New year brings changes for all plastic surgeons

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The 2018 CPT Book contains 172 new codes, 60 revisions and 82 code deletions. Within these updates are two areas of change that will be relevant to many plastic surgeons – two new codes related to the use of nerve allografts for tendon repair, and revisions to the previous head-and-neck muscle-flap code 15732, which will be discontinued and replaced with two new codes and additional instructions.

Nerve allografts

Two new codes were added to the nerve repair family to address the use of nerve allografts. Similar to the rest of the family, the first code, 64912, is to be used for the first cable of allograft, while 64913 is an add-on code to be used for additional strands.

These new additions complement the existing family of codes, which also includes the use of nerve autografts, vein allografts, vein autografts and synthetic conduits. As the use of a microsurgical technique is typically required for this procedure, the use of the microscope is bundled into valuation of the code and 69990 (Microsurgical techniques, requiring use of operating microscope [List separately in addition to code for primary procedure] may not be separately reported).

64912 Nerve repair; with nerve allograft, each nerve, first strand (cable)

+64913 Nerve repair; with nerve allograft, each additional strand (List separately in addition to code for primary procedure)

(Use 64913 in conjunction with 64912)

(Do not report 64912, 64913 in conjunction with 69990)

Head and neck flaps

The most significant change occurred in the muscle, myocutaneous or fasciocutaneous flap family of codes (1573X) that serve as the backbone for many reconstructive surgeons. The use of code 15734 (trunk), 15736 (upper extremity) and 15738 (lower extremity) remain unchanged in their definition. However, the previous code, 15732, which included muscle, myocutaneous and fasciocutaneous flaps in the head and neck, was discontinued due to a history of confusion, variable usage and frank misusage.

Two new codes now represent complex head and neck flap procedures with additional, explicit clarification provided in the CPT manual regarding the coding for other types of head and neck reconstruction.

New CPT 15730 (midface flap [i.e., zygomaticofacial flap] with preservation of vascular pedicle(s)) is a new code developed in conjunction with ophthalmology to describe what is classically considered a "midface lift" and can be done for support of the lower eyelid during reconstructive procedures. Use of this code requires more than just "a little undermining" of the midface. Dissection includes a lateral canthotomy with inferior cantholysis to the orbital rim, followed by dissection over the orbital rim and maxilla with preservation of the neurovascular bundles. The midface tissues (or flap) are then released and anchored to the deep temporal fascia, orbital rim, and/or lateral nasal wall.

New CPT code 15733 (muscle, myocutaneous or fasciocutaneous flap; head and neck with named vascular pedicle [i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae]) is most similar in intent to the now retired 15732. Of note, this code now includes a specific "i.e." in the parenthetical description listing the *only* flaps that may be coded with 15733. In CPT context, an "e.g." in the parenthetical description allows for similar procedures to be covered by the code, but "i.e." specifically limits code usage to only those procedures listed.

The development of a more restrictive usage for this code allowed for a code with preserved value. It's important to note that the inclusion of small area of mimetic musculature – such as nasalis with a bilobe flap on the nose or a orbicularis occulli as part of a lateral lid – are specifically *not* included in the new 15733, as these more minor flaps have always been more appropriately coded with the adjacent tissue transfer (140XX) codes.

Included in the new 15733 is more direction regarding other techniques which previously were incorrectly coded with 15732, including forehead flaps, pericranial flaps and many of the post-Mohs local flaps. The two new codes are listed below:

15730 Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s)

15733 Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)

(For forehead flap with preservation of vascular pedicle, use 15731)

(For anterior pericranial flap on named vascular pedicle, for repair of extracranial defect, use 15731)

(For repair of head and neck defects using non-axial pattern advancement flaps [including lesion] and/or repair by adjacent tissue transfer or rearrangement [e.g., Z-plasty, W-plasty, V-Y plasty, rotation flap, random island flap, advancement flap] see 14040, 14041, 14060, 14061, 14301, 14302)

Understanding these changes and updating any paper or electronic charge-capture systems will ensure appropriate coding and reimbursement for the services described by these codes.

What's new for QPP

The Quality Payment Program (QPP) final rule for 2018 was recently released and continues to build and improve upon CMS' transition-year policies, and it addresses elements of MACRA that were not included in the first year of the program.

In the 2017 transition year, the payment adjustment was set at +/- 4 percent. In performance Year 2, the payment adjustment has increased to +/- 5 percent. Adjustments will be assessed in payment year 2020.

CMS has updated the low-volume threshold for the second year. You are excluded from participation in MIPS if you or your group has less than or equal to $90,000 in Part B allowed charges or less than ***or*** equal to 200 Part B beneficiaries. This is an increase from the transition year, which excluded clinicians and groups that had less than or equal to $30,000 in Part B allowed charges or less than ***or*** equal to 100 Part B beneficiaries.

For 2018, clinicians who do not exceed the low-volume threshold are excluded from voluntary participation in MIPS and will receive a neutral payment adjustment in 2020.

PERFORMANCE COMPONENT	2017 PERFORMANCE YEAR	2018 PERFORMANCE YEAR	2019 PERFORMANCE YEAR AND BEYOND
Quality	60%	50%	30%
Cost	0%	10%	30%
Improvement Activities	15%	15%	15%
Advancing Care Information	25%	25%	25%

PERFORMANCE COMPONENT	MINIMUM PERFORMANCE PERIOD 2017	MINIMUM PERFORMANCE PERIOD 2018
Quality	90-days minimum; full year (12 months) was also an option	12 months
Cost	Not included. 12 months for feedback only.	12 months
Improvement Activities	90 days	90 days
Advancing Care Information	90 days	90 days

Weighting components

The biggest change we'll see for the 2018 performance year is that the cost component of MIPS now has a "weighting" associated with it. In the transition year, CMS did not associate a weighting to cost. For 2018, the quality component has a reduced weighting, while cost now has a weighting that will continue to increase for the subsequent performance period as well (*see top table above*).

Historic claims data will be evaluated to determine Medicare spending per beneficiary and per-capita costs. CMS has indicated it will provide feedback and additional education on the scoring of this MIPS component before the end of 2018.

Performance threshold

CMS is increasing the value of what will be considered an acceptable level of performance in the QPP, raising the threshold to 15 points, versus 3 points, which was the minimum number of points needed in 2017 to avoid a payment penalty in 2019. There are multiple ways in which a clinician can meet that 15-point threshold, including submitting the maximum number of improvement activities ***or*** full participation in the quality component of MIPS. For 2018, CMS is keeping its "Exceptional Performance" threshold, or the point at which bonuses are awarded, at 70 points.

Virtual groups

CMS has announced the inclusion of virtual groups in the second year of the QPP as an additional participation option. A virtual group is a combination of two or more Taxpayer Identification Numbers (TINs) made up of solo practitioners and/or groups of 10 or fewer eligible clinicians who come together "virtually" (no matter specialty or location) with others to participate in MIPS for a yearly performance period.

To be eligible to join or form a virtual group, you need to be a solo practitioner who exceeds the low-volume threshold individually and who is not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP) or a Partial QP choosing not to participate in MIPS. If you are a group of 10 or fewer eligible clinicians and exceed the low-volume threshold at the group level, you are eligible to participate.

Performance period

CMS previously allowed for a 90-day performance period for the transition year for quality component of MIPS. This will change for the second year, as CMS now requires a 12-month (full year) performance period for both Quality and Cost (*see bottom table to the left*).

Small practices

CMS realized it might be hard for small practices to participate in the QPP; therefore, it's offering some flexibilities for groups of 15 or fewer clinicians. Some of these flexibilities include adding **five bonus points to the final scores** of small practices, giving solo practitioners or small groups the option to form or join a virtual group if they exceed the low-volume thresholds, and continuing to award small practices three points for measures in the quality-performance component of MIPS when the reported data does not meet data completeness requirements. CMS has also added a new hardship exception for the ACI performance category as well.

CEHRT requirements

In an effort to reduce administrative burden, CMS is allowing MIPS-eligible clinicians to use either the 2014 or 2015 CEHRT, or a combination of both, for the 2018 performance year. Note that a 10 percent bonus is available for clinicians using only the 2015 edition.

Clinicians can also earn up to a **five-point bonus** for the treatment of complex patients. This is based on a combination of Hierarchical Condition Categories (HCC), a method used to account for a patient's health relative to risk. The number of Medicare/Medicaid dual-eligible patients treated by the clinician will also be factored into the bonus scoring.

ASPS has reviewed and submitted comments on this final rule. For more information, visit *plasticsurgery.org/for-medical-professionals/health-policy/macra*. PSN

Regrets? Had a few?

Attention ASPS members! *PSN* is interested in hearing your stories about equipment in which you've invested for your office – perhaps for skin-tightening or fat-reduction purposes – but later regretted due to poor performance, the lack of payoff it provided for the practice, or another reason you would like to explain. If you have stories or examples to share, please contact Paul Snyder at *psnyder@plasticsurgery.org*. PSN