
CMS Issues 2018 Proposed Physician Fee Schedule: What Spine Surgeons Should Know

[CMS-1676-P] - Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Overview

On July 13, 2017, 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, 2018. 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 11, 2017, and will issue the final rule by November 1, 2017.

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 2018 proposed conversion factor is \$35.9903 (the 2017 final conversion factor was \$35.8887).

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 comprehensive comparison of RVUs and reimbursements of spine procedures from the 2017 final rule to the 2018 proposed rule. Highlighted below is a new Category I spine code set to take effect January 1, 2018 as well as a spine code identified as potentially misvalued by CMS.

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Comment Deadline

CMS is accepting comments on the proposed rule until September 11, 2017 at [Regulations.gov](http://www.Regulations.gov). CMS will issue the final rule by November 1, 2017.

Resources

[CMS Fact Sheet](#)
[Full Text of Proposed Rule](#)
[Proposed Rule Data Files](#)

[New Category I Spine Code effective 01/01/18](#)

CPT 2093X – Bone Marrow Aspiration

At the September 2016 CPT Editorial Panel meeting, a new Category I add-on code (2093X) was approved for aspiration of bone marrow for spine autograft procedures.

2093X - Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision

Previously, CPT code 38220 (*Bone marrow aspiration*) was used to report this service. However, in early 2016, CPT code 38220 was redefined to reflect bone marrow aspiration for diagnostic purposes only. The newly developed CPT code 2093X was valued at the January 2017 RUC meeting and can only be utilized for spine surgery procedures starting January 1, 2018.

Code	Descriptor	RUC-Recommended Work RVU	CMS-Proposed Work RVU	Facility Practice Expense RVU	Mal-Practice RVU	Total Facility RVU
2093X	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision	1.16	1.16	0.59	0.18	1.93

[Potentially Misvalued Spine Code](#)

CPT 27279 – Minimally Invasive Sacroiliac Joint Fusion

CMS identified CPT 27279 (*Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device*) as potentially misvalued. This is a positive step as ISASS has repeatedly communicated with CMS about the value of this code and has shared data with the agency that supports a higher work RVU. The code is currently assigned 9.03 work RVUs, while objective data gathered by ISASS and other stakeholders indicates the work RVU should be 14.23. As part of the proposed rule, CMS is accepting public comments to gather stakeholder opinions on whether the code is potentially misvalued and stakeholder suggestions for an appropriate work RVU.

[Appropriate Use Criteria for Advanced Diagnostic Imaging Services](#)

The Protecting Access to Medicare Act (PAMA) required CMS to create a program that effective January 1, 2017 would have denied payment for advanced imaging services unless the physician ordering the service had consulted appropriate use criteria (AUC). The impact of this program is extensive as it will apply to every physician or other practitioner who orders or furnishes advanced diagnostic imaging services (e.g. MRI, CT, PET).

Under the program, a physician ordering advanced imaging services must consult AUC through a qualified clinical decision support mechanism (CDSM) prior to ordering the imaging, except under very limited exempted scenarios (i.e. for emergency services provided to individuals with emergency medical conditions; for an inpatient and for which payment is made under Medicare Part A; or ordering professionals who are granted a significant hardship exception to the Medicare EHR Incentive Program).

CMS has defined CDSM as an “interactive, electronic tool for use by clinicians that communicates AUC information to the user and assists them in making the most appropriate treatment decision for a patient’s specific clinical condition.” These tools may be modules within or available through certified EHR technology or other mechanisms independent from certified EHR technology.

In the 2017 final rule, CMS finalized a list of priority clinical areas for which prior authorization will eventually be required:

- Coronary artery disease (suspected or diagnosed)
- Suspected pulmonary embolism
- Headache (traumatic and non-traumatic)
- Hip pain
- **Low back pain**
- Shoulder pain (to include suspected rotator cuff injury)
- Cancer of the lung (primary or metastatic, suspected or diagnosed)
- **Cervical or neck pain**

CMS previously had delayed implementation of the AUC program until 2018 but now in response to pressure from stakeholders, the agency is proposing to further delay the requirements until January 1, 2019. This first year of reporting would be regarded as an opportunity for testing and education and would not affect payment to the physician providing the image. Those who wish to begin testing earlier could participate in a voluntary reporting period expected to begin on July 2018.

Patient Relationship Categories

The Medicare Access and CHIP Reauthorization Act (MACRA) directed CMS to create new patient relationship codes that physicians would be required to report on claims starting in 2018 for the purposes of determining which physician would be held accountable for a patient’s cost of care. CMS proposes 5 patient relationship categories and associated modifiers to report these patient relationship categories. CMS is proposing that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include the applicable modifier, as well as the NPI of the ordering physician or applicable practitioner.

Five Proposed Patient Relationship Categories and Modifiers

Proposed Patient Relationship Category	Definition	Proposed Modifier
Continuous/Broad Services	For reporting services by clinicians who provide the principal care for a patient, with no planned endpoint of the relationship. Services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role. Reporting clinician service examples include primary care services and specialists providing comprehensive care to patients in addition to specialty care.	X1
Continuous/Focused Services	For reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time. A reporting clinician service example would be a rheumatologist taking care of the patient’s rheumatoid arthritis longitudinally but not providing general primary care services.	X2

Episodic/Broad services	For reporting services by clinicians who have broad responsibility for the comprehensive needs of the patients, that is limited to a defined period and circumstance, such as a hospitalization. A reporting clinician service example would include a hospitalist providing comprehensive and general care to a patient while the patient is admitted to the hospital.	X3
Episodic/Focused Services	For reporting services by specialty focused clinicians who provide time-limited care. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention. A reporting clinician service example would be an orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period.	X4
Only as Ordered by Another Clinician	For reporting services by a clinician who furnishes care to the patient only as ordered by another clinician. This patient relationship category is reported for patient relationships that may not be adequately captured in the four categories described above. A reporting clinician service example would be a radiologist interpretation of an imaging study ordered by another clinician.	X5

Evaluation and Management (E/M) Guidelines

CMS calls for a multi-year effort to revise the Evaluation and Management Guidelines to accompany a desire to reduce administrative burden to physicians. CMS suggests a focus on eliminating guidelines related to history and physical examination, with greater importance placed on medical decision making and time spent performing the service.

PQRS and MU Quality Reporting

As established by the 2016 final rule, physicians were required to report 9 measures across 3 National Quality Strategy Domains, with one cross-cutting measure included. In the 2018 proposed rule, CMS proposes to revise the 2016 Physician Quality Reporting System (PQRS) and Meaningful use (MU) quality reporting requirements to only require physicians to report 6 measures with no domain or cross-cutting measure requirements. This proposal aligns the PQRS and MU quality reporting requirements with the new quality reporting requirements for physicians under MIPS. However, web-interface criteria would remain the same.

Value-Based Modifier (VM)

CMS proposes to:

- Hold all groups and solo practitioners who met 2016 PQRS reporting requirements harmless from any negative VM payment adjustments in 2018;
- Halve penalties for those who did not meet PQRS requirements to -2 percent for groups with 10 or more eligible professionals, and to -1 percent for smaller groups and solo practitioners;
- Reduce the maximum upward payment adjustment to 2 times an adjustment factor that is set at the rate needed to keep penalties and bonuses budget neutral; and
- Drop its earlier proposal to publicly report 2016 value modifier data on its Physician Compare web site.

Request for Information on CMS Flexibilities and Efficiencies

CMS invites public comment on ideas for regulatory, subregulatory, policy, practice and procedural changes to improve the health care system by reducing unnecessary burdens for clinicians, other providers, patients and their families. Ideas could include payment system redesign, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements and processes with those from Medicaid and other payers, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery, and facilitation of individual preferences. Responses to this Request for Information could also include recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, physicians, providers, and suppliers.

Next Steps

CMS is accepting public comments on the proposed rule through September 11, 2017 at [regulations.gov](https://www.regulations.gov). To submit a comment, click on the blue “Comment Now!” button on the top right of the page. CMS expects to release a final rule by November 1, 2017.

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