Highlights of 2018 Medicare Proposed Rules

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Outline

- What we will cover?
  - Payments to Physicians & Freestanding Cancer Centers under the MPFS
  - Payments to Hospital Outpatient Departments under HOPPS
  - Payments to Ambulatory Surgical Centers

2018 New CPT Codes

- 192X1 Preparation of tumor cavity with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy
  - Physician payment $107.97 (proposed)
  - Packaged, no separate payment to hospitals or ASCs

2018 New CPT Codes

- 55X87 Transperineal placement of biodegradable material, peri-prostatic, single or multiple injections(s), including image guidance, when performed
  - Physician payment $3,879.39 (proposed)
  - Hospital outpatient $3,597.65 if not on same claim as CPT 55875, otherwise bundled into the comprehensive payment with same payment (proposed)
  - ASC payment $1,778.50 (proposed)

2018 New CPT Codes

- GRRR1 Superficial radiation treatment planning and management service
  - Physician payment $560.73 (proposed)
  - No hospital outpatient or ASC payment assigned

2018 Deleted CPT Codes

- 77422 Neutron beam treatment, simple

2018 MPFS Overview

- Medicare Physician Fee Schedule (MPFS)
  - Medicare reimburses for more than 7,000 services and procedures
  - Physician Payment
    - Professional Component (-26 modifier)
  - Freestanding Center Payment
    - Global Payment = Technical Component (-TC modifier) + Professional Component (-26 modifier)

2018 MPFS Overview

- CPT codes assigned relative value units (RVUs) determined by professional societies and the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) and accepted by the Centers for Medicare & Medicaid Services (CMS)

- Three (3) RVU Components
  - Physician Work (physician time & intensity)
  - Practice Expense (staff time, equipment, supplies)
  - Malpractice Expense (professional liability insurance)

2018 MPFS Overview

- Payment is based on relative value units (RVUs) adjusted for locality cost differences (GPCI) and multiplied by a conversion factor (CF) that translates RVUs into dollars.

- 2018 payment for CPT 77336

  2.29 RVUs x $35.99 CF = $82.42*

- 2018 payment for CPT 77370

  3.53 RVUs x $35.99 CF = $127.05*

*Payment excludes the geographic practice cost index (GPCI) adjustment

Misvalued Code Target Adjustment

- Legislation establishes an annual target for reductions in MPFS expenditures resulting from adjustments to RVUs of misvalued codes
  - 0.5% target for 2018
  - Reduction to conversion factor if target not met
  - CMS estimates the 2018 net reduction of 0.31% in expenditures from misvalued codes adjustment
  - Negative 0.19% adjustment to 2018 conversion factor
  - CMS lists codes that apply to "adjustment to RVUs for misvalued codes"
    - Includes radiation oncology codes 777261-77263, 77280, 77300, 77332, 77334, 77401 and 77470

Conversion Factor

- 2017 CF = $35.8887
- 2018 CF = $35.9903
  - The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides a 0.5% update for CY 2018
    - MACRA repealed the SGR update methodology
  - Minus 0.19% “misvalued code” target adjustment
  - Budget neutrality adjustment

Practice Expense Overview

- Each CPT procedure code has three (3) RVU Components
  - Physician Work
  - Practice Expense
  - Malpractice Expense

- Two (2) types of Practice Expense
  - Direct (clinical staff, medical equipment & medical supplies)
  - Indirect (administrative staff, office equipment, office supplies, rent, overhead, etc.)

2018 Practice Expense Methodology

- Continue “Bottom-up” methodology to determine direct practice expense costs

- Continued use of AMA Physician Practice Information Survey (PPIS) data to determine practice expense per hour (PE/HR) for each specialty used to calculate indirect practice expense costs

2018 Practice Expense Policy

- 50% utilization rate for therapeutic imaging equipment or diagnostic imaging equipment less than $1 million
- 90% utilization rate for expensive diagnostic equipment over $1 million
  - Impacts all CT, CTA, MRI and MRA PE RVUs
- CMS practice expense (PE) database includes costs of radiation treatment vault and HDR brachytherapy treatment vault in 2018

Potentially Misvalued Codes

- HHS Secretary to periodically review and identify potentially misvalued services and to make appropriate adjustments as mandated by law

- CMS is <u>not</u> proposing a new screen for 2018

Phase-in of RVUs with Significant Reductions

- Mandated by legislation
- 2-year phase-in
  - CMS 19% reduction in first year and percentage remainder of reduction in the 2nd year
- Applies to existing codes
  - For 2018, applies to 4 radiation oncology codes: global & TC of 77332 simple treatment device and 77470 special treatment procedure
  - Not new or revised codes

Proposed Work RVUs for 2017

CPT Code	Current Work RVU	RUC Work RVU	CMS Work RVU	CMS Time Refinement
77261 Therapeutic radiology treatment planning; simple	1.39	1.30	1.30	No
77262 Therapeutic radiology treatment planning; intermediate	2.11	2.00	2.00	No
77263 Therapeutic radiology treatment planning; complex	3.14	3.14	3.14	No
192X1 Prep tumor cavity with applicator placement for IORT	New	3.00	3.00	No
55X87 Peri-prostatic implantation of biodegradable material	New	3.03	3.03	No
GRRR1 Superficial radiation treatment planning and management	New	n/a	7.93	No

Patient Access and Medicare Protection Act (S. 2425)

- Legislation passed by Congress on December 18, 2015 and signed into law by President
- Freeze work RVUs and direct practice expense inputs for HCPCS G-codes G6001-G6015 in 2017 & 2018
  - Continue use of HCPCS G-codes under the MPFS through 2018
  - Use existing CPT codes under HOPPS*, ASC and most private payers

*some exceptions for off-campus provider-based hospital departments

Radiation Treatment Delivery & Image Guidance Code Set

- CMS does not implement for 2017 or 2018 in the MPFS due to PAMPA legislation
  - Conventional external beam treatment delivery
    - 77402 Radiation treatment delivery, simple
    - 77407 Radiation treatment delivery, intermediate
    - 77412 Radiation treatment delivery, complex
  - IMRT treatment delivery
    - 77385 IMRT delivery, simple
    - 77386 IMRT delivery, complex
  - Image guidance
    - 77387 Guidance for localization of target volume

2018 Crosswalk Codes

77402 Radiation treatment delivery, single area; up to 5 MeV	G6003
77403 Radiation treatment delivery, single area; 6-10 MeV	G6004
77404 Radiation treatment delivery, single area; 11-19 MeV	G6005
77406 Radiation treatment delivery, single area; 20 MeV or greater	G6006
77407 Radiation treatment delivery, two areas; up to 5 MeV	G6007
77408 Radiation treatment delivery, two areas; 6-10 MeV	G6008
77409 Radiation treatment delivery, two areas; 11-19 MeV	G6009
77411 Radiation treatment delivery, two areas; 20 MeV or greater	G6010
77412 Radiation treatment delivery, three or more areas; up to 5 MeV	G6011
77413 Radiation treatment delivery, three or more areas; 6-10 MeV	G6012
77414 Radiation treatment delivery, three or more areas; 11-19 MeV	G6013
77416 Radiation treatment delivery, three or more areas; 20 MeV or greater	G6014

2018 Crosswalk Codes

77418 IMRT delivery	G6015
0073T Compensator-based IMRT delivery	G6016
76950 US guidance to place radiation fields	G6001
77421 Stereoscopic x-ray guidance	G6002

Non-Excepted Off-Campus Provider-Based Hospital Outpatient Departments

- CMS designated MPFS as the applicable payment system for nonexcepted items and services effective 2017
  - No longer paid under HOPPS
- For 2018, the MPFS Relativity Adjuster is 25% of the HOPPS payment
  - Currently 50% of HOPPS payment

Other Policy

- Malpractice RVUs
  - Proposing new malpractice RVUs using the most recent data
  - Radiation oncology is crosswalked to diagnostic radiology due to lack of premium data
  - 1% impact to radiation oncology codes

- Geographic Practice Cost Index (GPCIs)
  - Phased in over 2 years in 2017 and 2018
  - Establishes new GPCIs using updated data
  - No change to cost share weights

Other Policy

- Payment Incentive for Transition to Digital Radiography
  - Technical component payments of imaging services taken with x-rays using film reduced 20%
  - Technical component payment of imaging services taken using computed radiography technology reduced 7%
    - Defines as cassette-based imaging that utilizes an imaging plate to create the image involved
    - Modifier “XX” on technical component and global claims

- Add HCPCS code G0296 *Visit to determine low dose computed tomography eligibility* to the list of telehealth services

Other Policy

- Appropriate Use Criteria of Advanced Diagnostic Imaging
  - Promotes the use of Appropriate Use Criteria (AUC)
  - Applies to CT, MRI & PET services
  - Applies to MPFS, HOPPS & ASC payment systems
  - 2018 proposals related to requirements for an ordering professional to consult with a qualified Clinical Decision Support Mechanism (CDSM) when ordering an applicable imaging service and communicate information about the AUC consultation to the furnishing professional, and for the furnishing professional to include that information on applicable claims
  - Reporting begins January 1, 2019

2018 MFPS Impacts

Specialty	Medicare Allowed Charges (millions)	Impact Work RVU Changes	Impact Practice Expense RVU Changes	Impact Malpractice RVUs	Total Impact
Radiation Oncology & Radiation Therapy Centers	$1,784	0%	1%	1%	1%
Radiology	$4,683	0%	-1%	0%	-1%
Total	$92,628	0%	0%	0%	0%

2018 HOPPS Final Rule

- Medicare Hospital Outpatient Prospective Payment System (HOPPS)
  - Reimbursement to over 3,900 hospital outpatient departments
  - Proposed 2.0% increase in Medicare payments to hospitals

HOPPS Conversion Factor

- 2018 conversion factor = $76.48 for hospitals that meet quality reporting data requirements

- 2018 conversion factor = $74.95 for hospitals that do not report quality data
  - 2.0% reduction to update factor

2018 HOPPS

- Radiation therapy claims are typically multiple-procedure claims due to serial billing
- HOPPS payments are based on single and pseudo-single claims
- Pseudo-Single Claims
  - Date of Service
  - Bypass List
- More radiation oncology claims for rate setting ensures more appropriate payment rates

2018 Rate Setting Methodology

- Relative payment weights for APCs revised annually
- 2016 outpatient claims used to determine 2018 payments
- CMS uses geometric mean costs of services to determine relative payment weights

2018 APC Payments

APC	CPT Codes	2017 Payment	2018 Payment	% Change
5611 Level 1 Therapeutic Radiation Treatment Prep	77280, 77299, 77300, 77316, 77331, 77332, 77333, 77336, 77370, 77399	$117.59	$122.37	4.1%
5612 Level 2 Therapeutic Radiation Treatment Prep	77285, 77290, 77306, 77307 77317, 77318, 77321, 77334 77338	$311.57	$315.51	1.3%
5613 Level 3 Therapeutic Radiation Treatment Prep	32553, 49411, 55876, 77295, 77301, C9728	$1,066.24	$1,158.79	8.7%

Both physics consultation codes assigned to same APC

2018 APC Payments

APC	CPT Codes	2017 Payment	2018 Payment	% Change
5621 Level 1 Radiation Therapy	77401, 77402, 77407, 77789, 77799	$114.35	$124.45	8.8%
5622 Level 2 Radiation Therapy	77412, 77600, 77750, 77767, 77768, 0394T	$204.51	$213.83	4.6%
5623 Level 3 Radiation Therapy	77385, 77386, 77423, 77470, 77520, 77610, 77615, 77620, 77761, 77762	$494.63	$511.67	3.4%
5624 Level 4 Radiation Therapy	77605, 77763, 77770, 77771, 77772, 77778, 0395T	$738.63	$694.43	-6.0%

2018 APC Payments

APC	CPT Codes	2017 Payment	2018 Payment	% Change
5625 Level 5 Radiation Therapy	77522, 77523, 77525	$994.12	$941.77	-5.3%
5626 Level 6 Radiation Therapy	77373	$1,651.29	$1,635.59	-1.0%
5627 Level 7 Radiation Therapy*	77371, 77372, 77424, 77425	$7,455.99	$7,335.22	-1.6%

***Comprehensive APC**

2018 Imaging APCs

APC	2017 Payment	2018 Payment	% Change
5521 Level 1 Imaging Without Contrast	$59.86	$59.17	-1.2%
5522 Level 2 Imaging Without Contrast	$112.73	$96.54	-14.4%
5523 Level 3 Imaging Without Contrast	$225.91	$149.67	-33.7%
5524 Level 4 Imaging Without Contrast	$449.69	$264.07	-41.3%
5525 Level 5 Imaging Without Contrast*	n/a	$472.98	
5571 Level 1 Imaging With Contrast	$265.02	$227.35	-14.2%
5572 Level 2 Imaging With Contrast	$426.52	$339.14	-20.5%
5573 Level 3 Imaging With Contrast	$656.91	$487.72	-25.8%

*New APC proposed for 2018

Composite APCs

- Composite APCs provide a single payment for groups of services that are typically performed together during a single clinical encounter
  - Same day
- CMS deletes LDR Prostate Brachytherapy APC 8001
  - CPT 77778 + 55875
- Multiple Imaging Composite APCs 8004-8008
- No new composite APCs for 2018

2018 Multiple Imaging Composite APCs

APC	2017 Payment	2018 Payment	% Change
8004 Ultrasound	$288.36	$290.93	0.9%
8005 CT & CTA Without Contrast	$273.09	$269.53	-1.3%
8006 CT & CTA With Contrast	$489.37	$483.63	-1.2%
8007 MRI & MRA Without Contrast	$551.75	$548.88	-0.5%
8008 MRI & MRA With Contrast	$851.69	$853.56	0.2%

New CT & MRI Cost Centers effective 2014

Comprehensive APCs

- Single payment for entire hospital stay
  - Defined by a single claim regardless of the date of service span
- 62 Comprehensive APCs (C-APC) in 2018
  - 1 specific to radiation oncology
    - Single Session Stereotactic Radiosurgery & IORT
  - Multiple for brachytherapy insertion procedures
    - LDR Prostate Brachytherapy **(new for 2018)**
    - Breast Brachytherapy Catheter Placement
    - Insert Tandem & Ovoids and Heyman Capsules
    - Other Brachytherapy Catheter/Applicator Insertion
- Required code edit for brachytherapy insertion surgical codes must include a brachytherapy treatment delivery code (CPT 77750-77799)

Comprehensive APCs

- Comprehensive APC 5627 *Level 7 Radiation Therapy*
  - IORT codes 77424 and 77425 & Single Session Cranial SRS includes 77371 and 77372
  - $7,335.22, 1.6% payment decrease
  - CMS unbundles 10 codes and pays separately in 2018 for SRS codes 77371 & 77372
    - CT Localization (77011, 77014)
    - MRI Imaging (70551, 70552, 70553)
    - Clinical Treatment Planning (77280, 77285, 77290, 77295)
    - Physics Consultation (77336)
  - CMS deletes SRS requirement for “CP” modifier for every code that is adjunctive to the comprehensive service but is billed on a different claim effective 2018

2018 Comprehensive APCs

APC	CPT Codes	2017 Payment	2018 Payment	% Change
5091 Level 1 Breast/Lymphatic Surgery & Related Procedures	19499 Unlisted breast surgery	$2,499.48	$2,628.42	5.2%
5092 Level 2 Breast/Lymphatic Surgery & Related Procedures	19298 Breast brachytherapy catheter (tube & button)	$4,419.46	$4,616.48	4.5%
5093 Level 3 Breast/Lymphatic Surgery & Related Procedures	19296 Breast brachytherapy catheter (expandable)	$6,486.35	$7,023.71	8.3%

2018 Comprehensive APCs

APC	CPT Codes	2017 Payment	2018 Payment	% Change
5113 Level 3 Musculoskeletal	20555 Catheters into muscle/soft tissue	$2,438.34	$2,500.65	2.6%
5153 Level 3 Airway Endoscopy	31643 Diagnostic bronchoscope, catheter placement	$1,269.79	$1,263.62	-0.5%
5165 Level 5 ENT	41019 Catheters into head/neck	$4,130.94	$4,090.95	-1.0%
5302 Level 2 Upper GI	43241 Upper GI endoscopy, catheter placement	$1,334.83	$1,375.03	3.0%

2018 Comprehensive APCs

APC	CPT Codes	2017 Payment	2018 Payment	% Change
5341 Abdominal/ Peritoneal/ Biliary	55920 Catheters into pelvic organs/genitalia	$2,862.74	$2,788.26	-2.6%
5375 Level 5 Urology	55875 Needles/ catheters into prostate	$2,542.56	$3,597.65	41.5%
5414 Level 4 GYN	57155 Tandem/ovoids 58346 Heyman capsules	$2,085.47	$2,188.97	5.0%

Brachytherapy Sources

- Separate payment for brachytherapy sources as mandated by 2003 Medicare Modernization Act
- CMS continues current payment policy based on geometric mean cost of 2016 hospital outpatient claims
- Prospectively paid brachytherapy sources are subject to:
  - Additional outlier payments, when criteria and threshold are met
  - Additional payment to rural hospitals based on 7.1% rural adjustment
  - Scaling for purposes of budget neutrality

2018 Brachytherapy Source APCs

Code	Source Descriptor	2018 Payment	Code	Source Descriptor	2018 Payment
A9527	Iodine-125 solution	$26.08 (-12.9%)	C2638	Stranded Iodine-125	$36.79 (-3.1%)
C1716	Gold-198	$123.12 (-9.0%)	C2639	Iodine-125	$34.76 (-2.6%)
C1717	HDR Iridium-192	$285.71 1.5%	C2640	Stranded Palladium-103	$75.50 3.1%
C1719	Non-HDR Iridium-192	$19.99 (-40.9%)	C2641	Palladium-103	$66.62 1.8%
C2616	Yttrium-90	$16,540.88 0.2%	C2642	Stranded Cesium-131	$85.41 (-2.5%)
C2634	High Activity Iodine-125	$114.77 (-4.8%)	C2643	Cesium-131	$84.24 42.3%
C2635	High Activity Palladium-103	$25.51 (-0.7%)	C2644	Cesium-131, per mCi *No payment in 2017*	$100.97
C2636	Linear Palladium-103	$29.55 58.4%	C2645	Planar Palladium-103, per sq mm *No claims data available*	$0

2018 Packaged Services

- CMS continues to package payment for items and services in multiple categories into the primary diagnostic or therapeutic modality to which these items and services are typically ancillary and supportive
- No new proposals specific to radiation oncology in 2018
  - Low cost drug administration services

Payment Adjustment to Cancer Hospitals

- Payment adjustment to 11-designated cancer hospitals to provide additional HOPPS payments
  - Projected target payment-to-cost ratio of 0.89
  - CMS provides payment adjustment in form of an aggregate payment at cost report settlement, which avoids higher co-payments for beneficiaries

Payment Adjustment to Cancer Hospitals

Hospital	**Estimated % Increase 2018**
City of Hope Clinical Research Hospital	32.9%
USC Cancer Hospital	11.5%
Univ. of Miami Hospital & Clinic	24.3%
H. Lee Moffitt Cancer Center	23.1%
Dana-Farber Cancer Institute	45.8%
Memorial Sloan-Kettering Cancer Center	47.1%
Roswell Park Cancer Institute	21.4%
James Cancer Hospital	28.9%
Fox Chase Cancer Center	8.8%
M.D. Anderson Cancer Center	76.9%
Seattle Cancer Care Alliance	53.9%

Other 2018 HOPPS Policies

- Continues current 7.1% rural payment adjustment
- Maintains outlier policy
  - Services that exceed 1.75 times APC payment and fixed $4,325 threshold. CMS pays 50% of amount over the 1.75 times threshold
- Payment for X-rays using film reduced 20%
  - Hospitals required to use a modifier “FX”
- Payment for imaging using computed radiography technology (cassette-based) reduced 7%
  - Hospitals required to use a modifier “XX”

Other 2018 HOPPS Policies

- G0463 Hospital Outpatient Clinic Visit assigned to APC 5012 *Level 2 Examinations & Related Services*
  - 2018 payment $109.58
- ASP + 6% for drugs & radiopharmaceuticals
- ASP – 22.5% for drugs and biologicals acquired under 340B program
- Continues additional $10 payment for radioisotopes produced by non-highly enrich uranium sources

Other 2018 HOPPS Policies

- Appropriate Use Criteria for Advanced Diagnostic Imaging applies to CT, MRI and PET services provided in a hospital outpatient department

- CMS is reinstating non-enforcement of direct supervision for outpatient therapeutic services for critical access hospitals (CAHs) and small rural hospitals having 100 or fewer beds in 2018 & 2019

2018 ASC Policy

- CMS uses geometric mean costs to determine relative payment weights under the ASC standard rate setting methodology

- Continue ASC update based on Urban Consumer Price Index (CPI-U)
  - $45.88 CF for ASCs that meet reporting requirements
  - $44.98 for ASCs that do not meet reporting requirements (-2.0% reduction)

2018 ASC Policy

- Defines breast brachytherapy catheter codes 19296 & 19298 as “Device-Intensive”
  - All ancillary services receive separate ASC payment (not bundled like under HOPPS)
    - No Comprehensive APCs in the ASC payment system
  - Device offset applies
  - No cost/full credit or partial credit policy applies to implanted devices

2018 ASC Policy

- Proposes deletion of Composite Payment for LDR Prostate Brachytherapy in ASC
  - For 2018, separate payments for 55875 and 77778
  - 13.8% increase from current composite payment (G0458) of $1,893 to $2,153 separate payment for CPT 55875 & 77778
- Brachytherapy Sources paid same rate as HOPPS in the ASC setting

Questions?

- http://aapm.org/government_affairs/CMS/2018HealthPolicyUpdate.asp
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