2016 Medicare Physician Fee Schedule

Final Rule Summary

On October 30, 2015, the Centers for Medicare and Medicaid Services (CMS) released the Final Medicare Physician Fee Schedule (MPFS) for 2016. The final rule updates payment policies and payment rates for services furnished under the MPFS and includes changes to the quality reporting initiatives associated with the MPFS – the Physician Quality Reporting System (PQRS), the physician Value-Based Payment Modifier (VBM), and the Physician Compare Website.

The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code, can be found here. All of the provisions of the rule will be effective January 1, 2016, except for certain definitions related to Physician Self-Referral.

The following summarizes the major payment and quality provisions of the proposed rule.

PAYMENT PROVISIONS

Conversion Factor (CF) and Specialty Impact

The conversion factor for 2016 is $35.8279. This figure represents a 0.29 percent reduction from 2015 based on the budget neutrality adjustment, the 0.5% increase in the CF mandated by Congress further adjusted by the expenditure reduction target also mandated by Congress. Table 62 (see Attachment 1), extracted from the rule, provides a summary of the impact of the proposed changes in the rule by specialty. The changes in the rule are budget-neutral in the aggregate which explains why the impact for all physicians is shown as zero. The 2016 proposed rule is showing changes in the range of plus or minus 1% for most specialties, with Neurology seeing a -1 percent change. Proposed payment rates for most neurophysiology services and the evaluation and management codes provided by neurologists remain stable, except for EEG codes 95812 and 95813 which will see 19% reductions when provided in a physician office setting.

Misvalued Codes

Congress passed several bills, including provisions in the Affordable Care Act, directing CMS to identify "misvalued" services and requiring their re-evaluation. An annual Medicare savings target has been set at 1% (of total Part B spending) in 2016-2018 and at .5% in 2019-2020 to be achieved by lowering RVUs for misvalued codes. If the net reduction in misvalued codes is not equal to or greater than 1%, CMS must implement an across-the board reduction in all physician fee schedule services to reach the target, which is reflected in the 2016 CF.

In the final rule, CMS is seeking the review and re-evaluation of over 100 misvalued codes that represent high expenditure services that haven't been reviewed by the AMA RUC since 2009 with Medicare allowed charges of more than $10 million. Of interest to epilepsy centers are Code 95957 (which was

identified as misvalued in last year's rule as well), and the family of neurostimulator/VNS codes – 95970-95982, which have been identified as misvalued and will be reviewed by the RUC next year.

Two Year Phase In of RVU Reductions

CMS finalized its proposal to phase-in any RVU reductions of 20% or more over a two year period by reducing the maximum allowable payment by 19% in the first year of the payment reduction and taking the remainder of the reduction in the second year. This phase-in will not be applied to new or revised CPT codes and reductions in practice expense will be implemented separately based on the site of service.

"Incident to" Policy for 2016

CMS is finalizing its proposed changes to the current regulations related to services provided "incident to" a physician or other practitioner's service. The "incident to" regulations will specify that only the physician (or other practitioner) that supervises the auxiliary personnel that provide "incident to" services is permitted to bill Medicare Part B for those "incident to" services. CMS will also make clear that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) treating the patient more broadly. In addition, CMS will amend the definition of the term, "auxiliary personnel" that are permitted to provide "incident to" services to exclude individuals who have been excluded from the Medicare program or have had their Medicare enrollment revoked.

Advance Care Planning Services

CMS finalized its proposal to reimburse providers for advance care planning (ACP) services: CPT code 99497 and add-on CPT code 99489. The Medicare statute currently provides coverage for advance care planning under the "Welcome to Medicare" visit available to all Medicare beneficiaries, but patients don't often need these services when they first enroll in Medicare. This rule establishes separate payment for advance care planning codes to recognize additional practitioner time needed for this conversation. CMS is also finalizing payment for advance care planning when it is included as an optional element of the "Annual Wellness Visit."

Telehealth Services

Under limited conditions, CMS will reimburse for telehealth services. In these circumstances, CMS will pay a fee to the facility orchestrating the services in addition to a payment for the practitioner furnishing the service. These services include consultations, office visits, and office psychiatry visits, if they have been furnished using a telecommunications system. CMS finalized the addition of the Prolonged Service Inpatient Codes 99356, 99357 (these codes can only be billed in conjunction with subsequent hospital and nursing facility codes) to the list of services that can be provided through telehealth.

Physician Self-Referral Updates

The final rule provides for two new exceptions to the Physician Self-Referral regulations (Stark law) and clarification of current rules to address frequent questions and existing uncertainty due to court cases. The two exceptions: 1. Permit payments by hospitals, FQHCs, and Rural Health Clinics to physicians for compensating non-physician practitioners providing primary care services and 2. Permit timeshare arrangements for office space, equipment, personnel, and other services benefiting rural or underserved areas. The rule also updates requirements related to websites and advertising and makes changes to the calculations of a hospital's physician ownership taking effect on January 1, 2017.

QUALITY PROVISIONS

Physician Quality Reporting System (PQRS)

Since its initial implementation in 2007, PQRS has continued to evolve largely as a result of statutory updates enacted by Congress. It moved into a penalty phase with the CY 2013 program, which is continuing. As mandated by Congress, those providers who do not report quality measures in CY 2016 will have their payments adjusted by -2% in CY 2018. The Medicare and CHIP Reauthorization Act of 2015 (MACRA) amends the ACA by authorizing the end of the Physician Quality Reporting System (PQRS) in 2018 and the initiation of the Merit-based incentive Payment System (MIPS).

Criteria to Satisfactorily Report. To avoid the penalty, eligible providers are required to report at least 9 measures covering 3 of the National Quality Strategy domains for 50 percent of the Medicare Part B patients they see during the reporting period. Also, an eligible professional or group practice that sees at least 1 Medicare patient in a face-to-face encounter would be required to report on 1 cross-cutting PQRS measure, which are specified by CMS. (Telehealth visits are not considered face-to-face encounters for this requirement.) Eligible professionals and groups, who choose to report by claims or registry would be required to report 2 measures from the cross-cutting measures set. CMS will continue to allow eligible professionals using the claims-based reporting mechanism to report 3 measures on 50 percent of their applicable patients to avoid the payment adjustment.

Quality Measures. It is statutorily mandated that measures must be endorsed by the National Quality Forum or entities under contract with NQF. But, CMS will consider measures not NQF-endorsed when no endorsed measure in an area exists. In addition, CMS will not restrict the type of organizations that can develop quality measures and there are no requirements for measure development. CMS added measures where gaps exist and eliminate topped out or duplicative measures. These changes bring the total to 281 measures in the PQRS measures set and 18 measures in the GPRO Web Interface for 2016.

Value-Based Payment Modifier and Physician Feedback Program

The establishment of a value-based payment modifier (VBM) was mandated by the ACA in order to provide differential payment to physicians and group practices based upon the quality and cost of care furnished to Medicare beneficiaries during a specific performing period. The statute requires the VBM be implemented in a budget neutral manner, meaning that positive adjustments for high performance

must be offset by penalties imposed for poor performance. All physicians, groups of physicians and other eligible professionals, including physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) will be subject to the VBM by January 1, 2018, based on their reporting of quality and cost measures in 2016.

MACRA mandated that this program will expire in CY 2018 and be replaced by the Merit-Based Incentive Program (MIPS) in CY 2019. The policies in this final rule are designed to ensure a smooth transition between the two programs.

CMS establishes composite scores based on performance, one reflecting quality of care and the other cost. The quality of care composite is based on PQRS performance. Total per capita costs plus specific cost measures will be weighted equally to compute the cost composite. Quality tiering is the analysis used to determine the VBM type of adjustment (upward, downward or neutral) and the range of adjustment based on performance on quality and cost measures. Quality tiering will determine if a group practice's performance is statistically better, the same, or worse than the national mean. CMS will apply the quality-tiering methodology to all groups and solo practitioners who avoid the PQRS penalty.

CMS will continue to provide midyear and end of year Quality and Resource Use Reports (QRURs) to eligible professionals as a method of providing feedback on the quality and cost of care furnished to Medicare beneficiaries and will explain how the VBM impacts Medicare payments.

Physician Compare Website

CMS launched the Physician Compare Website, as mandated in the Affordable Care Act, on December 30, 2010. The site assists Medicare patients in comparing Medicare providers to help them make "informed decisions" regarding care. CMS is taking a phased approach to updating the website to meet the criteria required by ACA. CMS will continue to make individual and group-level PQRS measures publicly available. The agency is finalizing its proposal to publicly report an item-level benchmark for group practices and individual practitioners PQRS measures using the Achievable Benchmark of Care (ABC) methodology. The ABC is a hybrid of the comparative average and performance goal approaches, where current performance can be captured at the high end to create a "goal." The approach uses an algorithm that focuses on high performance and adjusts for small numbers of cases so that rare events will be considered without overly influencing the benchmark. The benchmark will be stratified by reporting mechanism to ensure comparability and make it more accessible to consumers.

Attachment 1

TABLE 62: CY 2016 PFS Final Rule Estimated Impact on Total Allowed Charges by Specialty*

(A)	(B)	(C)	(D)	(E)	(F)
	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
TOTAL	$89,020	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$221	0%	0%	0%	0%
ANESTHESIOLOGY	$1,970	0%	1%	-2%	0%
AUDIOLOGIST	$61	0%	-1%	1%	-1%
CARDIAC SURGERY	$343	0%	0%	0%	0%
CARDIOLOGY	$6,498	0%	0%	0%	0%
CHIROPRACTOR	$789	0%	0%	0%	0%
CLINICAL PSYCHOLOGIST	$720	0%	0%	0%	0%
CLINICIAL SOCIAL WORKER	$558	0%	0%	0%	0%
COLON AND RECTAL SURGERY	$161	-1%	0%	0%	-1%
CRITICAL CARE	$296	0%	0%	0%	0%
DERMATOLOGY	$3,217	0%	0%	0%	1%
DIAGNOSTIC TESTING FACILITY	$725	0%	0%	0%	0%
EMERGENCY MEDICINE	$3,120	0%	0%	0%	0%
ENDOCRINOLOGY	$454	0%	0%	0%	0%
FAMILY PRACTICE	$6,089	0%	0%	0%	0%
GASTROENTEROLOGY	$1,843	-2%	-1%	-1%	-4%
GENERAL PRACTICE	$478	0%	0%	0%	0%
GENERAL SURGERY	$2,210	0%	0%	0%	0%
GERIATRICS	$216	0%	0%	0%	0%
HAND SURGERY	$169	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	$1,788	0%	0%	0%	0%
INDEPENDENT LABORATORY	$834	1%	7%	0%	9%
INFECTIOUS DISEASE	$660	0%	0%	0%	0%
INTERNAL MEDICINE	$11,058	0%	0%	0%	0%
INTERVENTIONAL PAIN MGMT	$720	0%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	$298	0%	1%	0%	1%
MULTISPECIALTY CLINIC/OTHER PHY	$96	0%	0%	0%	0%
NEPHROLOGY	$2,199	0%	0%	0%	0%
NEUROLOGY	$1,524	0%	-1%	0%	-1%
NEUROSURGERY	$776	0%	0%	-1%	-1%
NUCLEAR MEDICINE	$46	0%	0%	0%	-1%
NURSE ANES / ANES ASST	$1,187	0%	2%	-2%	0%
NURSE PRACTITIONER	$2,551	0%	0%	0%	0%
OBSTETRICS/GYNECOLOGY	$669	0%	0%	0%	0%
OPHTHALMOLOGY	$5,506	0%	0%	0%	-1%
OPTOMETRY	$1,178	0%	0%	0%	0%
ORAL/MAXILLOFACIAL SURGERY	$47	0%	0%	0%	0%
ORTHOPEDIC SURGERY	$3,672	0%	0%	0%	0%
**Column F may not equal the sum of columns C, D, and E due to rounding.					

(A)	(B)	(C)	(D)	(E)	(F)
	Allowed Charges (mil)	**Impact of Work RVU Changes**	**Impact of PE RVU Changes**	**Impact of MP RVU Changes**	**Combined Impact**
OTHER	$25	0%	0%	0%	0%
OTOLARNGOLOGY	$1,197	0%	-1%	0%	0%
PATHOLOGY	$1,330	4%	4%	0%	8%
PEDIATRICS	$59	0%	0%	0%	0%
PHYSICAL MEDICINE	$1,035	0%	0%	0%	-1%
PHYSICAL/OCCUPATIONAL THERAPY	$3,102	0%	0%	0%	0%
PHYSICIAN ASSISTANT	$1,728	0%	0%	0%	0%
PLASTIC SURGERY	$376	0%	0%	0%	1%
PODIATRY	$1,999	0%	0%	0%	0%
PORTABLE X-RAY SUPPLIER	$106	0%	1%	0%	1%
PSYCHIATRY	$1,317	0%	0%	0%	0%
PULMONARY DISEASE	$1,780	0%	0%	0%	0%
RADIATION ONCOLOGY	$1,776	0%	-2%	0%	-2%
RADIATION THERAPY CENTERS	$52	0%	-2%	0%	-1%
RADIOLOGY	$4,494	0%	0%	0%	0%
RHEUMATOLOGY	$536	0%	0%	0%	0%
THORACIC SURGERY	$350	0%	0%	0%	0%
UROLOGY	$1,796	0%	0%	0%	0%
VASCULAR SURGERY	$1,019	0%	-1%	0%	-1%
**Column F may not equal the sum of columns C, D, and E due to rounding.					

2016 Final Physician Fee Schedule (CMS 1631-FC)					
Payment Rates for Medicare Physician Services - Neurology					
CPT Code	Mod	Descriptor	2015 CF = $35.8013*	2016 CF = $35.8279	% CHANGE 2015-2016
95812		EEG, 41-60 minutes	$422.10	$352.90	-16.39%
95812	TC	EEG, 41-60 minutes	$363.74	$294.15	-19.13%
95812	26	EEG, 41-60 minutes	$58.36	$58.76	0.69%
95813		EEG, over 1 hour	$505.16	$426.35	-15.60%
95813	TC	EEG, over 1 hour	$411.36	$332.84	-19.09%
95813	26	EEG, over 1 hour	$93.80	$93.51	-0.31%
95816		EEG, awake and drowsy	$361.95	$365.44	0.97%
95816	TC	EEG, awake and drowsy	$303.60	$306.69	1.02%
95816	26	EEG, awake and drowsy	$58.36	$58.76	0.69%
95819		EEG, awake and asleep	$412.79	$418.11	1.29%
95819	TC	EEG, awake and asleep	$354.43	$359.35	1.39%
95819	26	EEG, awake and asleep	$58.36	$58.76	0.69%
95822		EEG, coma or sleep only	$373.41	$376.55	0.84%
95822	TC	EEG, coma or sleep only	$315.05	$317.79	0.87%
95822	26	EEG, coma or sleep only	$58.36	$58.76	0.69%
95824	26	EEG, cerebral death only	$40.81	$40.13	-1.68%
95827		EEG, all night recording	$791.21	$704.02	-11.02%
95827	TC	EEG, all night recording	$733.21	$645.98	-11.90%
95827	26	EEG, all night recording	$58.00	$58.04	0.07%
95829		Surgery electrocorticogram	$1,901.41	$1,902.10	0.04%
95829	TC	Surgery electrocorticogram	$1,565.23	$1,559.23	-0.38%
95829	26	Surgery electrocorticogram	$336.17	$342.87	1.99%
95830	Hospital	Insert electrodes for EEG	$93.08	$93.87	0.84%
95830	Office	Insert electrodes for EEG	$248.46	$248.29	-0.07%
95950		Ambulatory eeg monitoring	$331.52	$333.92	0.72%
95950	TC	Ambulatory eeg monitoring	$250.61	$252.59	0.79%
95950	26	Ambulatory eeg monitoring	$80.91	$81.33	0.52%
95951	26	EEG monitoring/videorecord	$331.88	$325.32	-1.98%
95953		EEG monitoring/computer	$422.46	$425.99	0.84%
95953	TC	EEG monitoring/computer	$255.98	$259.04	1.19%
95953	26	EEG monitoring/computer	$166.48	$166.96	0.29%
95954		EEG monitoring/giving drugs	$463.27	$459.67	-0.78%
95954	TC	EEG monitoring/giving drugs	$336.53	$332.12	-1.31%
95954	26	EEG monitoring/giving drugs	$126.74	$127.55	0.64%
95955		EEG during surgery	$215.52	$218.19	1.24%
95955	TC	EEG during surgery	$161.11	$163.02	1.19%
95955	26	EEG during surgery	$54.42	$55.17	1.39%
95956		EEG monitoring, cable/radio	$1,683.38	$1,656.68	-1.59%
95956	TC	EEG monitoring, cable/radio	$1,488.98	$1,461.78	-1.83%
95956	26	EEG monitoring, cable/radio	$194.40	$194.90	0.26%
95957		EEG digital analysis	$319.35	$318.15	-0.37%
95957	TC	EEG digital analysis	$212.30	$211.03	-0.60%
95957	26	EEG digital analysis	$107.05	$107.13	0.07%
95958		EEG monitoring/function test	$586.78	$578.62	-1.39%
95958	TC	EEG monitoring/function test	$359.09	$348.25	-3.02%
95958	26	EEG monitoring/function test	$227.70	$230.37	1.18%
95961		Electrode stimulation, brain	$292.85	$298.09	1.79%
95961	TC	Electrode stimulation, brain	$132.82	$132.56	-0.20%
95961	26	Electrode stimulation, brain	$160.03	$165.52	3.43%

95962		Electrode stim, brain add-on	$258.84	$265.13	2.43%
95962	TC	Electrode stim, brain add-on	$88.07	$88.49	0.48%
95962	26	Electrode stim, brain add-on	$170.77	$176.63	3.43%
95965	26	MEG, spontaneous	$439.28	$427.43	-2.70%
95966	26	MEG, evoked, single	$221.25	$216.76	-2.03%
95967	26	MEG, evoked, each addÏl	$193.69	$188.81	-2.52%
95970	Hospital	Analyze neurostim, no prog	$24.34	$24.72	1.55%
95970	Office	Analyze neurostim, no prog	$67.66	$69.15	2.19%
95971	Hospital	Analyze neurostim, simple	$41.17	$41.56	0.94%
95971	Office	Analyze neurostim, simple	$58.00	$50.88	-12.28%
95972	Hospital	Analyze neurostim, complex	$42.25	$42.64	0.92%
95972	Office	Analyze neurostim, complex	$55.85	$59.47	6.49%
95974	Hospital	Cranial neurostim, complex	$167.19	$166.96	-0.14%
95974	Office	Cranial neurostim, complex	$210.87	$210.31	-0.27%
95975	Hospital	Cranial neurostim, complex	$94.52	$94.59	0.07%
95975	Office	Cranial neurostim, complex	$113.13	$113.22	0.07%

2016 Final Physician Fee Schedule (CMS 1631-FC)					
Payment Rates for Medicare Physician Services - Epilepsy Surgery					
CPT Code	Mod	Descriptor	2015 CF = $35.8013	2016 CF = $35.8279	% CHANGE 2015-2016
61531		Implant brain electrodes	$1,297.80	$1,290.16	-0.59%
61537		Removal of brain tissue	$2,605.26	$2,600.03	-0.20%
61538		Removal of brain tissue	$2,846.20	$2,838.64	-0.27%
61539		Removal of brain tissue	$2,515.40	$2,486.10	-1.16%
61540		Removal of brain tissue	$2,324.94	$2,324.51	-0.02%
61541		Incision of brain tissue	$2,288.78	$2,288.33	-0.02%
61543		Removal of brain tissue	$2,313.84	$2,234.59	-3.43%
61566		Removal of brain tissue	$2,395.11	$2,381.12	-0.58%
61567		Incision of brain tissue	$2,500.72	$2,728.65	9.11%
61720		Incise skull/brain surgery	$1,350.78	$1,350.35	-0.03%
61735		Incise skull/brain surgery	$1,691.97	$1,669.58	-1.32%
61750		Incise skull/brain biopsy	$1,488.62	$1,490.08	0.10%
61751		Brain biopsy w/ct/mr guide	$1,461.41	$1,463.93	0.17%
61760		Implant brain electrodes	$1,682.66	$1,682.12	-0.03%
61770		Incise skull for treatment	$1,729.20	$1,715.80	-0.78%
61790		Treat trigeminal nerve	$929.76	$933.32	0.38%
61791		Treat trigeminal tract	$1,194.69	$1,128.58	-5.53%
61796		Srs, cranial lesion simple	$1,075.83	$1,075.20	-0.06%
61797		Srs, cran les simple, addl	$236.29	$235.03	-0.53%
61798		Srs, cranial lesion complex	$1,468.93	$1,464.64	-0.29%
61799		Srs, cran les complex, addl	$325.43	$322.45	-0.92%
61800		Apply srs headframe add-on	$164.69	$164.09	-0.36%
61867		Implant neuroelectrode	$2,416.95	$2,397.24	-0.82%
61868		Implant neuroelectrde, add'l	$533.08	$524.52	-1.61%
61870		Implant neuroelectrodes	$1,258.06	$1,210.98	-3.74%
61880		Revise/remove neuroelectrode	$599.31	$600.12	0.13%
61885		Insrt/redo neurostim 1 array	$540.60	$542.08	0.27%
61886		Implant neurostim arrays	$889.30	$890.32	0.11%
61888		Revise/remove neuroreceiver	$416.01	$417.04	0.25%
63620		Srs, spinal lesion	$1,181.08	$1,184.11	0.26%
63621		Srs, spinal lesion, addl	$269.94	$270.14	0.07%

2016 Final Physician Fee Schedule (CMS 1631-FC)							
Payment Rates for Medicare Physician Services - Evaluation and Management							
CPT Code	Descriptor	NON-FACILITY (OFFICE)			FACILITY (HOSPITAL)		
		2015 CF = $35.8013	2016 CF = $35.8279	% CHANGE 2015-2016	2015 CF = $35.8013	2016 CF = $35.8279	% CHANGE 2015-2016
99201	Office/outpatient visit, new	$44.04	$44.43	0.89%	$26.85	$27.23	1.41%
99202	Office/outpatient visit, new	$75.18	$75.60	0.55%	$50.48	$50.88	0.78%
99203	Office/outpatient visit, new	$109.19	$109.28	0.07%	$77.69	$77.75	0.07%
99204	Office/outpatient visit, new	$166.12	$166.24	0.07%	$131.39	$131.49	0.07%
99205	Office/outpatient visit, new	$208.72	$208.52	-0.10%	$170.77	$170.90	0.07%
99211	Office/outpatient visit, est	$20.05	$20.06	0.07%	$9.31	$9.32	0.07%
99212	Office/outpatient visit, est	$44.04	$44.07	0.07%	$25.78	$25.80	0.07%
99213	Office/outpatient visit, est	$73.03	$73.45	0.56%	$51.20	$51.59	0.77%
99214	Office/outpatient visit, est	$108.48	$108.20	-0.26%	$79.12	$79.18	0.07%
99215	Office/outpatient visit, est	$146.43	$145.82	-0.42%	$112.42	$111.78	-0.56%
99221	Initial hospital care	NA	NA	NA	$102.75	$102.47	-0.27%
99222	Initial hospital care	NA	NA	NA	$138.55	$138.30	-0.18%
99223	Initial hospital care	NA	NA	NA	$205.14	$204.22	-0.45%
99231	Subsequent hospital care	NA	NA	NA	$39.38	$39.77	0.98%
99232	Subsequent hospital care	NA	NA	NA	$73.03	$72.73	-0.42%
99233	Subsequent hospital care	NA	NA	NA	$105.26	$104.98	-0.27%
99291	Critical care, first hour	$278.18	$277.31	-0.31%	$226.62	$226.07	-0.24%
99292	Critical care, add'l 30 min	$123.87	$123.96	0.07%	$113.13	$113.22	0.07%
99471	Ped critical care, initial	NA	NA	NA	$880.71	$887.10	0.73%
99472	Ped critical care, subseq	NA	NA	NA	$412.07	$414.17	0.51%
99495	Trans care mgmt 14 day disch	$165.76	$164.81	-0.57%	$112.06	$111.42	-0.57%
99496	Trans care mgmt 7 day disch	$232.71	$232.52	-0.08%	$161.46	$161.23	-0.15%