below are deleted spine codes and new Category I spine codes set to take effect January 1, 2017:

Deleted Codes effective 01/01/17:

Code	Descriptor
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)
62310	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
62318	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
62319	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)

New Category I Codes and RVUs effective 01/01/17:

Code	Descriptor	RUC-Recommended Work RVU	CMS-Proposed Work RVU	Facility Practice Expense RVU	Mal-Practice RVU	Total Facility RVU
228X1	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	15.00	13.50	10.72	4.24	28.46

228X2	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level	4.00	4.00	1.91	1.21	7.12
228X4	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	7.39	7.03	6.66	1.93	15.62
228X5	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level	2.34	2.34	1.13	0.68	4.15
22X81	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	4.88	4.25	2.03	1.36	7.64
22X82	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges) when performed to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect	5.50	5.50	2.63	1.77	9.90

22X83	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect	6.00	5.50	2.63	1.77	9.90
623X5	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	1.80	1.80	0.92	0.21	2.93
623X6	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	1.95	1.95	0.98	0.24	3.17
623X7	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	1.55	1.55	0.80	0.19	2.54

623X8	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	1.80	1.80	0.89	0.21	2.90
623X9	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	1.89	1.89	0.54	0.24	2.67
62X10	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	2.20	2.20	0.60	0.28	3.08

62X11	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	1.78	1.78	0.64	0.21	2.63
62X12	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	1.90	1.90	0.67	0.22	2.79
630X1	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	10.47	9.09	7.14	3.01	19.24

ISASS participated in the CPT and RUC processes for several of these codes and is disappointed that CMS did not follow the RUC recommendations for the work RVUs developed for 228X1, 228X4, 22X81, 22X83, and 630X1. In the proposed rule, CMS provides the following rationale for their revised work RVU proposals:

Insertion of Spinal Stability Distractive Device (CPT codes 228X1, 228X2, 228X4, and 228X5):

The CPT Editorial Panel converted two Category III codes to Category I codes describing the insertion of an interlaminar/interspinous process stability device (CPT codes 228X1 and 228X4) and developed two corresponding add-on codes (CPT codes 228X2 and 228X5). The RUC recommended a work RVU of 15.00 for CPT code 228X1, 4.00 for CPT code 228X2, 7.39 for CPT code 228X4, and 2.34 for CPT code 228X5.

CMS believes that the RUC recommendations for CPT codes 228X1 and 228X4 overestimate the work involved in furnishing these services. CMS believes that a crosswalk to CPT code 36832 (Revision, open, arteriovenous

fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)) which has a work RVU of 13.50, is a more accurate comparison because CPT code 36832 is similar in total time, work intensity, and number of visits to 228X1. CMS believes this is supported by the ratio between total time and work in the key reference service, CPT code 63047 (Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar). Therefore, CMS is proposing a work RVU of 13.50 for CPT code 228X1.

For CPT code 228X4, CMS believes that CPT code 29881 (Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed) is an appropriate crosswalk based on clinical similarity as well as intensity and total time. CPT code 29881 has an RVU of 7.03; therefore, CMS is proposing a work RVU of 7.03 for CPT code 228X4.

CMS is proposing to accept the RUC-recommended work RVU for CPT codes 228X2 and 228X5 without refinement.

Biomechanical Device Insertion (CPT codes 22X81, 22X82, and 22X83):

The CPT Editorial Panel established three new category I add-on codes and deleted one code (22851) to provide a more detailed description of the placement and attachment of biomechanical spinal devices. For CPT code 22X81, the RUC recommended a work RVU of 4.88. For CPT code 22X82, and CPT code 22X83, the recommended work RVUs are 5.50 and 6.00, respectively.

In reviewing the code descriptors, descriptions of work and vignettes associated with CPT codes 22X82 and 22X83, CMS determined that the two procedures, in addition to having identical work time, contain many clinical similarities and do not have quantifiable differences in overall intensity. Therefore, CMS is proposing the RUC-recommended work RVU of 5.50 for both CPT code 22X82 and CPT code 228X3. CMS believes that the RUC-recommended work RVU for CPT code 22X81 overestimates the work in the procedure relative to the other codes in the family. CMS is proposing a work RVU of 4.25 for CPT code 228X1 based a crosswalk from CPT code 37237 (Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)), which they feel is similar in time and intensity to the work described by CPT code 22X81.

Endoscopic Decompression of Spinal Cord (CPT code 630X1):

The CPT Editorial Panel created CPT code 630X1 to describe the endoscopic decompression of neural elements. The RUC recommended a work RVU of 10.47 based on a crosswalk to CPT code 47562 (Laparoscopy, surgical; cholecystectomy) with a higher intraservice time than reflected in the survey data. Since CMS believes CPT codes 630X1 and 47562 are similar in intensity, they believe using the same work RVU as the crosswalk code overestimates the work involved in furnishing CPT code 630X1. Reference CPT code 49507 (Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated) has a work RVU of 9.09 and CMS feels it has similar intensity and an identical intraservice time compared to CPT code 630X1. Therefore, CMS is proposing a work RVU of 9.09 for CPT code 630X1.

10- and 90-day Global Periods

Many surgical spine procedures are valued and paid for as part of global packages that include the procedure and the services typically furnished in the periods immediately before and after the procedure. Codes with 90-day global periods include any services provided to the patient one day prior to procedure through 90-days post-op. The global package includes the following services related to the procedure:

- Pre-operative Visits: Pre-operative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Intra-operative Services: Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- Complications Following Surgery: All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications that do not require additional trips to the operating room;
- Post-operative Visits: Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery;
- Post-surgical Pain Management: By the surgeon;
- Supplies: Except for those identified as exclusions; and
- Miscellaneous Services: Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Citing concerns with lack of data to verify and update the values of codes with global packages, CMS finalized a policy to transform all 10- and 90-day global codes to 0-day global codes beginning in 2018 as part of its misvalued code initiative contained in the 2015 final rule. Under this policy, CMS would have valued the surgery or procedure to include all services furnished on the day of surgery and paid separately for visits and services furnished after the day of the procedure. Subsequently, Congress enacted Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 prohibiting CMS from implementing this policy and requiring the agency to gather data on visits in the post-surgical period that could be used to accurately value these services.

In this year's proposed rule, CMS is proposing a three-pronged data collection strategy to gather information on the frequency of, and inputs involved in furnishing global services, including the procedure, pre-operative visits, post-operative visits, and other services for which payment is included in the global surgical payment for 4,200 codes with a 10- or 90-day global period. To the extent that this data results in proposals to revalue any surgical services, that revaluation will be done through notice and comment rulemaking at a future time. Specifically, the data collection effort would include:

1. Comprehensive claims-based reporting about the number and level of pre- and post- operative visits furnished for 10- and 90-day global services.
2. A survey of a representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks.
3. A more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, including some ACOs.

In order to collect claims-based data, CMS is proposing to require **ALL** physicians who furnish procedures with 10-day and 90-day global periods to report the number and level of pre- and post-operative visits using a new set of G-codes that distinguish between the setting of care (hospital, office, email/telephone) and whether the services are furnished by a physician or by their clinical staff. Physicians would be required to report the following G-codes for every 10 minutes dedicated to a patient before and after a procedure or surgery:

Inpatient	GXXX1	Inpatient visit, typical, per 10 minutes, included in surgical package
	GXXX2	Inpatient visit, complex, per 10 minutes, included in surgical package
	GXXX3	Inpatient visit, critical illness, per 10 minutes, included in surgical package
Office or Other Outpatient	GXXX4	Office or other outpatient visit, clinical staff, per 10 minutes, included in surgical package
	GXXX5	Office or other outpatient visit, typical, per 10 minutes, included in surgical package
	GXXX6	Office or other outpatient visit, complex, per 10 minutes, included in surgical package
Via Phone or Internet	GXXX7	Patient interactions via electronic means by physician/NPP, per 10 minutes, included in surgical package
	GXXX8	Patient interactions via electronic means by clinical staff, per 10 minutes, included in surgical package

Note: CMS is proposing these codes be used for reporting on claims the services actually furnished but not paid separately because they are part of global packages. No separate payment would be made for these codes. Also, CMS states they are not proposing to withhold payment for non-compliance at this time, but may do so in the future.

Moderate Sedation

In prior rulemakings, CMS noted certain procedures where anesthesia is increasingly being separately reported even though payment for sedation services is automatically included in payment to the physician furnishing the primary procedure. In response to CMS' requests in prior rulemaking, the CPT Editorial Panel created separate codes for reporting moderate sedation, and the RUC provided CMS with recommended values for the moderate sedation codes and recommended adjustments to valuation of the procedure codes. As part of this year's proposed rule, CMS is proposing values for the new CPT moderate sedation codes and proposing a uniform methodology for valuation of the procedural codes that currently include moderate sedation as an inherent part of the procedure. The following are the new moderate sedation codes and proposed values:

Code	Descriptor	CMS-Proposed Work RVU
991X1	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age	0.50

991X2	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older	0.25
991X3	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra- service time, patient younger than 5 years of age	1.90
991X4	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra- service time, patient age 5 years or older	1.65
991X5	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intra- service time (List separately in addition to code for primary service)	0.00
991X6	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)	1.25

The work RVUs of the following percutaneous vertebroplasty and vertebral augmentation codes are being adjusted to account for moderate sedation services previously considered to be inherent in the procedure:

Code	Descriptor	2016 Work RVU	2017 Proposed Work RVU
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	8.15	7.90
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	7.58	7.33
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	4.00	4.00
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	8.90	8.65
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	8.24	7.99

22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	4.00	4.00
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	6.10	5.85
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	3.03	3.03

Appropriate Use Criteria – Advanced Diagnostic Imaging Services

Section 218(b) of the Protecting Access to Medicare Act (PAMA) of 2014 establishes a new program under the statute for fee for service Medicare to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. CMS established the first of the four components of this program in the 2016 Physician Fee Schedule final rule focusing on requiring an evidence-based and transparent process for developing AUC. AUC under this program may only be developed by qualified provider-led entities (the initial list of qualified entities is posted on the CMS website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html).

This year's proposed rule focuses on the next component of the Medicare AUC program and includes proposals for priority clinical areas, clinical decision support mechanism (CDSM) requirements, the CDSM application process, and exceptions for ordering professionals for whom consultation with AUC would pose a significant hardship. CDSMs are the electronic tools through which a clinician consults AUC to determine the level of clinical appropriateness for an advanced diagnostic imaging service for that particular patient's clinical scenario. CMS has indicated in this proposed rule that the third component of the program (when ordering professionals must begin consulting CDSMs and furnishing professionals must append AUC related information to the Medicare claim) will not begin earlier than January 1, 2018.

The number of clinicians impacted by the scope of this program is massive as it will apply to every physician or other practitioner who orders or furnishes applicable imaging services; this crosses almost every medical specialty.

CMS is proposing this second component to the program to specify qualified CDSMs, identify the initial list of priority clinical areas, and establish requirements related to CDSMs, as well as consulting and reporting exceptions. Under this proposal, the first list of qualified CDSMs will be posted no later than June 30, 2017, allowing ordering professionals to begin aligning themselves with a qualified CDSM. CMS anticipates that furnishing professionals could begin reporting AUC information starting as early as January 1, 2018, but will provide details in the 2018 PFS rulemaking for how to report that information on claims.

CMS is proposing the following priority clinical areas based on an analysis of claims data alone:

Proposed Priority Clinical Area	Total Services	% Total Services	Total Payments	% Total Payments
Chest Pain (includes angina, suspected myocardial infarction, and suspected pulmonary embolism)	4,435,240.00	12%	$470,395,545	14%
Abdominal Pain (any locations and flank pain)	2,973,331.00	8%	$235,424,592	7%
Headache, traumatic and non-traumatic	2,107,868.00	6%	$89,382,087	3%
Low back pain	1,883,617.00	5%	$180,063,352	5%
Suspected stroke	1,810,514.00	5%	$119,574,141	4%
Altered mental status	1,782,794.00	5%	$83,296,007	3%
Cancer of the lung (primary or metastatic, suspected or diagnosed)	1,114,303.00	3%	$154,872,814	5%
Cervical or neck pain	1,045,381.00	3%	$83,899,299	3%

Add-On Payment for Patients with Mobility Impairments

CMS is proposing an add-on code that could be billed with Evaluation & Management (E/M) codes for physicians treating people with mobility-related impairments. This proposal is funded with an across-the-board cut in payment rates.

Next Steps

CMS is accepting comments on the proposed rule through September 6, 2016. Comments should be submitted at the following link: https://www.regulations.gov/document?D=CMS-2016-0116-0006 using the "Comment Now!" button on the right side of the page. A final rule is expected to be released by November 1, 2016.