[CMS-1654-F] - Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid 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; Medicare Shared Savings Program Requirements

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

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Overview

On November 2, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final 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.

To set physician 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 final conversion factor is $35.89 (the 2016 final conversion factor was $35.80).

Spine Codes

As part of the final rule, CMS issues values for new codes and codes deemed misvalued. Please see the spine code spreadsheet for a full listing of spine procedure RVUs and reimbursements from the 2016 final rule compared to the 2017 final rule. Highlighted below are new Category I spine codes and their corresponding values and reimbursements set to take effect January 1, 2017. ISASS participated in the CPT and RUC processes for several of these new codes and is disappointed that despite our best efforts, CMS did not follow the RUC recommendations for several of the new codes, and instead assigned lower final values.

Please note that the reimbursement amounts contained in this document are not calculated using the geographic practice cost indices (GPCI), so your reimbursement will be slightly different than the amounts listed based on the geographic location of your practice. Also note that these are the approximate reimbursement rates to the surgeon (not the facility); facility payments to hospitals and ASCs are made under separate payment systems.

New Category I Spine Codes effective January 1, 2017:

Code	Descriptor	2017 Final Work RVU	2017 Final Practice Expense RVU	2017 Final Mal-practice RVU	2017 Final Total RVU	2017 Final Reimburse-ment
22853	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	4.25	2.03	1.36	7.64	$274.19
22854	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	2.63	1.76	9.89	$354.94
22859	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	5.50	2.63	1.76	9.89	$354.94
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	13.50	10.78	4.27	28.55	$1,024.62
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level	4.00	1.92	1.22	7.14	$256.25
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	7.03	6.71	1.96	15.70	$563.45
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level	2.34	1.13	0.69	4.16	$149.30
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	Contractor Pricing	Contractor Pricing	Contractor Pricing	Contractor Pricing	*Contractor Pricing

(*Rather than assigning a final value to 62380, CMS instead chose to assign contractor pricing. This means that each individual Medicare Administrative Contractor (MAC) will set its own value and make its own reimbursement determination.)

In the final rule, CMS provides the following rationale for their revised work RVU proposals:

Biomechanical Device Insertion (CPT codes 22853, 22854, and 22859)

The CPT Editorial Panel established three new Category I add-on codes and deleted one code to provide a more detailed description of the placement and attachment of biomechanical spinal devices. For CPT code 22853, the RUC recommended a work RVU of 4.88. For CPT codes 22854 and 22859, the RUC-recommended work RVUs are 5.50 and 6.00, respectively.

In reviewing the code descriptors, descriptions of work and vignettes associated with CPT codes 22854 and 22859, CMS concluded 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 proposed the RUC-recommended work RVU of 5.50 for both CPT code 22854 and CPT code 22859. CMS believes that the RUC-recommended work RVU of 4.88 for CPT code 22853 overestimates the work in the procedure relative to the other codes in the family. CMS proposed a work RVU of 4.25 for CPT code 22853 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 is similar in time and intensity to the work described by CPT code 22853.

Comment: Several commenters, including ISASS, disagreed with CMS' proposed valuation of the work RVU of 4.25 for CPT code 22853 rather than the RUC-recommended work RVU of 4.88. Commenters requested clarification regarding CMS' crosswalk for this new code to CPT code 37237 instead of the RUC-recommended crosswalk of CPT code 57267.

CMS Response: CMS takes many factors into consideration when valuing a work RVU for a new code. CMS notes that CPT code 57267 and CPT code 37237 have identical intraservice times and very similar total work times. CMS notes that CPT code 37237 was most recently valued in April 2013, whereas the RUC crosswalk CPT code 57267 was last reviewed in 2004. CMS continues to believe that CPT code 37237 is an appropriate crosswalk for valuing the new CPT code 22859. Therefore, CMS finalized the proposed work RVU of 4.25 for CPT code 22853.

Comment: CMS received several comments, including comments from ISASS, objecting to its proposed work RVU of 5.50 for CPT code 22859, which is identical to the work RVU proposed by the RUC and accepted by CMS for CPT code 22854. Commenters provided detailed descriptions of the two procedures in an effort to demonstrate the higher intensity required by CPT code 22859 compared with CPT code 22854, thereby justifying the RUC-recommended work RVU of 6.00 for CPT code 22859. Several commenters expressed confusion about the descriptors for all three of the new CPT codes (CPT codes 22853, 22854, and 22859), in general, and stated their concern that the code descriptors do not clearly differentiate the work involved in furnishing the services.

CMS Response: While CMS is somewhat persuaded by commenters' detailed descriptions of the two procedures and the higher intensity of work involved in furnishing CPT code 22859 compared with CPT code 22854, CMS is concerned about a substantive disagreement between the RUC and survey respondents about the intensities of work involved in furnishing the services described by these new codes. The RUC and the survey respondents valued the

relative intensities of the two codes in the reverse order. The survey results indicated a work RVU of 8.16 (with 25th percentile of 7.0) for CPT code 22854 and a work RVU of 8.0 (with 25th percentile of 6.0) for CPT code 22859. The RUC reviewed the survey results and agreed that respondents overvalued the work involved in performing CPT code 22854. The RUC-recommended work RVU for CPT code 22854, which CMS accepted as recommended, was established through a crosswalk to CPT code 37234. CMS agrees that this is an appropriate crosswalk and valuation of this service. For CPT code 22859, the RUC also believed that the survey recommended work RVU of 8.0 was overvalued. The RUC recommended the 25th percentile of survey results, with a work RVU of 6.0. CMS finds it difficult to reconcile the conflicting valuations by the survey and the RUC of the absolute and relative intensity of these new codes.

In addition to the survey results and RUC recommendations, CMS reviewed the descriptors of these codes and agrees with commenters who found them vague and unclear. CMS shares the concern of stakeholders who indicated that the lack of differentiation in the codes may lead to inconsistent use and reporting.

Given the disagreement between the RUC and survey respondents regarding the order and level of intensity of these services, along with confusion about the code descriptors, CMS finds that valuing the services of 22854 and 22859 differently from each another is difficult to justify. Therefore, CMS finalized its proposed work RVU of 5.50 for CPT code 22859.

Insertion of Spinal Stability Distractive Device (CPT codes 22867, 22868, 22869, and 22870)

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 22867 and 22869) and developed two corresponding add-on codes (CPT codes 22868 and 22870). The RUC recommended a work RVU of 15.00 for CPT code 22867, 4.00 for CPT code 22868, 7.39 for CPT code 22869, and 2.34 for CPT code 22870.

CMS believes that the RUC recommendations for CPT codes 22867 and 22869 overestimate the work involved in furnishing these services and 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. CMS states CPT code 36832 is similar in total time, work intensity, and number of visits to CPT code 22867 and believes this crosswalk 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 proposed a work RVU of 13.50 for CPT code 22867. For CPT code 22869, CMS believed 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 a work RVU of 7.03; therefore, CMS proposed a work RVU of 7.03 for CPT code 22869. CMS proposed the RUC-recommended work RVU for CPT codes 22868 and 22870 without refinement.

Comment: Several commenters, including ISASS, disagreed with CMS' proposed valuation of the work RVU for CPT codes 22867 and 22869. Commenters stated that the RUC crosswalk for each of these codes, respectively, is either identical to or a better match than the proposed CMS crosswalk.

CMS Response: CMS recognizes that the RUC crosswalk of CPT code 29915 for CPT code 22867 has a total time that is more similar to the new code than the crosswalk we proposed (CPT code 36832). CMS considers multiple factors when identifying appropriate crosswalk codes. CMS note that RUC's crosswalk, CPT code 29915, had very low service utilization, 355 in 2015, and was last reviewed by CMS and the RUC in April 2010. CPT code 36832, in contrast, had service utilization of 21,529 in 2015, and was most recently reviewed in October 2013. CMS considered

the combination of these factors in choosing a crosswalk and determining a proposed work RVU. Commenters did not present any additional clinical information or data about this code that would lead CMS to reconsider its proposed valuation; therefore, CMS finalized the work RVU of 13.50 for CPT code 22867.

With regard to CPT code 22869, CMS disagrees that the RUC crosswalk to CPT code 29880 is a closer comparison than CPT code 29881. The intraservice time for the newly created CPT code 22869 (43 minutes) is between that of the RUC recommended crosswalk CPT code 29880 (45 minutes) and the CMS crosswalk CPT code 29881 (40 minutes). Total time for CPT code 29881, however, is identical to total time for CPT code 22869 (194 minutes), whereas the RUC recommended crosswalk CPT code 29880 has a higher total time (199 minutes). CMS continues to believe that their crosswalk is appropriate and therefore finalized the proposed work RVU of 7.03 for CPT code 22869.

Endoscopic Decompression of Spinal Cord (CPT code 62380)

The CPT Editorial Panel created CPT code 62380 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 62380 and 47562 are similar in intensity, CMS believes using the same work RVU as the crosswalk code overestimates the work involved in furnishing CPT code 62380. Reference CPT code 49507 (Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated) has a work RVU of 9.09 and has similar intensity and an identical intraservice time compared to CPT code 62380. Therefore, CMS proposed a work RVU of 9.09 for CPT code 62380.

Comment: Some commenters, including ISASS, reiterated that the RUC-recommended direct crosswalk to CPT code 47562 is appropriate since this code has a similar physician time, and the IWPUT of the RUC- recommended work RVU is 0.085, a comparable valuation when compared with other spinal decompression procedures. The RUC agreed that the intensity of CPT code 62380 was greater, which offsets the 10-minute difference in intraservice time between the two codes. The RUC indicated that the difference in intensity between these procedures is based on CPT code 62380 involving decompression about neural elements and the spinal cord, where the opportunity for complications and for loss of function is high. One commenter indicated that CMS' proposed work RVU would fall below the minimum survey results.

A few commenters expressed concerns about the structure of the CPT code descriptors and RUC-recommended valuations. Commenters suggested that the CPT Editorial Panel and the RUC did not take certain indications into account such as differences between the physician work required for endoscopic tubular microdiscectomy compared to lumbar spinal stenosis decompression and posterior cervical posterior laminoforaminotomy. Commenters indicated that the specialty society survey data was inadequate due to the inexperience of the survey respondents, with others suggesting that the survey times were not reflective of some practitioners' experience or patient complexity.

The commenters indicated that the current RUC recommendations for full endoscopic tubular endoscopic surgery are based on limited experience among survey respondents with lumbar microdiscectomy, and insufficient experience with lumbar spinal stenosis decompression and posterior cervical foraminotomy without fusion and are invalid for these indications.

Commenters requested that the current CPT codes and valuations for full endoscopic lumbar spinal stenosis decompression and posterior cervical foraminotomy without fusion remain unchanged until further RUC survey data are examined. Some commenters suggested alternative crosswalks including CPT code 61548 (Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic) with a work RVU of 23.37,

CPT code 63030 (Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar) with a work RVU of 13.18, and CPT code 63056 (Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)) with a work RVU of 21.86.

CMS Response: As discussed above, commenters raised multiple concerns about the accuracy of the survey results, the RUC's recommended valuation of this service, and CMS' subsequent proposed refinements. Therefore, at this time, CMS is finalizing contractor pricing for CPT code 62380. CMS notes that the summary of recommendations (SOR) included with the RUC recommendations indicated that the expert panel reviewing the survey data for this procedure believed the survey median and 25th percentile work RVU were inconsistent with the physician work as it related to other major open spine procedures. Subsequently, the RUC recommended a work RVU of 10.47 based on a crosswalk from CPT code 47562 (Laparoscopy, surgical; cholecystectomy). The RUC noted that procedures reported with CPT code 62380 have ten minutes less intraoperative time compared to the RUC's recommended crosswalk from CPT code 62380, but suggested that the physician work of endoscopic decompression in the small disc interspace near the spinal nerve roots of the cauda equina is more complex and will require more post-discharge office work for required imaging to confirm stabilization and for physical therapy orders and monitoring.

CMS notes that based on the RUC's utilization crosswalk, services that will be reported in 2017 with CPT code 62380 are currently reported using either CPT code 22899 (Unlisted procedure, spine) or CPT code 0275T (Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar)), which are both contractor priced for 2016. CMS welcomes feedback from interested parties and specialty societies regarding valuation of this service for consideration in future rulemaking.

Data Collection: Codes with 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. Citing concerns with lack of data to verify and update the values of codes with global packages, in the 2017 proposed rule, CMS proposed 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. Specifically, the data collection effort would have included:

1. Comprehensive claims-based reporting about the number and level of pre- and post- operative visits furnished for codes with global services via a series of new G-codes structured in 10-minute increments;
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; and
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.

After receiving substantial pushback, especially on the first prong of its plan, from the physician community and medical societies including ISASS, in the 2017 final rule, CMS finalized a data collection strategy that significantly reduces the burden on surgeons and their practices compared to the proposed rule:

- Instead of required reporting on all codes with 10- and 90-day global periods, CMS will only collect data on the number of visits for codes that are reported annually by more than 100 practitioners and with high volume or high allowed charges (furnished more than 10,000 times or have allowed charges of more than $10 million annually).

- Instead of required reporting on the number and level of pre- and post-operative visits using a new set of G-codes structured in 10-minute increments, CMS finalized use of existing CPT code 99024 to collect data on the number of post-operative visits. In addition, CMS will not require surgeons to report the level or time spent on each visit.

- Instead of required reporting from all physicians who perform procedures with 10- and 90-day global periods, CMS finalized reporting only from a sample of practitioners consisting of those in larger practices (10 or more practitioners) in specified states (Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island), and is allowing all others to report voluntarily.

Lastly, the start date for data collection has been pushed back from January 1, 2017 to July 1, 2017.

Appropriate Use Criteria – Advanced Diagnostic Imaging Services

Section 218(b) of the Protecting Access to Medicare Act (PAMA) of 2014 established a new program 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).

The 2017 final rule focuses on the next component of the Medicare AUC program and includes policies 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.

In the 2017 final rule, CMS finalized the first eight priority clinical areas:

(1) Coronary artery disease (suspected or diagnosed)

(2) Suspected pulmonary embolism

(3) Headache (traumatic and non-traumatic)

(4) Hip pain

(5) Low back pain

(6) Shoulder pain (to include suspected rotator cuff injury)

(7) Cancer of the lung (primary or metastatic, suspected or diagnosed)

(8) Cervical or neck pain

Priority clinical areas are intended to be the areas of focus for future outlier calculations when determining which ordering professionals will be subject to prior authorization.

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 program crosses almost every medical specialty.

Next Steps

The final rule goes into effect January 1, 2017.