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Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, Publisher

Valuation of Neurological Services: Reimbursement Environment

As discussed in the first installment of this Health Capital Topics series, neurological services are characterized by rising demand and a constrained supply of neurologists, trends expected to continue as the U.S. population ages.[1] This second instalment examines the reimbursement environment applicable to neurological services, including the Medicare Physician Fee Schedule (MPFS) payment framework, telehealth reimbursement policy, and neurological services-specific considerations arising from recent and forthcoming Centers for Medicare & Medicaid Services (CMS) rulemaking.

The U.S. government is the largest payor of medical costs through Medicare and Medicaid and exerts significant influence over physician reimbursement. In 2024, Medicare and Medicaid spending reached $1.1 trillion and $931.7 billion, respectively, representing 21% and 18% of total U.S. healthcare spending and reflecting increases of 7.8% and 6.6% over 2023.[2] The prevalence of these public payors in the healthcare marketplace often results in their acting as a price setter and benchmark for private reimbursement rates.

Medicare pays for physician services through the MPFS, which calculates payments according to the Resource-Based Relative Value Scale (RBRVS) system. Under this system, each procedure in the MPFS is assigned relative value units (RVUs) for three categories of resources:

(1) Physician work (wRVUs), representing the physician's contribution of time and effort to a procedure;

(2) Practice expense (PE RVUs), based on direct and indirect practice expenses, including clinical labor, medical supplies, medical equipment, and administrative overhead; and

(3) Malpractice expense (MP RVUs), corresponding to the relative malpractice costs of a given procedure.

Each procedure's RVUs are adjusted for local geographic differences using Geographic Practice Cost Indices (GPCIs) across 112 Medicare payment localities,[3] then summed and multiplied by a conversion factor (CF) to yield the Medicare payment amount:

$$\text{Payment} = [(\text{wRVU} \times \text{GPCI Work}) + (\text{PE RVU} \times \text{GPCI PE}) + (\text{MP RVU} \times \text{GPCI MP})] \times \text{CF}.[4]$$

The CF is updated annually pursuant to a schedule established by the Medicare Access and CHIP Reauthorization Act (MACRA). Payment rates were cut for the fifth consecutive year in 2025, with the CF decreasing 2.83% from 2024.[5] Beginning in 2026, MACRA provides for two separate CFs: a 0.75% update for Advanced Alternative Payment Model (APM) participants and a 0.25% update for Merit-based Incentive Payment System (MIPS) participants and other non-APM participants. CMS finalized 2026 CF increases to $33.57 (+3.77%) for qualifying APM participants and $33.40 (+3.26%) for non-qualifying participants, reflecting these statutory updates, a one-time 2.5% increase enacted under the One Big Beautiful Bill Act (OBBBA),[6] and a 0.49% budget-neutrality adjustment.[7] As set forth in Table 1 below, the 2026 MPFS adjustments yielded a combined payment impact of 1% for neurology and negative 5% for neurosurgery; the 2027 proposed rule, which was published in July 2026, would narrow these impacts to 0% and negative 2%, respectively.

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Table 1: MPFS Estimated Impact on Total Allowed Charges by Specialty, 2026 and 2027 (Proposed)[8]

Specialty	Setting	2026 Allowed Charges (millions)	2025-2026 wRVU Change	2025-2026 PE RVU Change	2025-2026 MP RVU Change	2026 Combined Impact	2027 Proposed Combined Impact
Neurology	**Total**	**$1,319**	**0%**	**1%**	**0%**	**1%**	**0%**
	Non-Facility	$836	0%	6%	0%	6%	-1%
	Facility	$483	0%	-9%	0%	-9%	0%
Neurosurgery	**Total**	**$687**	**-1%**	**-5%**	**0%**	**-5%**	**-2%**
	Non-Facility	$116	0%	5%	0%	6%	-1%
	Facility	$571	-1%	-7%	0%	-7%	-2%

On July 14, 2026, CMS released the 2027 MPFS proposed rule, proposing to decrease both CFs and reversing the prior year's increase. CMS proposes a qualifying APM conversion factor of $33.17, a decrease of $0.40 (-1.19%) from the current $33.57, and a non-qualifying APM conversion factor of $32.84, a decrease of $0.56 (-1.68%) from the current $33.40, driven primarily by the scheduled expiration of the OBBBA's one-time 2.5% CF increase, which applied only to 2026 and will not recur in 2027.[9] For further discussion of the proposed rule's broader payment implications, see the companion article in this issue.[10]

Several provisions of the 2027 proposed rule carry particular relevance for neurological services. CMS proposes to transition the office/outpatient evaluation & management (E/M) visit complexity add-on (HCPCS code G2211) from a flat-rate add-on code to a modifier appended to the associated E/M base code, increasing payment for the underlying E/M visit by 16%.[11] Neurologists, who routinely provide longitudinal care for complex chronic conditions such as epilepsy, Parkinson's disease, multiple sclerosis, and dementia, are among the specialties most reliant on this add-on and therefore most likely to be affected by the proposed modifier transition.[12]

CMS also proposes to reduce payment to 50% for a same-day office/outpatient E/M visit furnished alongside a 0-, 10-, or 90-day global procedure, with the more expensive of the two services paid at 100%. Neurologists who perform botulinum toxin injections for movement disorders, spasticity, or migraine prevention alongside an E/M visit in the same encounter would be directly affected by this proposed change.

The proposed rule further imposes new restrictions on remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services, requiring that RTM be furnished only to established patients, that a separately reportable initiating visit be furnished at the onset of monitoring, and that monitoring services be performed by clinical staff employed by the billing practice rather than by contractors.[13] These proposed changes carry meaningful implications for neurologists who rely on remote monitoring tools for epilepsy, Parkinson's disease, tremor, and other neurological conditions.

Separately, beginning January 1, 2027, neurosurgeons treating low back pain in CMS-designated geographic areas will be subject to mandatory participation in the Ambulatory Specialty Model (ASM), a five-year value-based payment model under which Medicare Part B payments are adjusted based on quality and cost performance relative to peers.[14] Market analysts have identified neurology as a candidate specialty for future expansion of the ASM or similar value-based specialty models, though CMS has not yet proposed such an expansion.

Medicare telehealth reimbursement is likewise governed by the MPFS. Prior to the COVID-19 public health emergency (PHE), Medicare telehealth coverage was narrow, generally limited to established patients located at rural originating sites; CMS relaxed these restrictions during the PHE and expanded the list of Medicare-covered telehealth services by approximately 135 services.[15]

The major telehealth flexibilities adopted during the PHE have since been extended through December 31, 2027, pursuant to the Consolidated Appropriations Act, 2026.[16] As telehealth continues to expand in scope and coverage, it is likely to create new opportunities for neurologists to extend access to care while reducing barriers associated with in-person visits; meaningful barriers to broader teleneurology adoption remain, however, including inconsistent reimbursement across payors, multi-state licensing burdens, and credentialing complexities.

Medicare reimbursement dynamics, including CF volatility, wRVU adjustments, expanding telehealth policy, and the proposed 2027 payment reductions following the scheduled expiration of the OBBBA's one-time increase, remain central drivers of the financial viability of neurological services and bear directly on Fair Market Value (FMV) analyses of neurological service arrangements. Whether Congress will act before the end of 2026 to extend or replace the expiring CF increase – as it has for prior temporary payment

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adjustments – is an open question with direct implications for physician compensation planning. The third installment of this series will examine the regulatory environment applicable to neurological service arrangements, including the federal Anti-Kickback Statute and the Stark Law.

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Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 30 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,500 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare - 2nd Edition*" [AICPA - 2015], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements* (BVR/AHLA); *The Accountant's Business Manual* (AICPA); V*aluing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the American Health Lawyers Association (AHLA); the American Bar Association (ABA); the Association of International Certified Professional Accountants (AICPA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute. He also serves on the Editorial Board of The Value Examiner and QuickRead, both of which are published by NACVA.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Certified Valuation Analyst (CVA) designation from NACVA. Mr. Zigrang also holds the Accredited in Business Valuation (ABV) designation from AICPA, and the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter. He is also a member of the America Association of Provider Compensation Professionals (AAPCP), AHLA, AICPA, NACVA, NSCHBC, and, the Society of OMS Administrators (SOMSA).

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of HCC. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: The Health Lawyer (American Bar Association); Physician Leadership Journal (American Association for Physician Leadership); The Journal of Vascular Surgery; St. Louis Metropolitan Medicine; Chicago Medicine; The Value Examiner (NACVA); and QuickRead (NACVA). She has previously presented before the American Bar Association (ABA), the American Health Law Association (AHLA), the National Association of Certified Valuators & Analysts (NACVA), the National Society of Certified Healthcare Business Consultants (NSCHBC), and the American College of Surgeons (ACS).

Janvi R. Shah, MBA, MSF, CVA, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis and the Certified Valuation Analyst (CVA) designation from NACVA. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.

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