Proposed Rule: CMS Updates Physician Payment System and Proposes Regulatory Changes

Every year, the Centers for Medicare & Medicaid Services (CMS) proposes regulations that impact the reimbursement of physicians. On July 29, CMS issued a proposed rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule in 2020. The proposed rule illustrates the importance of AAN’s regulatory advocacy efforts on behalf of neurologists and their patients.

Electroencephalography (EEG) Coding Changes

A new coding structure for reporting long term EEG monitoring services will go into effect January 1, 2020:
- Deletes existing codes 95950, 95951, 95953, and 95956
- Creates 10 new codes for the professional component (physician services)
- Creates 13 new codes for the technical component (technologist services)

As a reminder, the full CPT code language and reporting guidelines will become public in mid-August 2019. The AAN is conducting an in-depth analysis of the proposed payment rates to fully understand the financial impact to our members and will share detailed coding guidance in future publications as well as next steps. The AAN, along with the National Association of Epilepsy Centers (NAEC), American Clinical Neurophysiology Society (ACNS), and the American Epilepsy Society (AES), has spent the last several months actively advocating to maintain maximum reimbursement for these critical services. This included a meeting directly with CMS officials who oversee the Physician Fee Schedule.

The AAN is disappointed the agency’s proposed payment rates do not fully follow the recommendations of the American Medical Association (AMA) for the entire set of professional service codes and very concerned about implications of such a reduction. The AAN and our partners will take immediate action objecting to CMS and work toward improving the values. It is important to note that this is a proposed rule open for comment and not finalized until November, meaning the payment rates are subject to change.
Evaluation and Management (E/M)

CMS is proposing to make significant changes beginning in 2021 to policies related to outpatient evaluation and management (E/M) coding, leading to substantial payment increases for neurology. CMS is proposing to withdraw its plan to collapse the existing levels of E/M coding and instead implement revised E/M documentation guidelines as laid out by the AMA CPT Editorial Panel. It maintains the existing 5 levels of coding for established patients and reduces the number of levels for new patients to 4, by eliminating 99201. The proposed changes will also allow clinicians to choose E/M visit levels using either medical decision making or time. Additionally, CMS is proposing to implement an add-on code for prolonged service time and a separate add-on code to recognize the complexity inherent to E/M services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition.

These changes are positive news for neurology and represent a substantial change from the code collapse that was proposed by CMS in the previous fee schedule! The AAN commends CMS for listening to the AAN and recognizing the value of cognitive care. AAN members and staff committed extensive resources over the past year to work with CMS and the AMA to build a new E/M structure that will meet the needs of neurologists and their patients.

Changes to Care Management Services

CMS is proposing to make changes to several care management services in 2020, including increased payment for transitional care management (TCM) and eliminating billing restrictions on several codes that cannot currently be billed during the 30-day period. The agency is also proposing to adopt new codes that more accurately account for additional clinical staff time spent on chronic care management (CCM). New codes for principal care management (PCM) services are also proposed, which account for care management associated with patients with a single high-risk disease or complex chronic condition. The AAN commends the agency for continuing to recognize the additional care provided to complex patients that extends beyond a typical face to face encounter.

Quality Payment Program

This rule also includes proposed updates to the Quality Payment Program, which includes the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) tracks.

CMS is proposing no changes to the MIPS low-volume threshold, indicating those clinicians deemed eligible to participate in 2019 can expect to continue next year. The rule proposes increasing the performance and exceptional bonus thresholds for 2020 to 45 points and 80 points, respectively. Additionally, CMS proposes decreasing the weight of the MIPS Quality component to 40 percent from 45 percent and increasing the weight of the MIPS Cost component to 20 percent from 15 percent. There are no proposed changes to the Improvement Activities and Promoting Interoperability component weights. The rule also introduces proposed changes to the cost measure attribution methodology for the Total Per Capita Cost and Medicare Spending Per Beneficiary measures and 10 additional episode-based measures.
The rule introduces a new framework to begin in 2021 called MIPS Value Pathways (MVPs) which aims to align the four MIPS components based on specialty or condition, reduce administrative burden, and facilitate the transition into Advanced Alternative Payment Models.

On the APM side, CMS is proposing a Quality performance credit, equaling 50 percent of the MIPS Quality component score, for those MIPS-APM participants that cannot feasibly be scored on quality within their APM entity. These participants could report MIPS quality measures to add to their base 50 percent credit. Additionally, the rule proposes using average marginal risk rates for Advanced APMs across all possible levels of actual expenditures, instead of the current practice of using the lowest marginal risk rate.