



CY 2019 Medicare Physician Fee Schedule Final Rule Summary

On November 1, the Center for Medicare and Medicaid Services (CMS) released the final Medicare Physician Fee Schedule (MPFS) for 2019. The final rule updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found [here](#). The rule's provisions are effective January 1, 2019 unless stated otherwise. The following summarizes the major payment policies in the final rule.

Conversion Factor and Specialty Impact

The conversion factor for 2019 will be \$36.0391 and remains essentially flat. Table 94 (see Attachment 1), extracted from the rule, provides a summary of the impact of the changes in the final 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 final rule shows changes in the range of minus 5% to plus 4%, with neurology experiencing no change in 2019.

2019 Relative Values and Payment Rates for Epilepsy Center Services

Attached to this summary are charts showing the relative value units and national average payments for the major medical and surgical services provided at epilepsy centers and for evaluation and management (E/M) services. In general, the relative value units for the professional component for procedural services provided by epilepsy centers remain stable in 2019; there are reductions in multiple technical component services, which would only be billed if done in a physician office or IDTF. There is a new code taking effect for ECoG of the monthly review of data for patients on the RNS system and the neurostimulator analysis and programming codes have been changed for 2019. The changes in payment and policies for these codes and for E/M services are described below.

*New Electrocorticography Code for RNS (**CPT code 95836**)*

A new CPT code (95836) will take effect on January 1, 2019 for an Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days. This code is to be used for the non-face-to-face service to review a month's worth or more of stored data from patients on the RNS system. CMS finalized its proposed work RVUs for this service of 1.98, which is lower than the AMA RUC recommended work RVUs of 2.30.

Revisions to Neurostimulator Analysis/Programing Codes

The VNS codes 95974 and 95975 will be deleted as of January 1, 2019. Two new codes have been established for cranial nerve neurostimulator services, with definitions that are no longer time-based. CMS did not accept the RUC recommended values for these services. The codes and RVUs are:

- **CPT Code 95976** – Electronic analysis of implanted neurostimulator pulse generator/transmitter, by physician or other qualified health care professional; with **simple** (1 to 3 parameters) cranial nerve neurostimulator pulse generator/transmitter programing by physician or other qualified health care professional; (**0.73 Physician Work RVUs**)
- **CPT Code 95977** - Electronic analysis of implanted neurostimulator pulse generator/transmitter, by physician or other qualified health care professional; with **complex** (more than 3 parameters) cranial

nerve neurostimulator pulse generator/transmitter programing by physician or other qualified health care professional. (**0.97 Physician Work RVUs**)

The brain neurostimulator codes 95978 and 95979 have also been deleted in 2019 and replaced by new codes 95983 and 95984, which are reported according to the face-to-face time and differentiated by the initial 15 minutes and each additional 15-minutes. The new codes and RVUs are:

- **CPT Code 95983** - Electronic analysis of implanted neurostimulator pulse generator/transmitter, by physician or other qualified health care professional; with **brain** neurostimulator pulse generator/transmitter programming, **first 15 minutes** face-to-face time with physician or other qualified health care professional (**0.91 Physician Work RVUs**)
- **CPT Code 95984** - Electronic analysis of implanted neurostimulator pulse generator/transmitter, by physician or other qualified health care professional; with **brain** neurostimulator pulse generator/transmitter programming, **each additional 15 minutes** face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure) (**0.80 Physician Work RVUs**)

Evaluation & Management Proposals

In the proposed rule, CMS proposed significant changes to how E/M services will be paid and documented. In response to overwhelming stakeholder opposition to the proposal, CMS will not make any E/M payment changes until January 1, 2021, having significantly revised its payment proposals which will be discussed in more detail in this summary. For 2019 and 2020, CMS will continue to use the current coding and payment structure for outpatient E/M visits, and practitioners should continue to use the 1995/1997 guidelines to document them.

Documentation Requirements to be Implemented on January 1, 2019:

- For home visits, CMS is eliminating the requirement to document the medical necessity of providing a visit at home rather than in the office.
- Physicians will no longer be required to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated.
- Physicians will no longer need to re-enter in the medical record information on the patient's chief complaint and history if it has already been entered by ancillary staff or the beneficiary.

Payment Policy to be Implemented January 1, 2021

CMS finalized a single payment rate for level 2-4 new and established outpatient visits. Providers will still bill the existing CPT codes for the appropriate level of service (99202-99204 or 99212-99214), but Medicare will reimburse at the new consolidated rate. Level 5 visits will remain separate and retain their current value to better account for the care and needs of particularly complex patients.

Add-On Codes: The agency finalized the new primary care and non-procedural specialized care complexity add-on codes that can be billed with all level 2-4 new and established patient office visits. These add-on codes will not have any additional documentation requirements and are not restricted by specialty. CMS also recognizes that there may be rare instances where the primary care and non-procedural specialty add-on codes may be billed together. In addition, CMS finalized the extended visit add-on code, which can be billed with the consolidated level 2 – 4 E/M service. These new codes are described below:

- Primary Care add-on code (0.25 Work RVUs) - In response to comments, CMS revised the value of the primary care add-on so it will be valued the same as the specialty care add-on code and

providers will be able to bill the add-on for new and established patients rather than just established patients as proposed. A specialist may report this add-on code whenever additional primary care services are provided separate from the specialty care being provided.

- Specialty Care Complexity add-on code (0.25 Work RVUs) – CMS revised this code descriptor to add several specialties to the code which can be billed with the consolidated level 2 through 4 E/M service for new and established patients for non-procedural specialty care. The specialties that can bill this add-on include: endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonology.
- Extended Visit add-on code (1.17 Work RVUs) - CMS finalized its proposal to establish an “extended visit” add-on code that can only be billed with the consolidated level 2 – 4 E/M service for new or established patients and set the work RVUs for this service at 1.17. The code can be reported for a single range of minutes that applies to the overall duration of face-to-face time during the visit without regard to whether level 2, 3, or 4 was reported: 34-69 minutes for established patients and 38-89 minutes for new patients. CMS also states that any visits that exceed the length of time ranges for the level 2-4 visits plus the extended visit add-on could be reported using the level 5 visit E/M code and the existing prolonged services code. For audit purposes, CMS expects the medical record to reflect that the practitioner actually spent the amount of time with the patient described by the code and that the entire visit was medically necessary. However, the agency will not require additional documentation to demonstrate the difference in time between the visit code and the extended visit service to determine medical necessity.

CMS E&M Payment Amounts Comparison Chart

	Complexity Level under CPT	Visit Code (2018 Payment Rates)	Visit Code (2019 Payment Rates)	Visit Code with Either Primary Care or Specialized Care Add-on	Visit Code with Add-on and New Extended Services Code	Current Prolonged Service Code Added
New Patient	2	\$76	\$130	\$143	\$197	
	3	\$110				
	4	\$167				
	5	\$211	\$211			\$344 (at least 90 min)
Established Patient	2	\$45	\$90	\$103	\$157	
	3	\$74				
	4	\$109				
	5	\$148	\$148			\$281 (at least 70 min)

E/M Documentation Requirements to be Implemented January 1, 2021

To bill the single payment level 2-4 outpatient E/M visit. CMS will require providers to document a level 2 service when using medical decision making or the 1995/1997 guidelines. If providers choose to document using time, they will have to document medical necessity and that they met the current typical time for the reported CPT code. For level 5 visits, providers will be allowed to document using the current 1995/1997 guidelines or the current level 5 definition of medical decision making. Providers can also document a level 5 visit by time, 40 minutes for an established patient and 60 minutes for a new patient.

Other Proposed E/M Policies Not Implemented

Based on stakeholder feedback, CMS chose not to implement its proposal to apply a multiple procedure payment reduction when an E/M service is billed with a procedure and reduce payment by 50% for the least expensive service.

The agency also chose not to finalize the policy to create a single E/M practice expense (PE) per hour value because of the unintended negative impact it would have on the indirect practice expense for certain specialties. They stated that they did not believe it was in the public interest to allow the allocation of indirect PE to have such an outsized impact on payment rates.

Teaching Physician Documentation Requirements for Evaluation and Management Services

CMS finalized its proposal to allow a physician, resident, or nurse to document in the medical record that the teaching physician was present at the time the service is delivered. They also eliminated the requirement for the teaching physician to document the extent of his own participation in the review and direction of the services furnished to each beneficiary and instead allow the resident or nurse to document the extent of the teaching physician's participation.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

In this final rule, CMS aimed to increase access for beneficiaries to physicians' services that are routinely furnished via communication technology by establishing new codes. These services do not replace office visits. A description of these services follows:

Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code G2012):

CMS believes that the more physicians leverage technology to furnish check-ins there will potentially be a reduction in unnecessary office visits. Physicians will be able to deliver this service by telephone or synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. This code cannot be billed for clinical staff phone calls. Patients' verbal consent to receiving this service must be included in the medical record since patients will be billed a co-pay for it. The agency received broad support for CMS to provide separate payment for this service and will monitor utilization to determine if any limits should be placed on the use of this code.

CODE DESCRIPTOR for G2012: Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health professional who may report evaluation and management services provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

Remote evaluation of pre-recorded patient information (HCPCS code G2010)

Like the virtual check-in, CMS believes this service does not take the place of an office visit and may in fact reduce the number of unnecessary visits by determining whether an office visit is warranted. The agency finalized its proposal to make separate payment for this service for established patients only and will monitor its utilization. This service will also require a patient co-pay, so the agency is finalizing a requirement to receive verbal or written beneficiary consent for each service that is documented in the medical record. Follow-up with the patient could take place by phone, audio/video communication, secure text messaging, email, or patient portal communication.

CODE DESCRIPTOR for G2010: Remote evaluation of recorded video and/or images submitted by the patient (e.g. store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

Interprofessional Internet Consultation (CPT code 99451, 99452, 99446, 99447, 99448, 99449)

CPT revised 4 existing codes and created 2 new codes to describe inter-professional telephone/internet/electronic medical record consultation services. CPT codes 99446-99449 had previously considered to be bundled services and were not separately payable. CMS is finalizing its proposal to convert these to active codes based on changes in medical practice and technology and will monitor their utilization potentially making refinements to billing and documentation requirements in future rulemaking. Like the other new services, these will require a patient co-pay so providers must document verbal consent in the medical record.

Changes to Direct PE Inputs for Specific Services - Market-Based Supply and Equipment Pricing Update

CMS finalized its proposal to adopt updated direct PE input prices for supplies and equipment based on a market research study undertaken for this update. Due to the significant changes in payment (increases for many items) that will occur the new pricing policy will be phased in over a 4-year period beginning in CY 2019. The agency is proposing to use a 25/75 percent split between new and old pricing in year one, 50/50 in year two, 75/25 in year three, and 100/0 in year four. The CY 2019 PE values found in Addendum B reflect this 25/75 pricing phase in. New supply and equipment codes that are implemented during this 4-year period will be fully implemented with no transition.

Payment for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of Hospitals

Starting in January 2017, CMS no longer recognized under the Hospital Outpatient Prospective Payment System (OPPS) certain items and services furnished by certain off-campus provider-based departments (PBDs) and paid for these services under the fee schedule. In 2017, payment for these services were paid at 50% of the OPPS payment rate and in 2018 payment was set at 40% of the OPPS rate. This payment policy is called the PFS Relativity Adjuster. In addition, all claims for these services were submitted with specific modifiers, so that CMS could determine future payment levels that would be more appropriate for PBDs.

For CY 2019, CMS finalized the proposal to continue applying the PFS Relativity Adjuster of 40%, which means that nonexcepted items and services furnished by nonexcepted off-campus PBDs will be reimbursed at 40% of the OPPS payment rate. CMS is also maintaining the same geographic adjustment and beneficiary cost sharing policies that were in effect in CY 2018. If and when they decide to change this policy, the agency will do so through rulemaking.

Note: Services that are “excepted” from this payment change are provided in: dedicated emergency departments; off-campus PBDs that were billing for covered outpatient department services furnished prior to November 2, 2015; in “on campus” PBDs or within 250 yards of the hospital or a remote location of the hospital. All services that do not meet these requirements are considered “non-excepted.”

Part B Drugs: Application of Add-on Percentage for certain WAC-based payments

Drugs are typically reimbursed under Medicare Part B at the average sales price (ASP) for the drug or biological plus a 6% add-on payment. Part B payments are based on the wholesale acquisition cost (WAC) of the drug or biological when ASP is not available during the first quarter of sales or when Medicare Administrative Contractors (MACs) determine pricing, which is for drugs not appearing on the ASP pricing files or for new drugs. The WAC of a drug typically exceeds the ASP, as it does not include any prompt pay or other discounts, rebates or reductions in price included in the ASP.

CMS finalized the proposal, effective January 1, 2019, to reduce payment for drugs when WAC-based payments are applied by reducing the add-on percentage to 3% (from 6%). The agency clarified that the reduced add-on payment will be applied to new drugs and other drugs when MACs use WAC reimbursement, but would not apply to the add-on to ASP-based payments.

Physician Self-Referral Law

The physician self-referral law prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies. The law also prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third-party payer) for those referred services.

In this final rule, CMS clarified the requirements for written agreements and signatures and codified the agency's existing policy that allows a collection of documents to satisfy the requirement for a compensation agreement to be in writing. The agency also finalized the policy that the signature requirement can be satisfied if the compensation agreement complies with all criteria of the exception and also is obtained "90 consecutive calendar days immediately following the date" of a required signature. They agency did not receive any comments opposing these changes.

Table 94: CY 2019 Estimated Impact on Total Allowed Charges By Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	\$239	0%	-1%	0%	-1%
Anesthesiology	\$1,982	0%	0%	0%	0%
Audiologist	\$68	0%	1%	0%	1%
Cardiac Surgery	\$293	0%	0%	0%	0%
Cardiology	\$6,616	0%	0%	0%	0%
Chiropractor	\$754	0%	-1%	0%	-1%
Clinical Psychologist	\$776	0%	3%	0%	3%
Clinical Social Worker	\$728	0%	3%	0%	2%
Colon And Rectal Surgery	\$166	0%	1%	0%	1%
Critical Care	\$342	0%	-1%	0%	-1%
Dermatology	\$3,489	0%	1%	0%	1%
Diagnostic Testing Facility	\$734	0%	-5%	0%	-5%
Emergency Medicine	\$3,121	0%	0%	0%	0%
Endocrinology	\$482	0%	0%	0%	0%
Family Practice	\$6,207	0%	0%	0%	0%
Gastroenterology	\$1,754	0%	0%	0%	0%
General Practice	\$428	0%	0%	0%	0%
General Surgery	\$2,090	0%	0%	0%	0%
Geriatrics	\$197	0%	0%	0%	0%
Hand Surgery	\$214	0%	0%	0%	0%
Hematology/Oncology	\$1,741	0%	-1%	0%	-1%
Independent Laboratory	\$646	0%	-2%	0%	-2%
Infectious Disease	\$649	0%	0%	0%	-1%
Internal Medicine	\$10,766	0%	0%	0%	0%
Interventional Pain Mgmt	\$868	0%	1%	0%	1%
Interventional Radiology	\$384	1%	1%	0%	2%
Multispecialty Clinic/Other Phys	\$149	0%	0%	0%	0%
Nephrology	\$2,188	0%	0%	0%	0%
Neurology	\$1,529	0%	0%	0%	0%
Neurosurgery	\$802	0%	0%	0%	0%
Nuclear Medicine	\$50	0%	-1%	0%	-1%
Nurse Anes / Anes Asst	\$1,242	0%	0%	0%	0%
Nurse Practitioner	\$4,060	0%	0%	0%	0%
Obstetrics/Gynecology	\$637	0%	0%	0%	0%
Ophthalmology	\$5,451	0%	-1%	0%	-1%
Optometry	\$1,309	0%	-1%	0%	-1%
Oral/Maxillofacial Surgery	\$67	0%	0%	0%	0%
Orthopedic Surgery	\$3,741	0%	0%	0%	0%
Other	\$31	0%	4%	0%	4%
Otolaryngology	\$1,222	0%	0%	0%	0%
Pathology	\$1,165	0%	-1%	0%	-2%
Pediatrics	\$61	0%	0%	0%	0%
Physical Medicine	\$1,107	0%	0%	0%	0%
Physical/Occupational Therapy	\$3,950	0%	-1%	0%	-1%
Physician Assistant	\$2,438	0%	0%	0%	0%
Plastic Surgery	\$376	0%	0%	0%	0%
Podiatry	\$1,974	0%	2%	0%	2%
Portable X-Ray Supplier	\$99	0%	1%	0%	1%
Psychiatry	\$1,187	0%	1%	0%	1%
Pulmonary Disease	\$1,714	0%	0%	0%	0%
Radiation Oncology And Radiation Therapy Centers	\$1,765	0%	0%	0%	-1%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Radiology	\$4,907	0%	0%	0%	0%
Rheumatology	\$541	0%	0%	0%	0%
Thoracic Surgery	\$357	0%	0%	0%	0%
Urology	\$1,738	0%	1%	0%	1%
Vascular Surgery	\$1,141	0%	2%	0%	2%
Total	\$92,733	0%	0%	0%	0%

* Column F may not equal the sum of columns C, D, and E due to rounding.

2019 Final Physician Fee Schedule (CMS-1693-F)
Payment Rates for Medicare Physician Services - Neurology

CPT Code	Mod	Descriptor	RVUs	2019	2018	% payment change 2018 to 2019
				Payment CF=\$36.0391	Payment CF = \$35.9996	
95812		Eeg 41-60 minutes	9.19	\$331.20	\$329.76	0.4%
95812	TC	Eeg 41-60 minutes	7.54	\$271.73	\$270.36	0.5%
95812	26	Eeg 41-60 minutes	1.65	\$59.46	\$59.40	0.1%
95813		Eeg over 1 hour	11.42	\$411.57	\$414.36	-0.7%
95813	TC	Eeg over 1 hour	8.94	\$322.19	\$325.44	-1.0%
95813	26	Eeg over 1 hour	2.48	\$89.38	\$88.92	0.5%
95816		Eeg awake and drowsy	10.27	\$370.12	\$371.88	-0.5%
95816	TC	Eeg awake and drowsy	8.62	\$310.66	\$312.48	-0.6%
95816	26	Eeg awake and drowsy	1.65	\$59.46	\$59.40	0.1%
95819		Eeg awake and asleep	12.08	\$435.35	\$432.36	0.7%
95819	TC	Eeg awake and asleep	10.43	\$375.89	\$372.96	0.8%
95819	26	Eeg awake and asleep	1.65	\$59.46	\$59.40	0.1%
95822		Eeg coma or sleep only	10.90	\$392.83	\$389.52	0.8%
95822	TC	Eeg coma or sleep only	9.24	\$333.00	\$330.12	0.9%
95822	26	Eeg coma or sleep only	1.66	\$59.82	\$59.40	0.7%
95824	26	Eeg cerebral death only	1.13	\$40.72	\$40.68	0.1%
95827		Eeg all night recording	17.20	\$619.87	\$640.43	-3.2%
95827	TC	Eeg all night recording	15.59	\$561.85	\$582.47	-3.5%
95827	26	Eeg all night recording	1.61	\$58.02	\$57.96	0.1%
95829		Surgery electrocorticogram	53.66	\$1,933.86	\$1,953.70	-1.0%
95829	TC	Surgery electrocorticogram	43.97	\$1,584.64	\$1,607.02	-1.4%
95829	26	Surgery electrocorticogram	9.69	\$349.22	\$346.68	0.7%
95830	Hospital	Insert electrodes for EEG	2.64	\$95.14	\$94.68	0.5%
95830	Office	Insert electrodes for EEG	10.97	\$395.35	\$239.40	65.1%
95836		Ecog implt brn npgt <30 d	3.14	\$113.16	NEW IN 2019	NA
95950		Ambulatory eeg monitoring	8.27	\$298.04	\$350.28	-14.9%
95950	TC	Ambulatory eeg monitoring	6.03	\$217.32	\$267.84	-18.9%
95950	26	Ambulatory eeg monitoring	2.24	\$80.73	\$82.44	-2.1%
95951	26	Eeg monitoring/videorecord	9.14	\$329.40	\$328.68	0.2%
95953		Eeg monitoring/computer	12.56	\$452.65	\$442.80	2.2%
95953	TC	Eeg monitoring/computer	7.88	\$283.99	\$274.32	3.5%
95953	26	Eeg monitoring/computer	4.68	\$168.66	\$168.48	0.1%
95954		Eeg monitoring/giving drugs	11.32	\$407.96	\$436.32	-6.5%
95954	TC	Eeg monitoring/giving drugs	8.02	\$289.03	\$312.48	-7.5%
95954	26	Eeg monitoring/giving drugs	3.30	\$118.93	\$123.84	-4.0%
95955		Eeg during surgery	5.95	\$214.43	\$219.24	-2.2%
95955	TC	Eeg during surgery	4.40	\$158.57	\$163.80	-3.2%
95955	26	Eeg during surgery	1.55	\$55.86	\$55.44	0.8%
95956		Eeg monitor technol attended	41.20	\$1,484.81	\$1,628.62	-8.8%
95956	TC	Eeg monitor technol attended	35.77	\$1,289.12	\$1,432.06	-10.0%
95956	26	Eeg monitor technol attended	5.43	\$195.69	\$196.56	-0.4%
95957		Eeg digital analysis	7.62	\$274.62	\$294.12	-6.6%
95957	TC	Eeg digital analysis	4.67	\$168.30	\$187.20	-10.1%
95957	26	Eeg digital analysis	2.95	\$106.32	\$106.92	-0.6%
95958		Eeg monitoring/function test	16.34	\$588.88	\$594.71	-1.0%
95958	TC	Eeg monitoring/function test	9.86	\$355.35	\$361.08	-1.6%
95958	26	Eeg monitoring/function test	6.48	\$233.53	\$233.64	0.0%
95961		Electrode stimulation brain	8.69	\$313.18	\$311.40	0.6%
95961	TC	Electrode stimulation brain	4.05	\$145.96	\$145.44	0.4%
95961	26	Electrode stimulation brain	4.64	\$167.22	\$165.96	0.8%
95962		Electrode stim brain add-on	7.46	\$268.85	\$268.92	0.0%
95962	TC	Electrode stim brain add-on	2.51	\$90.46	\$90.72	-0.3%

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Payment Rates for Medicare Physician Services - Neurology

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95962	26	Electrode stim brain add-on	4.95	\$178.39	\$178.20	0.1%
95965	26	Meg spontaneous	12.07	\$434.99	\$434.52	0.1%
95966	26	Meg evoked single	6.11	\$220.20	\$221.04	-0.4%
95967	26	Meg evoked each addl	5.34	\$192.45	\$194.76	-1.2%
95970	Hospital	Alys npgt w/o prgrmg	0.53	\$19.10	\$24.84	-23.1%
95970	Office	Alys npgt w/o prgrmg	0.54	\$19.46	\$70.92	-72.6%
95971	Hospital	Alys smpl sp/pn npgt w/prgrm	1.17	\$42.17	\$42.12	0.1%
95971	Office	Alys smpl sp/pn npgt w/prgrm	1.44	\$51.90	\$52.20	-0.6%
95972	Hospital	Alys cplx sp/pn npgt w/prgrm	1.19	\$42.89	\$42.84	0.1%
95972	Office	Alys cplx sp/pn npgt w/prgrm	1.62	\$58.38	\$60.12	-2.9%
95974	Hospital	Cranial neurostim, complex	DELETED IN 2019	DELETED IN 2019	\$168.48	NA
95974	Office	Cranial neurostim, complex	DELETED IN 2019	DELETED IN 2019	\$212.76	NA
95975	Hospital	Cranial neurostim, complex	DELETED IN 2019	DELETED IN 2019	\$95.40	NA
95975	Office	Cranial neurostim, complex	DELETED IN 2019	DELETED IN 2019	\$114.48	NA
95976	Hospital	Alys smpl cn npgt prgrmg	1.14	\$41.08	NEW IN 2019	NA
95976	Office	Alys smpl cn npgt prgrmg	1.16	\$41.81	NEW IN 2019	NA
95977	Hospital	Alys cplx cn npgt prgrmg	1.52	\$54.78	NEW IN 2019	NA
95977	Office	Alys cplx cn npgt prgrmg	1.54	\$55.50	NEW IN 2019	NA
95978	Hospital	Analyze neurostim brain/1h	DELETED IN 2019	DELETED IN 2019	\$198.36	NA
95978	Office	Analyze neurostim brain/1h	DELETED IN 2019	DELETED IN 2019	\$258.12	NA
95979	Hospital	Analyz neurostim brain addon	DELETED IN 2019	DELETED IN 2019	\$91.80	NA
95979	Office	Analyz neurostim brain addon	DELETED IN 2019	DELETED IN 2019	\$110.88	NA
95983	Hospital	Alys brn npgt prgrmg 15 min	1.44	\$51.90	NEW IN 2019	NA
95983	Office	Alys brn npgt prgrmg 15 min	1.46	\$52.62	NEW IN 2019	NA
95984	Hospital	Alys brn npgt prgrmg addl 15	1.26	\$45.41	NEW IN 2019	NA
95984	Office	Alys brn npgt prgrmg addl 15	1.27	\$45.77	NEW IN 2019	NA

2019 Final Physician Fee Schedule (CMS-1693-F)						
Payment Rates for Medicare Physician Services - Epilepsy Surgery						
CPT Code	Mod	Descriptor	2019		2018	% payment change 2018 to 2019
			RVUs	Payment CF=\$36.0391	Payment CF = \$35.9996	
61531		Implant brain electrodes	35.27	\$1,271.10	\$1,289.15	-1.4%
61534		Removal of brain lesion	47.44	\$1,709.69	\$1,737.34	-1.6%
61536		Removal of brain lesion	75.23	\$2,711.22	\$2,722.65	-0.4%
61537		Removal of brain tissue	72.46	\$2,611.39	\$2,593.41	0.7%
61538		Removal of brain tissue	78.29	\$2,821.50	\$2,817.69	0.1%
61539		Removal of brain tissue	69.64	\$2,509.76	\$2,492.97	0.7%
61540		Removal of brain tissue	63.07	\$2,272.99	\$2,305.41	-1.4%
61541		Incision of brain tissue	62.71	\$2,260.01	\$2,269.41	-0.4%
61543		Removal of brain tissue	61.72	\$2,224.33	\$2,294.25	-3.0%
61566		Removal of brain tissue	64.87	\$2,337.86	\$2,374.17	-1.5%
61567		Incision of brain tissue	72.94	\$2,628.69	\$2,703.57	-2.8%
61720		Incise skull/brain surgery	37.33	\$1,345.34	\$1,341.35	0.3%
61735		Incise skull/brain surgery	46.80	\$1,686.63	\$1,678.30	0.5%
61750		Incise skull/brain biopsy	41.42	\$1,492.74	\$1,488.22	0.3%
61751		Brain biopsy w/ct/mr guide	40.48	\$1,458.86	\$1,454.02	0.3%
61760		Implant brain electrodes	46.05	\$1,659.60	\$1,664.26	-0.3%
61770		Incise skull for treatment	47.78	\$1,721.95	\$1,715.74	0.4%
61790		Treat trigeminal nerve	25.78	\$929.09	\$925.55	0.4%
61791		Treat trigeminal tract	33.03	\$1,190.37	\$1,186.91	0.3%
61796		Srs, cranial lesion simple	29.74	\$1,071.80	\$1,068.83	0.3%
61797		Srs, cran les simple, addl	6.48	\$233.53	\$234.72	-0.5%
61798		Srs, cranial lesion complex	40.56	\$1,461.75	\$1,456.18	0.4%
61799		Srs, cran les complex, addl	8.98	\$323.63	\$322.56	0.3%
61800		Apply srs headframe add-on	4.52	\$162.90	\$163.08	-0.1%
61867		Implant neuroelectrode	66.88	\$2,410.30	\$2,400.81	0.4%
61868		Implant neuroelectrde, add'l	14.73	\$530.86	\$530.27	0.1%
61870		Implant neuroelectrodes	34.79	\$1,253.80	\$1,249.19	0.4%
61880		Revise/remove neuroelectrode	16.68	\$601.13	\$595.79	0.9%
61885		Insrt/redo neurostim 1 array	14.97	\$539.51	\$537.83	0.3%
61886		Implant neurostim arrays	24.77	\$892.69	\$884.87	0.9%
61888		Revise/remove neuroreceiver	11.57	\$416.97	\$416.88	0.0%
63620		Srs, spinal lesion	32.89	\$1,185.33	\$1,181.15	0.4%
63621		Srs, spinal lesion, addl	7.48	\$269.57	\$270.00	-0.2%

2019 Final Physician Fee Schedule (CMS-1693-F)									
Payment Rates for Medicare Physician Services - Evaluation and Management									
CPT Code	Descriptor	NON-FACILITY (OFFICE)				FACILITY (HOSPITAL)			
		2019	2018	% payment change 2018 to 2019		2019	2018	% payment change 2018 to 2019	
		RVUs	Payment CF=\$36.0391	Payment CF = \$35.9996		RVUs	Payment CF=\$36.0391	Payment CF = \$35.9996	
99201	Office/outpatient visit new	1.29	\$46.49	\$45.36	2.5%	0.76	\$27.39	\$27.36	0.1%
99202	Office/outpatient visit new	2.15	\$77.48	\$76.32	1.5%	1.43	\$51.54	\$51.48	0.1%
99203	Office/outpatient visit new	3.05	\$109.92	\$109.80	0.1%	2.15	\$77.48	\$78.12	-0.8%
99204	Office/outpatient visit new	4.63	\$166.86	\$167.40	-0.3%	3.64	\$131.18	\$131.76	-0.4%
99205	Office/outpatient visit new	5.82	\$209.75	\$210.60	-0.4%	4.75	\$171.19	\$172.08	-0.5%
99211	Office/outpatient visit est	0.64	\$23.07	\$21.96	5.0%	0.26	\$9.37	\$9.36	0.1%
99212	Office/outpatient visit est	1.27	\$45.77	\$44.64	2.5%	0.72	\$25.95	\$25.92	0.1%
99213	Office/outpatient visit est	2.09	\$75.32	\$74.16	1.6%	1.44	\$51.90	\$52.20	-0.6%
99214	Office/outpatient visit est	3.06	\$110.28	\$109.44	0.8%	2.22	\$80.01	\$79.92	0.1%
99215	Office/outpatient visit est	4.10	\$147.76	\$147.60	0.1%	3.13	\$112.80	\$113.04	-0.2%
99221	Initial hospital care	NA	NA	NA	NA	2.86	\$103.07	\$103.32	-0.2%
99222	Initial hospital care	NA	NA	NA	NA	3.86	\$139.11	\$139.32	-0.1%
99223	Initial hospital care	NA	NA	NA	NA	5.70	\$205.42	\$206.64	-0.6%
99231	Subsequent hospital care	NA	NA	NA	NA	1.11	\$40.00	\$39.96	0.1%
99232	Subsequent hospital care	NA	NA	NA	NA	2.05	\$73.88	\$74.16	-0.4%
99233	Subsequent hospital care	NA	NA	NA	NA	2.93	\$105.59	\$106.20	-0.6%
99291	Critical care first hour	7.82	\$281.83	\$279.36	0.9%	6.28	\$226.33	\$226.80	-0.2%
99292	Critical care addl 30 min	3.46	\$124.70	\$124.92	-0.2%	3.15	\$113.52	\$113.76	-0.2%
99446	Interprof consult 5-10	NA	NA	NA	NA	0.51	\$18.38	\$18.36	0.1%
99447	Interprof consult 11-20	NA	NA	NA	NA	1.01	\$36.40	\$36.36	0.1%
99448	Interprof consult 21-30	NA	NA	NA	NA	1.52	\$54.78	\$54.72	0.1%
99449	Interprof consult 31/>	NA	NA	NA	NA	2.02	\$72.80	\$73.08	-0.4%
99451	Interprof consult report	1.04	\$37.48	NEW IN 2019	NEW IN 2019	1.04	\$37.48	NEW IN 2019	NEW IN 2019
99452	Prep interprof consult 30 min	1.04	\$37.48	NEW IN 2019	NEW IN 2019	1.04	\$37.48	NEW IN 2019	NEW IN 2019
99471	Ped critical care initial	NA	NA	NA	NA	22.51	\$811.24	\$811.43	0.0%
99472	Ped critical care subsq	NA	NA	NA	NA	11.53	\$415.53	\$419.76	-1.0%
99487	Cmplx chron care w/o pt vsit	2.58	\$92.98	\$94.68	-1.8%	1.47	\$52.98	\$53.28	-0.6%
99489	Cmplx chron care addl 30 min	1.29	\$46.49	\$47.16	-1.4%	0.74	\$26.67	\$26.64	0.1%
99490	Chron care mgmt svc 20 min	1.17	\$42.17	\$42.84	-1.6%	0.90	\$32.44	\$32.76	-1.0%
99491	Chrnc care mgmt svc 30 min	2.33	\$83.97	NEW IN 2019	NEW IN 2019	2.33	\$83.97	NEW IN 2019	NEW IN 2019
99495	Trans care mgmt 14 day disch	4.62	\$166.50	\$167.04	-0.3%	3.11	\$112.08	\$112.32	-0.2%
99496	Trans care mgmt 7 day disch	6.52	\$234.97	\$236.52	-0.7%	4.51	\$162.54	\$163.08	-0.3%
G0396	Alcohol/subs interv 15-30mn	1.01	\$36.40	\$36.36	0.1%	0.94	\$33.88	\$34.20	-0.9%
G0397	Alcohol/subs interv >30 min	1.89	\$68.11	\$69.84	-2.5%	1.83	\$65.95	\$67.68	-2.6%
G0506	Comp asses care plan ccm svc	1.76	\$63.43	\$64.44	-1.6%	1.29	\$46.49	\$46.44	0.1%