



AANS/CNS Washington
Committee for
Neurological Surgery



Congress of
Neurological
Surgeons

2024 Medicare Physician Fee Schedule Proposed Rule Summary

Overview

On July 13, 2023, the Centers for Medicare & Medicaid Services (CMS) released the 2024 Medicare Physician Fee Schedule (MPFS) [Proposed Rule](#). According to the proposal, the proposed rule's relative value unit (RVU) provisions will result in an overall -1% cut in neurosurgery payments. In addition to the RVU-related cuts, CMS proposes a ~3.5% reduction in the 2024 conversion factor (CF) for all physicians. The estimated 2024 conversion factor will be \$32.7476, down \$1.1396 compared to 2023. These additional cuts stem from the budget neutrality adjustment related to the new G2211 office visit add-on code for complex services (recall that the implementation of this code was postponed for three years in the Consolidated Appropriations Act, 2021) and a reduction in the temporary increase to CF provided by Congress in the omnibus spending bill. Unfortunately, these cuts come as practice costs continue to rise (CMS projects the increase in the Medicare Economic Index (MEI) for 2024 will be 4.5%).

When all is said and done, overall total **Medicare cuts to neurosurgical fees in 2024 will be at least 2.5%**.

The deadline for comments on the proposed rule is Sept. 11, 2023. More details are available in a CMS [fact sheet](#) (with links to multiple additional releases). Below are further details on issues of interest to neurosurgery.

Reimbursement Issues

CMS Review of RUC-passed Neurosurgery Codes

Below is a list of codes presented to the RUC by the AANS and the CNS showing the RUC-passed work relative values (wRVUs) and the CMS proposed values. In most cases this year, CMS agreed with the RUC.

CPT Code	Descriptor	RUC-passed wRVU	CMS Proposed wRVU
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar	27.13	27.13
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	7.50	6.88

CPT Code	Descriptor	RUC-passed wRVU	CMS Proposed wRVU
2X000	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device	7.86	7.86
2X002	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	32.00	32.00
2X003	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	35.50	35.50
2X004	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	36.00	36.00
619X1	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	25.75	25.75
619X2	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	11.25	11.25
619X3	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed	15.00	15.00
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver requiring pocket creation and connection between electrode array and pulse generator or receiver	5.19	5.19
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	4.35	4.35
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver direct or inductive coupling, requiring pocket creation and connection between electrode array and pulse generator or receiver	5.10	5.10

CPT Code	Descriptor	RUC-passed wRVU	CMS Proposed wRVU
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	3.79	3.79
64XX2	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator including imaging guidance, when performed; initial electrode array	Carrier Priced	Carrier Priced
64XX3	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator including imaging guidance, when performed; each additional electrode array	Carrier Priced	Carrier Priced
64XX4	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator	Carrier Priced	Carrier Priced

Potentially Misvalued Codes—CPT Code 27279

CMS received a comment nominating 27279 (Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device), as misvalued. Specifically, the commenter is asking CMS to price the service in the non-facility setting in addition to the facility setting. CMS has expressed concerns about whether this 90-day surgical service can be safely and effectively furnished in the non-facility/office setting (for example, in an office-based surgical suite). The agency invites comments on this topic.

Medicare Economic Index

In the 2023 MPFS Final Rule, CMS finalized updated MEI weights for the different cost components of the MEI for CY 2023. However, CMS also noted that it postponed implementing the MEI changes until sometime in the future, noting the need for continued public comment due to the significant impact on physician payments. If the MEI weights are implemented in a budget-neutral manner, overall physician work payment would be cut by 7 percent, and malpractice payments would be reduced several fold. These large shifts are due to a substantial error in CMS’ analysis of the U.S. Census Bureau’s Service Annual Survey, which omitted nearly 200,000 facility-based physicians. After correcting this significant omission, the physician work MEI weight would increase instead, and malpractice values would experience a much smaller reduction.

In the 2024 proposed rule, CMS announced it would postpone implementing the updated MEI weights until the AMA completes its soon-to-be-launched national study on physician practice expenses. The AANS the CNS are encouraging neurosurgeons to participate in the AMA’s Physician Practice Information survey.

Global Surgical Services

For 2024, CMS proposes updating the work RVUs and work times of maternity procedures with an “MMM” global period to reflect any relevant Evaluation and Management (E/M) updates associated with MMM global period. However, CMS continues to stay silent on the issue of incorporating E/M increases

into the global surgical package valuation. The surgical community has written CMS multiple letters, including a thorough technical analysis of the issues, and CMS has never responded.

Evaluation and Management Issues

- **“Add-on” Code for Complex Patients.** As noted above, CMS proposes implementing a separate add-on code and payment for enhanced visit complexity of primary care and longitudinal care of complex patients. G2211 would generally apply to outpatient office visits as an additional payment, recognizing the costs clinicians may incur when longitudinally treating a patient’s single, serious or complex chronic condition. CMS has lowered the estimated utilization assumption of the add-on code from 90% in its 2021 rule to 38% when initially implemented in 2024 and 54% once the code has been fully adopted.

Unfortunately, although the utilization assumption has been cut in half, the add-on code will still lead to an additional across-the-board cut to the CF due to Medicare’s budget neutrality requirements. Furthermore, the G2211 code will be predominately used by primary care and other office-based specialties. Generally speaking, it will not be available for neurosurgeons to use.

The AANS and the CNS will resume their advocacy with CMS and Congress, along with the Surgical Coalition and other negatively impacted specialties, to halt (or delay) the implementation of the G2211 code — which would eliminate the majority of the anticipated 2024 CF cut.

- **Split/Shared E/M Visits.** Once again, CMS plans on postponing its proposal for “Split or Shared” E/M visits, defined as visits provided in a facility setting by a physician and a non-physician provider in the same group. Two years ago, CMS implemented a condition allowing only the practitioner who provides the substantive portion by time to bill for the visit. The AANS and the CNS opposed the restriction. Under the proposal, the agency plans to delay any changes in this policy until 2025. Clinicians who furnish split (or shared) visits will continue to have a choice of history, physical exam, medical decision making (MDM) or time spent to define the substantive portion instead of using only total time to determine the substantive portion. In the meantime, the AMA CPT Editorial Panel has strengthened the guidance for reporting split/shared visits using MDM in the hopes that CMS will find this guidance helpful and rescind its plan to change the policy in 2025.

Telehealth Provisions and Inflation Reduction Act Implementation

CMS proposes implementing several telehealth-related provisions of the Consolidated Appropriations Act, 2023 that would be in effect until Dec. 31, 2024. Specifically of interest to neurosurgery, CMS proposes not to add Deep Brain Stimulation analysis and programming CPT codes 95970, 95983 and 95984 to the list of codes with permanent telehealth status. However, CMS proposes keeping these services on the list for 2024. The agency would consider additional evidence in future rulemaking to determine whether to add the services permanently.

Other telehealth provisions include:

- The temporary expansion of telehealth originating sites for services furnished via telehealth to include any site in the U.S. where the beneficiary is located at the time of the telehealth service will continue through Dec. 31, 2024. Extended policies include:
 - (1) Telehealth at an individual’s home;
 - (2) Delaying the requirement for an in-person visit with the physician or practitioner within six months before initiating mental health telehealth services; and
 - (3) Coverage and payment of telehealth services on the [Medicare Telehealth Services List](#).
- A proposal to continue defining direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive

telecommunications.

- A proposal to allow teaching physicians to use audio/video real-time communications technology in all residency training locations when the resident furnishes Medicare telehealth services.
- Telephone E/M codes 99441-99443 and 98966-98968.
- A proposal to extend current opioid treatment program flexibilities for periodic assessments furnished via audio-only telecommunications.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

CMS proposes to pause efforts to implement the Appropriate Use Criteria (AUC) for the advanced diagnostic imaging program for reevaluation. Per the proposal, the agency plans to rescind the current AUC program regulations at 42 CFR 414.94. CMS will continue to identify a workable implementation approach and propose adopting any such approach through subsequent rulemaking. The AANS and the CNS have been advocating that Congress repeal this program, which requires neurosurgeons ordering advanced diagnostic imaging, such as MRI scans, to consult AUC using an approved clinical decision support mechanism before the radiologist can provide the scan.

Quality Provisions

CMS proposes numerous policies related to the Quality Payment Program starting with the 2024 performance year, which affects 2026 payments.

Merit-Based Incentive Payment System (MIPS)

CMS sets forth several proposed changes to the MIPS program.

- Increasing the MIPS performance threshold — the minimum number of points needed to avoid a penalty — from 75 to 82 points starting in 2024.
- CMS previously finalized to increase the data completeness threshold for quality measures to 75% (up from 70%), beginning with the 2024 performance year. CMS proposes maintaining this level through 2026 but increasing it to 80% starting in 2027.
- Removing from traditional MIPS quality measure #128: Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan.
- Adding a new measure to the Neurosurgical Specialty Set titled “Connection to Community Service Provider,” which evaluates patients screened for health-related social needs.
- Establishing a new Rehabilitative Support for Musculoskeletal Care MIPS Value Pathway, which does not include measures that are specifically relevant to surgeons.
- Adopting a new Low Back Pain episode-based cost measure for 2024. Neurosurgeons participated in the workgroup that developed this measure, but the AANS and the CNS continue to have concerns that non-operative patients could be attributed to neurosurgeons under this chronic condition measure and will continue to request that neurosurgeons and orthopedic surgeons be removed from the list of eligible specialties for attribution.
- Increasing the Promoting Interoperability (PI) performance period to at least 180 days rather than 90 days.

- Only accepting a “yes” response to the PI SAFER Guides measure attestation. A “no” would result in a score of 0 for the entire PI category. The PI SAFER Guides measure is intended to promote EHR safety.
- Expanding its public reporting of utilization data to include Medicare Advantage data in addition to FFS data.

Alternative Payment Models

Per statute, CMS is required to increase the thresholds for becoming a Qualifying APM Participant (QP), which makes a clinician eligible for an incentive payment and exempt from MIPS. The threshold percentages will increase beginning with the 2024 performance year/2026 payment year as follows:

- Medicare payments: QP threshold increasing from 50% to 75%
- Medicare patients: QP threshold increasing from 35% to 50%

Per statute, eligible clinicians who are QPs for the 2023 performance year will receive a 3.5% APM Incentive Payment in the 2025 payment year (down from 5%). Beginning with the 2024 performance year/2026 payment year, QPs will receive a higher PFS payment rate (calculated using a higher “qualifying APM conversion factor”) of 0.75% versus non-QPs, who will receive 0.25%. QPs will remain excluded from MIPS reporting and payment adjustments for the applicable year. CMS also proposes making QP determinations at the individual eligible clinician level instead of at the APM entity level, which could benefit specialists.