AAN Regulatory Advocacy Pays Off: CMS to Reimburse for More E/M Activities

Each year, the Centers for Medicare & Medicaid Services (CMS) issues regulations that impact how physicians are paid. On November 2, 2016, CMS issued its final rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule (MPFS) in 2017. Total payments for neurology in 2017 will remain unchanged compared to the 2016 calendar year.

In September, the AAN submitted comments to the agency advocating on behalf of our members. We are pleased to see CMS finalize several coding and payment changes that will increase reimbursement opportunities for neurologists starting January 1.

Summary of Key Topics
- Major Improvements in Reimbursement for Cognitive Care Services
- Telehealth: Adding Critical Care Consultations to the List of Covered Services
- Consulting Appropriate Use Criteria (AUC) Prior to Ordering Certain Advanced Diagnostic Imaging Services
- Global Surgical Services

Major Improvements in Reimbursement for Cognitive Care Services

Over the last several years, the AAN has engaged CMS to highlight the value of cognitive specialists. These proactive efforts are evident in the final MPFS as CMS will now reimburse for four new CPT codes and four existing, previously unpaid, codes. New codes capture non-face-to-face work associated with patient care outside of an E/M visit.

CMS agrees with the AAN regarding the value neurologists play in the health care system, and will begin paying for cognitive and functional assessment and care planning services for patients with cognitive impairment.

CMS is finalizing several revisions to CPT codes to more accurately recognize the work of cognitive specialties like neurology. In the past, care management and cognitive work was “bundled” into E/M visit codes, meaning that any additional efforts by the neurologist were not paid for outside of the E/M visit. In the final rule, CMS aims to improve payment for this kind of care by recognizing codes that separately pay for chronic care management.

CMS also is finalizing payment for non-face-to-face time spent outside of E/M. Under the new policy, neurologists will be paid for the significant amount of time spent outside of the in-person office visit caring for the individual needs of their patients. The final rule also improves payment for visits that initiate chronic care management (CCM) services. This change more appropriately recognizes the effort neurologists must put forth as they handle extensive patient assessments and establish CCM care plans that are not accounted for in the initiating visit.

Telehealth: Adding Critical Care Consultations to the List of Covered Services
CMS recognizes the potential benefit of critical care consultation services that are furnished remotely, and specifically distinguishes telestroke as an approach that allows a neurologist to provide remote treatment to stroke victims. Teleneurology offers consultations for neurologic problems from a remote location and may be initiated by a physician or patient for conditions such as headaches, dementia, strokes, multiple sclerosis, and epilepsy.

CMS is finalizing payment through two new codes that describe initial and subsequent encounters for critical care consultations furnished via telehealth. The new codes provide a mechanism to report an intensive telehealth consultation service for the critically ill patient—such as a stroke patient—under the circumstance when a qualified health care professional has in-person responsibility for the patient but the patient benefits from additional services from a distant-site consultant specially trained in providing critical care services. Like the other telehealth consultations, these services are valued relative to existing E/M services.

**Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services**

CMS lays the groundwork for a future program that will require physicians to consult appropriate use criteria (AUC) prior to ordering advanced diagnostic imaging services. CMS has articulated requirements and processes for specification of qualified clinical decision support mechanisms (CDSMs) under the Medicare AUC program and the initial list of priority clinical areas. 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 patient’s clinical scenario.

In the final rule, CMS included headache under what it describes as a priority clinical area of focus. CMS will release the first qualified CDSMs on June 30, 2017, at the earliest, and CMS anticipates that providers may begin reporting as early as January 1, 2018.

CMS finalized three exceptions to the AUC consultation and reporting requirements:

1. Applicable imaging services ordered for an individual with an emergency medical condition;
2. Applicable imaging services ordered for an inpatient and for which payment is made under Medicare Part A; and
3. An ordering professional who CMS determines, on a case-by-case basis and subject to annual renewal, that consultation with applicable AUC would result in a significant hardship, such as in the case of a professional practicing in a rural area without sufficient Internet access.

**Global Surgical Services**

Under the misvalued code initiative in the 2015 final rule, CMS finalized a policy to transform all 10- and 90-day global codes to 0-day global codes beginning in 2018. Under this policy, CMS would have valued the surgery or procedure to include all services furnished on the day of surgery and paid separately for visits and services furnished after the day of the procedure.
Although Congress ultimately intervened, CMS is now required to gather data on visits in the post-surgical period that could be used to accurately value these services.

The 2017 payment rule finalizes a reduced data collection strategy to gather data on the activities and resources involved in furnishing these services. To the extent that this data results in proposals to revalue any surgical services, that revaluation will be done through future rulemaking. As per the final rule, required reporting will be limited to a sample of practitioners for selected services. Specifically, reporting will be required only for services related to codes reported annually by more than 100 practitioners and that are reported more than 10,000 times or have allowed charges in excess of $10 million annually.

Visit the AAN’s Medicare Payments page for regulatory updates, including more details on the new payment and coding changes finalized by CMS. Register for the free December 13, 2016, webinar Decoding the 2017 Medicare Fee Schedule and MACRA Rule.