Neurology Sees Major Victory and Future Advocacy Opportunities in 2016 Medicare Physician Fee Schedule

Each year, the Centers for Medicare & Medicaid Services (CMS) issues regulations that impact how physicians are paid. On October 30, 2015, CMS issued its final rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule (MPFS) in 2016. In September, the AAN submitted comments to the agency advocating on behalf of our members. We are very pleased to see the inclusion of advance care planning codes in the final rule, but there is more work to be done.

Advance Care Planning
The AAN is very pleased with the inclusion of advance care planning in the final rule. This CMS decision provides Medicare coverage for neurologists to have conversations with their patients regarding future care for their serious illness. The AAN and coalition stakeholders advocated for this coverage and participated in defining and valuing these codes.

The rule offers access to voluntary services under Medicare and provides individuals with an important opportunity to establish and document their preferences and goals of care. Medicare will now pay a physician’s office $86 for the first 30 minutes of advance care planning and $80 if the service takes place in a hospital setting. Medicare will further pay $75 for an additional 30 minutes of consultation. These amounts are scaled to reflect the geographic location where the service takes place.

CMS further stated that advance care planning is to take place at the discretion of the beneficiary. Additionally, other staff like social workers and nurses may perform this service under direct supervision of a physician. The AAN is pleased to see the CMS decision to not impose any frequency limitations on the benefit, but the agency did note it would monitor utilization for potential fraud.

Reimbursement for Care Management Services
The AAN has been a leader in efforts to seek additional CMS research into evaluation and management (E/M) activities. We remain encouraged by the agency’s interest in ways to recognize the different resources in cognitive work involved in the delivery of broad-based, ongoing treatment. CMS did not finalize any policies through this rulemaking, but stated it will be developing proposals for next year’s MPFS. We will continue to advocate for codes that allow for the reporting of the additional time and intensity of the cognitive work undertaken by neurologists in conjunction with an E/M service. The AAN will also continue to push for improvements to the accuracy of payments for care coordination, particularly for patients requiring more extensive care.

Impact to Neurology
The AAN will continue advocating the value of neurology to CMS as the final rule’s estimated overall impact to neurology’s allowed charges for 2016 is -1%. This will vary depending on the mix of services provided by neurology practices. Those neurologists that report electroencephalogram codes 95812 and 95813 will be impacted as CMS implemented a reduction in the dollars associated with technician time for these EEG services, resulting in a decrease in the overall payment.

**MACRA Implementation**
In the proposed rule, CMS solicited stakeholder feedback on the [Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)](https://www.cms.gov/Regulations-and-Guidance/Legislation/MACRA.html). The AAN offered comments on aspects of the new Merit-based Incentive Payment System (MIPS) and alternative payment models. Although CMS did not establish final MACRA policies in this rulemaking, we expect proposed rules to be announced in the spring of 2016.

**Global Surgical Package**
The AAN continues to support efforts to accurately capture the work associated with surgical global service periods. In the final rule, CMS stated its intention to continue developing and implementing the process to gather information needed to value surgical services. CMS intends to issue proposals in next year’s rule. The agency suggested the possibility of open forums or town hall meetings to discuss the process.

**Value Modifier**
CMS uses the value-based payment modifier (VBPM) to assess both quality of care furnished and the cost of that care under the Fee Schedule. It rewards high-performing providers with increased payments while reducing payments for low-performing providers. Implementation of the VBPM is based in part on participation in the [Physician Quality Reporting System (PQRS)](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/). Quality and cost data from this year (2015) will be applied in 2017 for all providers. This means that all providers who have not successfully reported for PQRS during the 2015 reporting period will be assessed a reduction, depending on the size of the practice, in all Medicare fee-for-service payments in 2017.

As stated by the final rule, CMS will use calendar year 2016 as the performance period for the calendar 2018 value modifier and continue to apply the 2018 value modifier based on participation in the PQRS by groups and solo practitioners. Furthermore, application of the value modifier on 2018 payments will be expanded to non-physician eligible professional solo practitioners and group practices, such as physician assistants, nurse practitioners and clinical nurse specialists, based on the 2016 performance period. The value modifier is set to expire at the end of 2018, as a new comprehensive program, required by MACRA, called the Merit-based Incentive Payment System (MIPS) begins in 2019. The AAN website can help answer questions you may have and provides additional resources to help you and your practice successfully navigate the VBPM program.

Please continue to visit the AAN’s [Medicare Payments](https://www.aan.com/advocacy/covered_treatment_coverage) page for regulatory updates.