**2016 Final Physician Fee Schedule**

On October 30, 2015, the Centers for Medicare and Medicaid Services (CMS) released the final 2016 Physician Fee Schedule (PFS). In the [final rule](https://www.federalregister.gov/articles/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions), CMS finalizes RVUs for Calendar Year (CY) 2016 for the PFS and other Medicare Part B payment policies to ensure that CMS payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in the statute. This is the first PFS final rule since the repeal of the Sustainable Growth Rate formula by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The final rule goes into effect on January 1, 2016. CMS is accepting public comments on the final rule until 5 p.m. EST on December 29, 2015.

**Changes to RVUs and Reimbursements for Spine Codes**

ISASS staff looked at commonly used CPT**®**codes for spine and compared the 2015 final RVUs and reimbursements to the final 2016 RVUs and reimbursements in the attached spreadsheet. There are over 200 codes listed. If you are curious about a procedure code you do not see listed in the spreadsheet, please email ISASS/IASP Director of Health Policy and Advocacy, Liz Vogt (liz@isass.org) with your inquiry. Be sure to pay particular attention to Column M as it shows the difference in reimbursement from 2015 to 2016. The following is a list of codes with a change in reimbursement greater than $100:

* CPT 22112 (remove part thoracic vertebra) -$157.55
* CPT 22856 (pre-sacral fuse with instrumentation L5-S1) -$239.84
* CPT 22812 (anterior fusion, 8 or more vertebral segments) $225.39
* CPT 22857 (lumbar artificial discectomy) $202.00
* CPT 22862 (revise lumbar artificial disc) $257.98
* CPT 27279 (MIS SIJ fusion) $145.20
* CPT 27280 (open SIJ fusion) $295.87
* CPT 63182 (laminectomy and section of dentate ligaments, with or without dural graft, cervical, more than 2 segments) -$306.79
* CPT 63195 (laminectomy with cordotomy, thoracic) $426.02
* CPT 63250 (laminectomy for excision or occlusion of arteriovenous malformation of spinal cord, cervical) -$210.69
* CPT 63305 (vertebral corpectomy, intradural, thoracic by transthoracic approach) -$106.39
* CPT 63306 (vertebral corpectomy, intradural, thoracic by thoracolumbar approach) $339.25
* CPT 63307 (vertebral corpectomy, intradural, lumbar or sacral by transpirational or retroperitoneal approach) $139.44

**Potentially Misvalued Codes**

The Affordable Care Act instructed CMS to identify “misvalued codes” in the PFS, which CMS does through the annual rulemaking process. The Achieving a Better Life Experience Act of 2014 (ABLE) set the misvalued code target at 1.0% for 2016. If the estimated net reductions in PFS expenditures resulting from changes in values for misvalued codes in 2016 are not equal to or greater than 1.0%, a reduction equal to the percentage difference between target and the estimated net reduction in expenditures resulting from misvalued code reductions must be made to all PFS services. In the 2016 final PFS, CMS has identified changes that achieve 0.23% in net reductions. This requires a 0.77% reduction to all PFS services, as required by the statute. As such, the conversion factor used to calculate reimbursement rates is being lowered from 36.1096 in the 2016 proposed rule to 35.8279 in the 2016 final rule. The reduction in the conversion factor reflects not only the 0.77% target recapture amount to meet the misvalued code target required by ABLE, but also the budget neutrality adjustment and the 0.5% upward adjustment factor specified under MACRA.

In the 2015 PFS rule, CMS proposed and finalized the high expenditure tool as a way to identify potentially misvalued codes in the statutory category of “codes that account for the majority of spending under the PFS.” In the proposed 2016 rule, CMS identified 118 codes as potentially misvalued codes using the high expenditure tool. Specific to spine surgery codes, CMS identified four codes as potentially misvalued:

|  |  |
| --- | --- |
| **Code** | **Descriptor** |
| 22614 | Fusion of spine bones, posterior or posterolateral approach |
| 22840 | Insertion of posterior spinal instrumentation at base of neck for stabilization, 1 interspace |
| 22842 | Insertion of posterior spinal instrumentation for spinal stabilization, 3 to 6 vertebral segments |
| 22845 | Insertion of anterior spinal instrumentation for spinal stabilization, 2 to 3 vertebral segments |

After reviewing comments on the proposed rule, CMS agreed with commenters that services that are add-ons to the excluded 10- and 90-day global services should be removed from the list of codes identified through the high expenditure screen in order to maintain relativity. Therefore, CMS removed these codes from the potentially misvalued code list in the 2016 PFS final rule and these codes will not be reviewed as potentially misvalued. However, CMS noted that it will consider these and similar add-on codes in conjunction with efforts to improve the valuation of the global surgery packages.

**CMS Actions on Codes with 2015 Interim Final RVUs**

CMS finalized the interim final work RVUs for nine spine surgery codes in the 2016 final PFS rule:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Code** | **Descriptor** | **CY 2015 Interim Final Work RVU** | **CY 2016 Work RVU** | **CY 2016 CMS Action** |
| 22510 | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic | 8.15 | 8.15 | Finalize |
| 22511 | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral | 7.58 | 7.58 | Finalize |
| 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 | Finalize |
| 22513 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic | 8.90 | 8.90 | Finalize |
| 22514 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar | 8.24 | 8.24 | Finalize |
| 22515 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., 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 | Finalize |
| 22856 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical | 24.05 | 24.05 | Finalize |
| 22858 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure) | 8.40 | 8.40 | Finalize |
| 27279 | Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device | 9.03 | 9.03 | Finalize |

Note that ISASS submitted comments on the 2015 final PFS to CMS in December 2014 expressing disagreement with the interim final work RVU assigned to CPT 27279 (9.03 RVUs). ISASS requested CMS refer the code to the Refinement Panel, a multi-specialty group of physicians who review new clinical data that was not available at the time of the RUC valuation that might affect work RVUs of interim final codes.

As part of our refinement panel request, ISASS conducted two paired comparison surveys utilizing Rasch analysis on the work involved in CPT 27279. Additionally, Dr. David Polly and his colleagues at the University of Minnesota compared time utilization for MIS SIJ fusion and primary lumbar discectomy. The results of the first paired comparison survey conducted by ISASS in December 2014 suggests that the work RVUs for CPT 27279 should be 14.36; the results of the second paired comparison survey conducted by ISASS and SMISS in March and April 2015 suggests that the work RVUs for CPT 27279 should be 14.1; the study conducted by Dr. David Polly and his colleagues suggests that MIS SI joint fusion requires more physician time and effort than open primary lumbar microdiscectomy and that the work RVUs for MIS SI joint fusion should be at a minimum equal to the work RVUs for open primary lumbar microdiscectomy (13.18).

ISASS presented all of this data to the 2015 Multi-Specialty Refinement Panel hosted by CMS in August 2015, but despite the new data suggesting a higher work RVU value, the outcome of the refinement panel was a median of 9.03 work RVUs. After consideration of the comments and the results of the refinement panel, CMS finalized the interim final work RVU of 9.03 for CPT 27279. It should be noted that CMS did increase the Practice Expense RVUs from 5.88 to 8.61 and the Malpractice RUVs from 1.14 to 2.51, which results in an increase in total RVUs for CPT 27279 from 16.05 to 20.15.

**Changes to Direct Practice Expense Inputs for Vertebroplasy Codes**

After the publication of the 2015 PFS final rule, stakeholders identified several clerical inconsistencies in the clinical labor nonfacility intraservice time for several vertebroplasty codes with interim final values for 2015. In the 2016 proposed rule, CMS proposed to correct these inconsistencies to reflect the RUC recommended values. Commenters on the 2016 proposed rule noted that there were remaining clinical labor errors beyond those detailed by CMS in the proposed rule. After consideration of comments received, CMS finalized changes to clinical labor inputs that account for the additional corrections identified by commenters:

* For CPT codes 22510 (percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic) and 22511 (percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral), a value of 45 minutes for labor code L041B (“Radiologic Technologist”) CMS finalized the proposal to assign for the “assist physician” task and a value of 5 minutes for labor code L037D (“RN/LPN/MTA”) for the “Check dressings & wound/ home care instructions /coordinate office visits /prescriptions” task.
* For CPT code 22514 (percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar), CMS finalized the nonfacility intraservice time of 50 minutes for L041B, 50 minutes for L051A (“RN”), 38 minutes for a second L041B, and 12 minutes for L037D.

**Quality Reporting Programs**

Modifications to the Physician Quality Reporting System (PQRS)

CMS is finalizing requirements for the 2018 PQRS payment adjustment consistent with the requirements for the 2017 PQRS payment adjustment; CMS establishes the same criteria for satisfactory reporting that was established for the 2017 PQRS payment adjustment, which is generally to require the reporting of nine measures covering three National Quality Strategy domains. If an individual eligible professional or group practice does not satisfactorily report or satisfactorily participate in PQRS for 2016, a 2% negative payment adjustment will apply to covered professional services furnished by that individual eligible professional or group practice during 2018.

There will be 281 measures in the PQRS measure set and 18 measures in the GPRO Web Interface for 2016. Also, as recently authorized under MACRA, CMS is adding a reporting option that will allow group practices to report quality measure data using a Qualified Clinical Data Registry (QCDR).

Please note that the 2018 PQRS payment adjustment is the last adjustment that will be issued under the PQRS. Starting in 2019, adjustments to payment for quality reporting and other factors will be made under the Merit-Based Incentive Payment System (MIPS), as required by MACRA. CMS sought comment related to other MACRA provisions in the 2016 PFS proposed rule and in a previously published Request for Information.

Physician Compare

CMS will continue to make all 2016 individual eligible professional and group practice PQRS measures available for public reporting. CMS is also finalizing the following proposals:

* To include an indicator on profile pages for individual eligible professionals who satisfactorily report the new PQRS Cardiovascular Prevention measures group in support of the Million Hearts initiative;
* To continue making individual-level Qualified Clinical Data Registry (QCDR) measures available for public reporting, and, new to 2016, to publicly report group-level QCDR measures;
* To publicly report an item (or measure)-level benchmark derived using the Achievable Benchmark of Care (ABC™) methodology;
* CMS is finalizing the proposal to publicly report an item-level benchmark for group practice and individual eligible professional PQRS measures using the ABC methodology; the benchmark will be stratified by reporting mechanism to ensure comparability and reduce the interpretation burden for consumers. On Physician Compare, the benchmark will be displayed as a five-star rating. CMS will conduct analysis and stakeholder outreach around the star attribution methodology prior to public reporting in 2017.
* To include in the downloadable database the Value Modifier tiers for cost and quality, noting if the group practice or EP is high, low, or neutral on cost and quality; a notation of the payment adjustment received based on the cost and quality tiers; and an indication if the individual EP or group practice was eligible to but did not report quality measures to CMS; and
* To publicly report in the downloadable database utilization data for individual EPs.

CMS is not finalizing the proposal to include a visual indicator on profile pages for group practices and individual EPs who receive an upward adjustment for the Value Modifier.

The Medicare EHR Incentive Program

CMS is revising the definition of certified EHR technology in accordance with criterion finalized by the Office of the National Coordinator for Health Information Technology and CMS’ form and manner requirements for electronic submission of CQMs.

Physician Value-Based Payment Modifier

The Value Modifier is set to expire at the end of 2018, as a new comprehensive program, required by MACRA, called the MIPS begins in 2019. The final policies established in this rule are intended to help provide a smooth transition from the Value Modifier to MIPS. This year, CMS is finalizing the following key provisions:

* To apply the Value Modifier to nonphysician eligible professionals who are Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Certified Registered Nurse Anesthetists (CRNAs) (and not to other nonphysician eligible professional types) in groups and to PAs, NPs, CNSs, and CRNAs who are solo practitioners, in the 2018 payment adjustment period;
* To apply the quality-tiering methodology to all groups and solo practitioners that meet the criteria to avoid the downward adjustment under the PQRS. Groups and solo practitioners would be subject to upward, neutral, or downward adjustments derived under the quality-tiering methodology, with the exception that PAs, NPs, CNSs, and CRNAs in groups consisting of nonphysician eligible professionals and PAs, NPs, CNSs, and CRNAs who are solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology in 2018;
* To continue to set the maximum upward adjustment under the quality-tiering methodology for the 2018 Value Modifier at: +4.0 times an adjustment factor (to be determined after the conclusion of the performance period), for groups of physicians with ten or more eligible professionals; +2.0 times an adjustment factor, for groups of physicians with between two to nine eligible professionals and physician solo practitioners; and +2.0 times an adjustment factor for groups that consist of nonphysician eligible professionals and solo practitioners who are PAs, NPs, CNSs, and CRNAs; and
* To set the amount of payment at risk under the 2018 Value Modifier to -4.0 percent for groups of physicians with ten or more eligible professionals, -2.0 percent for groups of physicians with between two to nine eligible professionals and physician solo practitioners, and -2.0 percent for groups that consist of nonphysician eligible professionals and solo practitioners who are PAs, NPs, CNSs, and CRNAs.
* To waive application of the Value Modifier for groups and solo practitioners, as identified by their Taxpayer Identification Number (TIN), if at least one eligible professional who billed for PFS items and services under the TIN during the applicable performance period for the Value Modifier participated in the Pioneer ACO Model, Comprehensive Primary Care Initiative (CPCI), or other similar Innovation Center model (such as Comprehensive ESRD Care Initiative, Oncology Care Model (OCM), and the Next Generation ACO Model) during the performance period, beginning with the 2017 payment adjustment period;
* To use 2016 as the performance period for the 2018 Value Modifier and continue to apply the 2018 Value Modifier based on participation in the PQRS by groups and solo practitioners;
* Beginning with the 2017 payment adjustment period, CMS is increasing the minimum episode size for the Medicare Spending per Beneficiary measure to be included in the Value Modifier to 125 episodes for all groups and solo practitioners.  Also, beginning with the 2017 payment adjustment period, for solo practitioners and groups with two to nine eligible professionals, CMS is finalizing that the All-Cause Hospital Readmissions measure will not be used in the quality composite calculation for the Value Modifier;
* To not apply the automatic downward adjustment applicable to TINs that do not meet the criteria to avoid the downward adjustment under PQRS, when PQRS determines on informal review that at least 50% of the TIN’s eligible professionals meet the criteria to avoid the downward PQRS payment adjustment.  Also, CMS notes that if the group was initially determined to have not met the criteria to avoid the PQRS downward payment adjustments and consequently was initially subject to the automatic downward adjustment under the Value Modifier, then CMS does not expect to have data for calculating their quality composite, in which case they would be classified as “average quality.”

**Physician Self-Referral Updates**

The 2016 final PFS rule establishes two new exceptions to physician self-referral regulations and clarifies certain regulatory terminology and requirements.

New Exceptions:

The rule establishes a new exception to permit payment by hospitals, Federally Qualified Health Centers, and Rural Health Clinics to physicians for the purpose of compensating nonphysician practitioners under certain conditions. It also establishes a new exception to permit timeshare arrangements for the use of office space, equipment, personnel, items, supplies, and other services. CMS believes these new exceptions will enhance access to care across all areas and will be particularly helpful in rural and underserved areas.

Updating Physician-Owned Hospital Requirements:

The Affordable Care Act established restrictions on physician-owned hospitals, including setting a baseline physician ownership percentage that they cannot exceed and requiring them to state on their websites and in their advertising that they are owned by physicians.

CMS updated the regulations to clarify that a broad range of actions comply with the website and advertising requirements. CMS also finalized conforming changes that better align the regulations to the statute so that the baseline and future calculations of a hospital’s physician ownership percentage includes all physicians rather than only those physicians who refer to the hospital. The physician ownership calculation change takes effect on January 1, 2017.

Clarifying Terminology and Providing Policy Guidance:

The Self-Referral Disclosure Protocol allows CMS to settle overpayments resulting from physician self-referral law violations. Review of self-disclosures indicates that clarifying terminology and providing policy guidance could reduce perceived or actual noncompliance without risk of abuse. CMS is making the following updates:

* Clarifying that compensation paid to a physician organization cannot take into account the referrals of any physician in the physician organization, not just a physician who stands in the shoes of the physician organization, and that employees and independent contractors need not sign arrangements between the physician organization and a DHS entity;
* Clarifying that the writing required in many of the exceptions to the physician self-referral law’s referral and billing prohibitions can be a collection of documents (as opposed to a single formal contract) and making the terminology that describes types of arrangements consistent throughout the regulations;
* Clarifying that the term of a lease or personal service arrangement need not be in writing if the arrangement lasts at least 1 year and is otherwise compliant;
* Allowing expired leasing and personal services arrangements to continue indefinitely on the same terms if otherwise compliant;
* Allowing a 90-day grace period to obtain missing signatures without regard to whether the failure to obtain the signature was inadvertent;
* Clarifying that DHS entities can give to physicians items used solely for one or more of the purposes identified in the statute;
* Clarifying that a financial relationship does not exist when a physician provides services to hospital patients in the hospital if both the hospital and the physician bill independently for their services;
* Updating obsolete language in the exception for ownership in publicly traded entities to allow over-the-counter transactions and removing unnecessary language from the definition of a locum tenens physician;
* Clarifying the geographic service area for the Federally Qualified Health Centers and Rural Health Clinics using the physician recruitment exception; and
* Correcting a drafting error so that the retention exception indicates that retention payments based on physician certification may be no more than 25% of the physician’s current annual salary averaged over 24 months (as opposed to no more than 24 months).

**Next Steps**

CMS is accepting comments on the proposed rule until 5 p.m. EST on December 29, 2015. The final rule goes into effect on January 1, 2016.

**Important Links**

Final Rule: <https://www.federalregister.gov/articles/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>

PFS Addenda and Other Attachments: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1631-FC.html>

Fact Sheet: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-2.html>

Submit Individual Comments to the Final Rule at: <http://www.regulations.gov/#!documentDetail;D=CMS-2015-0081-2290>

Note: Click on the blue “Comment Now!” button in the upper right hand corner.