Neurology Payment Victories in 2015 Medicare Physician Fee Schedule

Each year, the Centers for Medicare & Medicaid Services (CMS) issues regulations that impact how physicians are paid. On October 31, 2014, CMS issued a final rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule (MPFS) in 2015.

The latest Sustainable Growth Rate (SGR) patch keeps payments at 2014 levels through March 31, 2015. Without congressional action, on April 1, 2015, the payment rate for physician services will decrease 21.2 percent in accordance with an adjustment to the SGR formula.

CMS projects that overall allowed charges for neurologists will remain neutral in 2015. This is welcome news in light of the decreases neurologists experienced in 2013 and 2014.

Chronic Care Management Codes
Neurology practices that treat patients with multiple chronic conditions and satisfy the reporting requirements will be able to report and be reimbursed for chronic care management (CCM) services using new CPT code 99490. The AAN, along with other members of the physician community, have been working closely and met with CMS several times to underscore the importance of allowing separate payment to physicians for the non-face-to-face care management involved for beneficiaries with multiple chronic conditions. In response, for 2015, CMS will pay more than $40 for the CCM code, which can be billed no more frequently than once per calendar month per qualified patient.

Advance Care Planning
While there are two new CPT codes to report this service, CMS will not pay separately for the service in 2015, though the agency indicates it may consider paying for advance care planning in the future. Neurology practices should check with private payers to see if they will reimburse for these services.

Global Surgical Periods
The AAN is very pleased that CMS is planning to eliminate 10- and 90-day global periods, a change the AAN has encouraged for years. Most services that neurologists perform are XXX or 0 day global. In 2017-2018, all 10- and 90-day globals will transition to 0-day globals, meaning all visits following the surgery will need to be billed separately. Physicians should be required to perform and document the services they provide in follow up to surgery, rather than having a set number of visits automatically included in the overall payment for a surgical procedure. Any money CMS does not spend on unperformed follow-up visits would be redistributed back into the rest of the fee schedule.

Transparency in Rate Setting
The AAN is pleased that CMS is finalizing their proposal to publish and allow for a public comment period on values for all new and revised codes before they are finalized starting with the 2017 rulemaking cycle. The earlier publication will give greater notice to practitioners and allow for public comments on the proposals before they are finalized. The 2016 rulemaking cycle will be used as a transition year, with values for codes for which CMS receives recommended values from the RUC published in the proposed rule.
Telemedicine
CMS will cover several new services delivered by telemedicine, including prolonged E/M services.

Physician Quality Reporting System
The Physician Quality Reporting System (PQRS) is a pay-for-reporting program that uses a combination of bonuses and penalties to promote reporting of quality information by physicians.

Neurology-related measures in PQRS in 2015 include:
- Sleep apnea
- Dementia
- Parkinson’s disease
- Stroke
- Epilepsy: counseling for women of childbearing potential

In addition, CMS is adding one new measure from the AAN for ALS patient care preferences.

For 2015, CMS will require physicians to report on at least one measure from a new cross-cutting measure set as part of the nine measures they are required to report on. Failure to do so could result in a 2-percent penalty on 2017 payments.

Electronic Health Records (EHR) Incentive Program
For 2015, CMS will lessen one burden in its EHR Incentive Program by no longer requiring that EHR products be recertified to the most recent version of the electronic specifications for clinical quality measures.

Value-based Payment Modifier (VM)
Fulfilling a statutory mandate from the Affordable Care Act (ACA), CMS is finalizing that all physicians—including solo practitioners—will be subject to a value-based payment modifier (VM) in 2017 based on 2015 quality and cost data.

In 2017, groups with 2-9 providers as well as solo practitioners will receive either a bonus or no adjustment. Groups with 10+ providers will begin receiving a bonus, no adjustment, or a penalty in 2016.

For the first time, CMS has made Quality and Resource Use Reports (QRURs) available to all physicians based on their performance in 2013. Each QRUR contains the group or solo practitioner’s performance information on the quality and cost measures used to calculate the quality and cost composites of the VM and show how they would fare under the policies established for the VM for the 2015 calendar year. Access your QRUR here.

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