Coding & Documentation Updates Part Two

2016 Radiation Oncology Conference for Therapists & Dosimetrists

September 9, 2016

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Objectives of this Presentation

- Basic Review of MPFS and HOPPS
- Discuss the MPFS Proposed Rule Items
- Discuss the MPFS Proposed Payment Rates
- Discuss the HOPPS Proposed Rule Items
- Discuss the HOPPS Proposed Payment Rates
- Review the Coding Change for 77295 and 77300

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HOPPS and MPFS Payment Systems

HOPPS

- Payments based on costs
- Adjusted by a wage index
- Grouped in APCs
- Example : Tx Plans
  - 77295 & 77301
    - Historically the same payment rate under HOPPS

MPFS

- Codes have RVUs
- CF is applied to all RVUs
- GPCI's
- Codes can be split into Global, TC, 26 payment
- Example: Tx Devices
  - 77332, 77333, 77334
    - Historically different payment rates under MPFS

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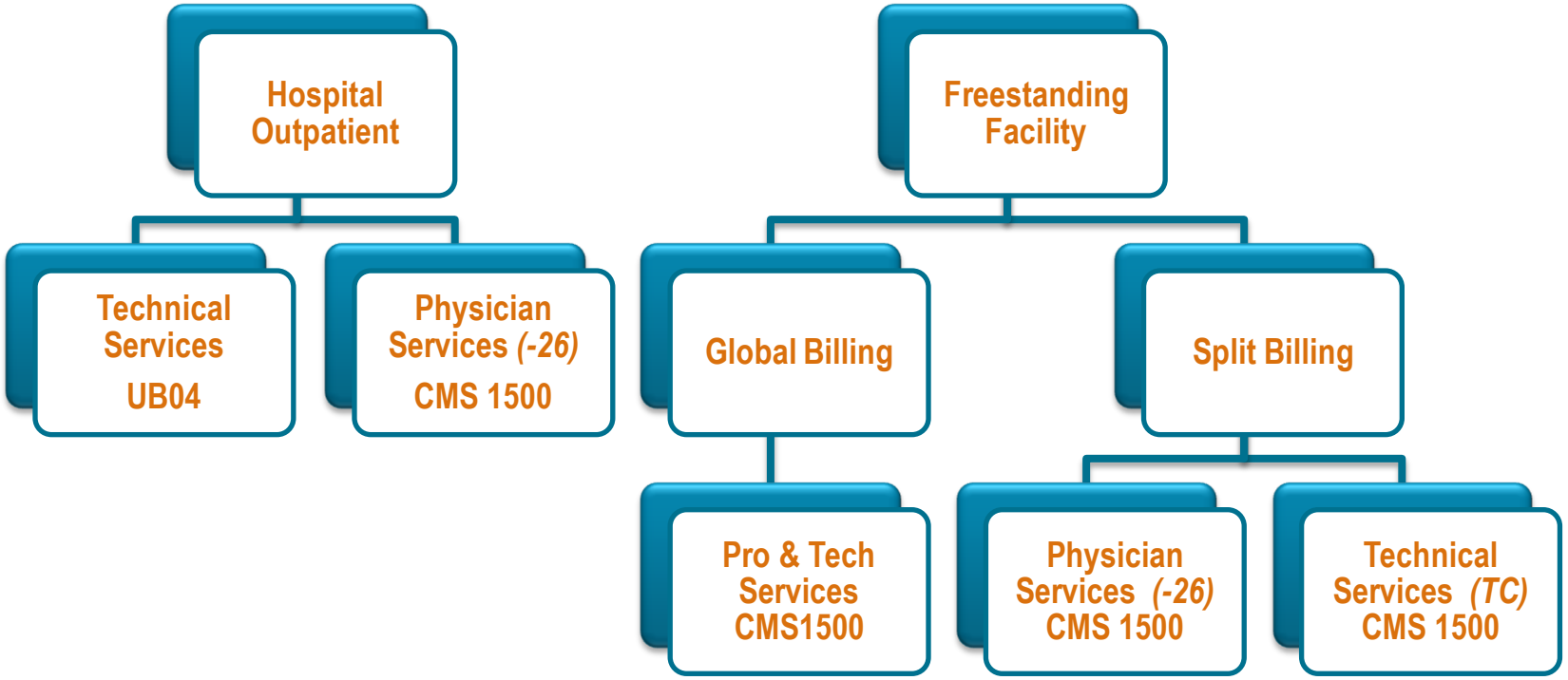
Billing Scenarios



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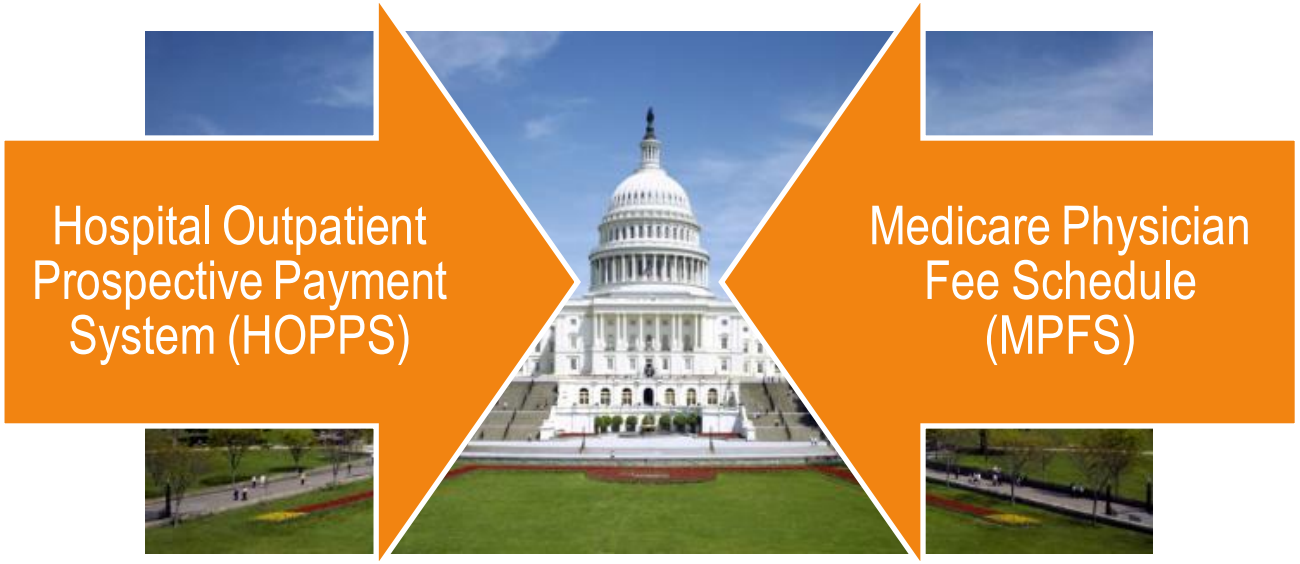
Federal Register

- Document actions of Federal agencies and forum for public review and comment
- Publications include: Presidential Documents, Rule & Regulations, Proposed Rules and Notices



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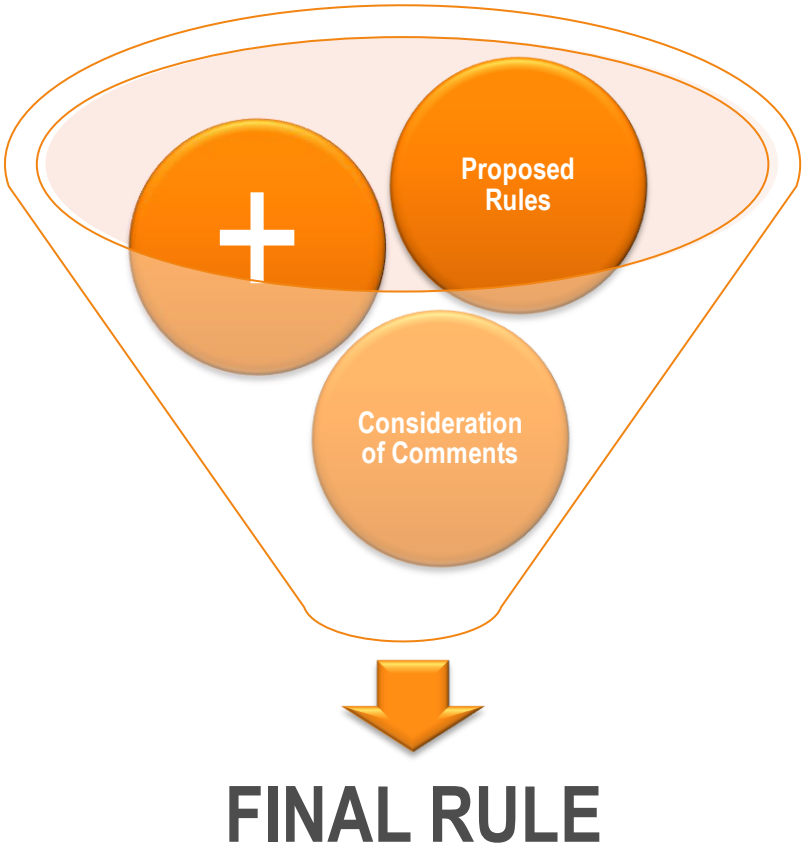
Proposed vs. Final Rule

Proposed Rule:

- CMS plans, goals, solutions to problems and proposed rulemaking
- Opportunity for public to make comments

Final Rule:

- Final legal effect after consideration of comments



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MPFS Proposed Rule CY 2017

www.federalregister.gov/articles/2016/07/15/2016-16097/medicare-program-payment-policies-under-the-physician-fee-schedule-medicare-advantage-pricing-data

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MPFS Proposed Highlights

- Payment rates – Conversion Factor (CF) is proposed to be $35.7751
  - 0.5% increase to CY 2016 CF $35.8043 per MACRA
  - -0.51% Budget Neutrality Adjustment
  - 0% Target Recapture Amount
  - -0.07% Imaging Multiple Procedure Payment Reduction (MPPR) Adjustment
- Estimated Impact on Total Allowed Charges by Specialty
  - Radiation Oncology = 0%
  - Radiation Therapy Centers = -1%

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MPFS Proposed Highlights cont.

- Valuation of Specific Codes
  - Codes in CY 2016 were added as potentially misvalued, for CY 2017 some of the codes are proposed to be changed
  - Codes 77332, 77333 and 77334 (treatment devices) proposed work RVU changes for CY 2017, CMS did not accept the RUC's recommendations
  - Code 77470 (special treatment procedure) proposed work RVU change for CY 2017, CMS accepted the RUC's recommendations
  - Codes 77778 (interstitial brachytherapy treatment) & 77790 (handling and loading) work RVU change for CY 2017, CMS accepted the RUC's recommendations
  - Code 31575 (diagnostic laryngoscopy) proposed work RVU changes for CY 2017, CMS did not accept the RUC's recommendations

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MPFS Proposed Highlights cont.

- Imaging codes proposed Direct PE (practice expense) adjustments
  - Proposing to add the professional PACS workstation to many CPT® codes in 70000 series that include technical PACS workstation (ED050) and include professional work on the workstation
  - Not proposing to add to the Radiation Therapy section (77261 – 77799)
  - Proposing half of the preservice work time for the professional PACS workstation, understand practitioner is not spending all of preservice time at workstation
  - Proposing to include 76873 (volume study) and 77014 (CT for placement of radiation therapy fields) in Direct PE adjustments

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MPFS Proposed Highlights cont.

- Proposed Valuations for Endoscopy Services Minus Moderate Sedation
  - To account for moderate sedation services CMS is proposing to maintain current values of the procedure codes less the work RVUs associated with the most frequently reported moderate sedation code
- Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services
  - As outlined in HOPPS CY 2017 proposed rule and proposed for MPFS, services performed using X-ray film, the technical reimbursement will be reduced by 20%
  - Reduction is made prior to any other adjustments in place
- Recoupment or Offset of Payments to Providers Sharing the Same Taxpayer Identification Number
- Modification of fee schedule areas for State of California

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Conversion Factor (CF) Update

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) put into law April 16, 2015
  - Repealed sustainable growth rate (SGR)
  - Revised and established PFS updates for several years
  - Established a Merit-based Incentive Payment System (MIPS)
- The MACRA proposed rule closed from comments after June 27, 2016 – New payment system effective 1/1/19
- **CY 2017 CF Proposed to be $35.7751**

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Calculating Conversion Factor

- Budget Neutrality keeps CMS budget in expected range, factor subtracted from CF of 2016 + the 0.5% update factor
- Target Recapture Amount = 0%
- Imaging MPPR (Multiple Procedure Payment Reduction) – Reduced from 25% to 5% - to offset adjustment = -0.07%

TABLE 41: Calculation of the Proposed CY 2017 PFS Conversion Factor

Conversion Factor in effect in CY 2016		35.8043
Update Factor	0.50 percent (1.0050)	
CY 2017 RVU Budget Neutrality Adjustment	-0.51 percent (0.9949)	
CY 2017 Target Recapture Amount	0 percent (1.0000)	
CY 2017 Imaging MPPR Adjustment	-0.07 percent (0.9993)	
CY 2017 Conversion Factor		**35.7751**

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MPFS Payment

- Work: Relative time and intensity of service
- Practice Expense (PE): Costs of maintaining practice, i.e. rent, supplies, equipment
- Malpractice (MP): Costs of malpractice insurance
- Geographic Practice Cost Index (GPCI): Adjusts for geographic variation in costs
- Conversion Factor (CF): Converts to dollar amount

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MPFS Payment Impact Table

Table 43: CY 2017 PFS 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**
Radiation Oncology	$1,720	0%	0%	0%	0%
Radiation Therapy Centers	$43	0%	-1%	0%	-1%

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

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Geographic Practice Cost Index (GPCI)

- Factor applied to the reimbursement equation to account for geographic location of provider and variation in costs of furnishing services in the particular location
- Required to be reviewed and if necessary adjusted every 3 years
- CY 2017 reviews completed and few items to address
  - Frontier States 1.0 PE GPCI
  - Fee Schedule Adjustments for State of California

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Frontier States PE GPCI

- Frontier States include
  - Montana, Wyoming, North Dakota, South Dakota and Nevada
- Due to population/size of each state
  - CMS is again proposing to cap the PE (Practice Expense) GPCI at 1.0 for the Frontier States even if the value would be lower than the “floor value”

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Adjustments to CA GPCIs

- Per MACRA, beginning CY 2017 fee schedule areas for CA must be Metropolitan Statistical Areas (MSAs) as defined by the Office of Management and Budget (OMB) as of December 31 of the previous year
- All areas not located in an MSA must be treated as a single rest-of-state fee schedule area.
- Change from 9 current localities to 27 in CY 2017
- Values to be implemented gradually over 6 year period in increments of 1/6 each year.

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TABLE 15: MSA-Based Fee Schedule Areas in California

Current Locality Number	Proposed New Locality Number	Fee Schedule Area (MSA NAME)	Counties	Transition Area
99	54	Bakersfield, CA	Kern	YES
99	55	Chico, CA	Butte	YES
99	71	El Centro, CA	Imperial	YES
99	56	Fresno, CA	Fresno	YES
99	57	Hanford-Corcoran, CA	Kings	YES
18	18	Los Angeles-Long Beach-Anaheim, CA *(Los Angeles County)*	Los Angeles	NO
26	26	Los Angeles-Long Beach-Anaheim, CA *(Orange County)*	Orange	NO
99	58	Madera, CA	Madera	YES
99	59	Merced, CA	Merced	YES
99	60	Modesto, CA	Stanislaus	YES
3	51	Napa, CA	Napa	YES
17	17	Oxnard-Thousand Oaks-Ventura, CA	Ventura	NO
99	61	Redding, CA	Shasta	YES
99	75	REST OF STATE	All Other Counties	YES

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Table 15 cont.

Current Locality Number	Proposed New Locality Number	Fee Schedule Area (MSA NAME)	Counties	Transition Area
99	62	Riverside-San Bernardino-Ontario, CA	Riverside, And San Bernardino	YES
99	63	Sacramento--Roseville--Arden-Arcade, CA	El Dorado, Placer, Sacramento, And Yolo	YES
99	64	Salinas, CA	Monterey	YES
99	72	San Diego-Carlsbad, CA	San Diego	YES
7	7	San Francisco-Oakland-Hayward, CA *(Alameda County/Contra Costa County)*	Alameda, Contra Costa	NO
3	52	San Francisco-Oakland-Hayward, CA *(Marin County)*	Marin	YES
5	5	San Francisco-Oakland-Hayward, CA *(San Francisco County)*	San Francisco	NO

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Table 15 cont.

Current Locality Number	Proposed New Locality Number	Fee Schedule Area (MSA NAME)	Counties	Transition Area
6	6	San Francisco-Oakland-Hayward, CA *(San Mateo County)*	San Mateo	NO
99	65	San Jose-Sunnyvale-Santa Clara, CA *(San Benito County)*	San Benito	YES
9	9	San Jose-Sunnyvale-Santa Clara, CA *(Santa Clara County)*	Santa Clara	NO
99	73	San Luis Obispo-Paso Robles-Arroyo Grande, CA	San Luis Obispo	YES
99	66	Santa Cruz-Watsonville, CA	Santa Cruz	YES
99	74	Santa Maria-Santa Barbara, CA	Santa Barbara	YES
99	67	Santa Rosa, CA	Sonoma	YES
99	73	Stockton-Lodi, CA	San Joaquin	YES
3	53	Vallejo-Fairfield, CA	Solano	YES
99	69	Visalia-Porterville, CA	Tulare	YES
99	70	Yuba City, CA	Sutter, And Yuba	YES

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Valuation of Specific Codes

- Codes evaluated on annual basis, the RUC recommends values by 2/10 of each year
  - CMS evaluates recommendations and also reviews claims data, review of medical literature, comparative databases, comparison to other codes and discussion with physicians and other healthcare professionals before deciding whether or not to accept the RUC's recommendations or establish different values
- CY 2016 Rad Onc codes identified as potentially misvalued
- CY 2017 Rad Onc codes proposed value changes
  - 31575
  - 77332, 77333 and 77334
  - 77470
  - 77778 and 77790

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Valuation of 77332, 77333 & 77334

- Identified through high expenditure specialty screening tool
  - RUC recommended no changes
  - CMS believes current RVUs overstate work involved in furnishing service of treatment devices
- Based on research, CMS found 34% decrease in total time to provide service for code 77332
  - RUC did not incorporate time into recommended value
- Due to incremental increase in work value (simple, intermediate and complex) the intermediate (77333) and complex (77334) codes proposed to change as well

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Valuation of 77470

- Identified through high expenditure specialty screening tool
- Proposing to use value recommended by RUC
- Believe description of code and vignette describe different and unrelated treatment being performed by the physician and clinical staff for a typical patient
  - Disparity between work RVUs and PE RVUs
- CMS is also seeking comment to determine if two G-codes, one which describes the work portion of the special treatment procedure service and another which describes the PE portion may be more accurate method of valuing and paying for the services under this code

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Valuation 77778 & 77790

- CY 2015 definition for 77778 did not include handling and loading
  - Definition changed for CY 2016, it now includes what was previously billed with code 77790 ***BUT*** does not include the work RVU value for 77790
- CY 2016 Interim work RVU for 77778 = 8.00 & 77790 = 0
- No new clinical info provided to support changing value, proposing to finalize work RVU for 77778 as 8.00 and continue 77790 work RVU as 0

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Valuation of 31575

- Diagnostic laryngoscopy is performed on many of the head and neck radiation therapy patients throughout their course of treatment
- CMS believes the time assigned to code 31575 is too high, current time is 28 minutes and CMS feels 24 minutes is more accurate
- CMS is not accepting of the RUC's recommendations on this code and is proposing to decrease the work RVU

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Proposed CY 2017 Work RVUs for New, Revised and Potentially Misvalued Codes

HCPCS code	Descriptor	Current Work RVU	RUC work RVU	CMS work RVU	CMS time refinement
31575	Laryngoscopy, flexible fiberoptic; diagnostic	1.10	1.00	0.94	No
77332	Treatment devices, design and construction; simple (simple block, simple bolus)	0.54	0.54	0.45	No
77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)	0.84	0.84	0.75	No
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)	1.24	1.24	1.15	No
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	2.09	2.03	2.03	No
77778	Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed	8.00	-	8.00	No
77790	Supervision, handling, loading of radiation source	0.00	-	0.00	No

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Valuations for Endoscopy Services

- Trend in which sedation for certain procedures is performed by different physician than endoscopy
  - Resource costs are not incurred by endoscopic procedure, need to change values to reflect this
- Separate sedation codes created by CPT Editorial Committee
- Proposing GI endoscopy-specific procedures new moderate sedation code, GMMM1, instead of new CPT moderate sedation codes
- Many fiducial placement codes proposed work RVU changes

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Proposed Valuations for Endoscopy Services Minus Moderate Sedation

HCPCS code	CY 2016 Work RVU	CY2017 Proposed Work RVU	Use GMMM1 to Report Moderate Sedation (Y/N)
31626	4.16	3.91	N
32553	3.80	3.55	N
49411	3.82	3.57	N
57155	5.40	5.15	N
77371	0.00	0.00	N
77600	1.56	1.31	N
77605	2.09	1.84	N
77610	1.56	1.31	N
77615	2.09	1.84	N

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Imaging Codes Direct PE Adjustments

- CY 2015 RUC recommended all supply and equipment items associated with film technology removed from codes
- Recommendations to include the Picture Archiving and Communication System (PACS) equipment for imaging services in the code – not enough data to do this
- CY 2017 CMS received invoices on PACS equipment
- Proposing to add professional PACS workstation to many 70000 series of codes
  - Exclude Radiation Therapy section codes (77261 – 77799)

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PACS Equipment Time Values

- CMS is proposing to assign equipment time equal to the intraservice work plus half of the preservice work time associated with the codes. Only half of the service time is proposed since it is understood that the practitioner does not typically spend all of the preservice work using the equipment.
- Impacted codes include
  - MRI diagnostic codes for the brain, US volume study and CT for the placement of radiation therapy fields.

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Codes with Professional PACS workstation in the Proposed Direct PE Input database

HCPCS code	ED053 Minutes
70551	21
70552	23
70553	28
76873	40
77014	9

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CMS Recoupment of Overpayments

- Historically when an overpayment by CMS to a provider occurred, CMS would use the National Provider Identifier (NPI) to recoup overpayments from Medicare providers and suppliers
  - When not paid in full, referred to Department of Treasury further collection action under the Debt Collection Improvement Act of 1996 and the Digital Accountability and Transparency Act of 2014
  - Treasury uses various tools , including offset of federal payments against entities that share the same provider Taxpayer Identification Number (TIN)

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Recoupment per ACA

- Affordable Care Act (ACA) indicates obligated provider of services that owes a past-due overpayment to the Medicare program can also affect other applicable providers sharing a TIN
- Per statutes defined within the ACT (MACRA), applicable providers may also receive necessary adjustment to the payments to satisfy the amount due from the obligated provider

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"For example, a health care system may own a number of hospital providers and these providers may share the same TIN while having different NPI or Medicare billing numbers. If one of the hospitals in this system receives a demand letter for a Medicare overpayment, then that hospital (Hospital A) will be considered the obligated provider while its sister hospitals (Hospitals B and C) will be considered the applicable providers. This authority allows us to recoup the overpayment of the obligated provider, Hospital A, against any or all of the applicable providers, Hospitals B and C, with which it, Hospital A, shares a TIN."

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Notification of Overpayment by CMS

- Notification provided in writing by CMS or Medicare contractor – proposed changes would include notification to both the obligated and applicable providers
- Prior to the effective date of this rule, CMS intends to notify those potentially affected through Medicare Learning Network (MLN) or MLN Connects Provider eNews article(s), updates to the Internet Only Manual instructions and clarification in the demand letters issued to the obligated providers.

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Transitioning from X-ray to Digital

- CMS has outlined reimbursement reductions for services provided to patients in which traditional film is used under MPFS (outlined similar rules under HOPPS)
- Proposing 20% reduction to technical or global component for any service in CY 2017 where X-ray films were used
- Starting 2018 – 2022 X-rays taken using computed radiography reduced 7%
- CY 2023 and beyond 10% reduction
- Proposing “XX” modifier to be applied to all services where X-ray films were taken

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CY 2017 Proposed Rule MPFS Global Non-Facility Course Compare				
Type	2016 Course Collections - CF = $35.8043	2017 Course Collections - CF = $35.7751	2016 - 2017 Variance	
	2016 Global - CF = $35.8043	2016 Global - CF = $35.7751	Global	GLOBAL % Change
2D 10 fxs	$5,228.50	$5,146.61	-$81.90	-2%
3D w/IGRT 28 fxs	$16,394.79	$16,193.24	-$201.55	-1%
3D - w/out IGRT 33 fxs	$13,789.67	$13,622.08	-$167.58	-1%
IMRT 42 fxs	$23,798.76	$23,702.79	-$95.97	0%
IMRT 30 fxs	$19,623.98	$19,551.81	-$72.17	0%
SRS - Linac	$5,125.74	$4,940.54	-$185.20	-4%
SBRT Linac 5 Fractions	$11,462.39	$11,268.08	-$194.31	-2%
APBI Single Cath	$7,730.51	$7,708.10	-$22.40	0%
APBI MultiCath	$10,580.89	$9,967.66	-$613.23	-6%
Prostate - HDR	$5,509.21	$5,477.17	-$32.04	-1%
GYN Cyl 1 Chan HDR	$4,947.80	$5,123.71	$175.91	4%
GYN Multi Chan HDR	$6,592.65	$6,579.76	-$12.89	0%

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HOPPS Proposed Rule CY 2017

www.federalregister.gov/articles/2016/07/14/2016-16098/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

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HOPPS Proposed Highlights

- Payment Rates:
  - Increase payment rate under OPPS for outpatient departments by 1.55%
  - Apply -0.5% Multifactor Productivity Adjustment (MFP) and -0.75% Affordable Care Act (ACA) required adjustment
  - Rural sole community hospitals (SCHs) and essential access community hospitals (EACHs) – continue 7.1% payment adjustment.
  - Cancer Hospital Payment Adjustment – continue to provide payment-to-cost ratio (PCR) = 0.92 for each cancer hospital
  - Hospitals which fail to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements continue to be subject to additional 2% point reduction from Outpatient Department (OPD) fee schedule
- Propose continue using G0463, clinic visit, in APC 5012 to standardize APC relative payment weights for all APCs. APC 5012, to be assigned relative payment weight of 1.00

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HOPPS Proposed Highlights cont.

- Outlier Payments - continue policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS
  - Criteria set at 1.75x threshold and $3,825 exceeds APC payment amount – then 50% of difference to be paid
- Provider-based Departments (PBDs):
  - Implementation of section 603 of the Bipartisan Budget Act of 2015
  - Define the Medicare Physician Fee Schedule (MPFS) as the applicable payment system for non-excepted items and locations that will not be covered under the OPPS payment
- Hospital Outpatient Quality Reporting (OQR) Program:
  - Adopt seven (7) new measures including oncology specific measure
    - OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy
    - OP-33: External Beam Radiotherapy for Bone Metastases no changes

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HOPPS Proposed Highlights cont.

- Meaningful Use:
  - Eliminate specific objectives and measures used for Modified Stage 2 and Stage 3
  - One-time significant hardship exemption for the 2018 payment adjustment
- The Panel to reduce meetings to once per year
  - Next meeting scheduled for summer 2017
  - Subcommittees developed
    - Data Subcommittee
    - Visits and Observation Subcommittee
    - Subcommittee for APC Groups and Status Indicator (SI) Assignments

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HOPPS Proposed Highlights cont.

- Brachytherapy Sources – proposing to use costs derived from CY 2015 claims data
  - Propose to base payment rates on geometric mean cost for each source
  - Proposing to pay C2698 and C2699 (stranded and non-stranded not otherwise specified (NOS)) codes at rate equal to the lowest stranded or non-stranded prospective payment rate for such sources
  - Current brachytherapy sources have status indicator (SI) of "U"
  - Proposing new SI of "E2" for items and services for which pricing information and claims data are not available
- Low Dose Rate (LDR) Prostate Brachytherapy Composite APC
  - Continue to pay LDR prostate brachytherapy services using composite APC 8001
  - 202 claims which contained both 55875 and 77778 were used to set proposed rate

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HOPPS Proposed Highlights cont.

- New Category III code, 0438T, transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance effective July 1, 2016
- Off-campus provider based departments – certain items and services provided in certain off-campus provider-base departments (PBDs) proposed to not be covered under OPD for OPPS payments, instead paid under MPFS
- Payment Modifier for X-ray Films – proposed for 2017 and beyond, payment for imaging services using film for x-rays will be reduced by 20%

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HOPPS Payment Rates

- Payment rates for HOPPS under the Outpatient Department (OPD) fee schedule are proposed to increase by 1.55%
  - Based on the 2.8% increase proposed for the hospital inpatient market basket
  - Minus the proposed 0.5% multifactor productivity (MFP) adjustment
  - Minus 0.75% adjustment required by the Affordable Care Act
- Estimated the total payments for CY 2017 would be $63 billion, which is a $5.1 billion increase compared to estimated CY 2016 payments

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Additional Payment Adjustments

- CMS has also proposed to continue to apply a 2% reduction in payments for hospitals failing to meet the hospital quality reporting requirements
- Rural adjustment is proposed to continue with an adjustment of 7.1% to the HOPPS payments for certain rural sole community hospitals (SCHs)
  - Proposed to exclude separately payable drugs and biologicals, devices paid under pass-through policy and items paid at charges reduced to cost
- Frontier states are also proposed to continue receiving the floor wage index of 1.00 when they might otherwise have a wage index less than 1.00
- Cancer hospital payment adjustment is proposed to continue for CY 2017
  - Payment-to-cost ratio (PCR) of 0.92 proposed for CY 2017

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APC Relative Payment Weight

- CMS proposing to continue using code G0463 for hospital outpatient clinic visits in APC 5012 (Level 2 Examinations and Related Services) as the standardized relative payment weight
- Standard value for APC 5012 would be 1.00
- All other APCs unscaled relative payment weight values would be valued by taking the geometric mean costs for each APC and divide it by the relative payment rate assigned to APC 5012 of 1.00

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Outlier Payments

- Proposing to continue reimbursing outlier payments
  - Services which are considered high in cost to the hospital, and the established Medicare APC reimbursement does not cover the cost
- To meet aggregate outlier payments of 1.0%
  - Service must exceed the 1.75 times APC payment amount and
  - Exceeds the APC payment amount plus $3,825
  - If threshold met, 50% of difference is reimbursed

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Brachytherapy Sources

- Proposing to use geometric mean costs derived from CY 2015 claims data for CY 2017 rates
- Proposing to pay stranded and nonstranded NOS (not otherwise specified) codes C2698 & C2699 at rate equal to lowest stranded or nonstranded prospective payment rate
  - On a per source rather than per mCi
- Proposing for new sources to continue policy where no claims data to assign based on cost, CMS will assign HCPCS codes and new APC
  - Rates to be based on external data for new sources only

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Established Sources, no Claims Data

- Current source status indicator (SI) is “U”
  - Proposing new SI of “E2” for new sources and those with no claims data, *”Items and Services for Which Pricing Information and Claims Data Are Not Available”*
- Ex. Code C2644, (brachytherapy source, cesium-131 chloride solution, per millicurie) new code in 2014, never reported in CY 2015
  - No cost data to establish a payment per claims
  - Since established will not consider external data for rate setting

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New Source Code Recommendations

- Hospitals and other parties invited to submit recommendations for new brachytherapy source codes
- Recommendations should be directed to

  Division of Outpatient Care

  Mail Stop C4-01-26

  Centers for Medicare and Medicaid Services

  7500 Security Boulevard

  Baltimore, MD 21244

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LDR Composite APC

- Composite APC 8001 proposed to continue
  - Codes 55875 & 77778 when billed on same claim for same surgical event are paid a composite APC amount
  - When reported separately for not being performed together, paid separately
- Using geometric mean cost data of 202 cases (6 months of data) to set proposed rate of $3,426.25 for CY 2017

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Hydrogel Spacer Cat III Code

- Code C9743 deleted effective June 30, 2016
- New Category III code 0438T, transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance
  - Effective July 1, 2016
- Since both codes are same procedure, one is replacing the other same APC is proposed
  - CY 2017 proposed APC 5374, $2,527.29
  - Gel packaged into placement
  - Physician rate is Carrier/Contractor priced

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Provider Based Departments (PBDs)

- CMS has proposed to implement section 603 of Bipartisan Budget Act of 2015
- Requires non-excepted items and services furnished in certain off-campus PBDs paid *"under the applicable payment system"* rather than OPPS.
- In defining term *"off-campus outpatient department of a provider"* CMS provided an exception to off-campus PBDs billing under OPPS prior to November 2, 2015
  - Items performed in these excepted off-campus PBDs would continue to be paid under OPPS on or after January 1, 2017

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Excepted Services

- CMS has proposed that this exception would not apply if the excepted off-campus PBD moves, relocates from the physical address listed on the hospital enrollment form as of November 1, 2015, changes ownership or if additional items and services are furnished that were not part of the clinical family of services furnished and billed originally
- CMS is proposing to define 19 clinical families of hospital outpatient service types
- An excepted off-campus PBD billed for any service within a clinical family of services prior to November 2, 2015, this family of services would be considered excepted and eligible for OPPS payment

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Clinical Families	APCs
Advanced Imaging	5523-25, 5571-73, 5593-4
Airway Endoscopy	5151-55
Blood Product Exchange	5241-44
Cardiac/Pulmonary Rehabilitation	5771, 5791
Clinical Oncology	5691-94
Diagnostic tests	5721-24, 5731-35, 5741-43
Ear, Nose, Throat (ENT)	5161-66
General Surgery	5051-55, 5061, 5071-73, 5091-94, 5361-62
Gastrointestinal (GI)	5301-03, 5311-13, 5331, 5341
Gynecology	5411-16
Minor Imaging	5521-22, 5591-2
Musculoskeletal Surgery	5111-16, 5101-02
Nervous System Procedures	5431-32, 5441-43, 5461-64, 5471
Ophthalmology	5481, 5491-95, 5501-04
Pathology	5671-74
Radiation Oncology	5611-13, 5621-27, 5661
Urology	5371-77
Vascular/Endovascular/Cardiovascular	5181-83, 5191-94, 5211-13, 5221-24, 5231-32
Visits and Related Services	5012, 5021-25, 5031-35, 5041, 5045, 5821-22, 5841

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Reimbursement for Services

- CMS intends to provide a mechanism for an off-campus PBD to bill and receive payment for furnishing non-excepted items and services under an applicable payment system that is not OPPS
  - Mechanism is not in place to allow this to occur before January 1, 2017
- Many services in off-campus PBD identical to freestanding physician practices
  - Proposing to reimburse non-excepted items performed under MPFS nonfacility rate

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Hospital Outpatient Quality Reporting (OQR) Program

- Rad Onc measure finalized CY 2016
  - NQF# 1822 OP-33 External Beam Radiotherapy for Bone Metastases
    - Established fractionation schemes for bone mets
- No changes made to measure
  - Data required to be submitted via CMS's Web-based tool QualityNet Web site for the CY 2018 payment determination https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1205442125082

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Changes for Payment for Film X-Ray

- CMS has outlined reimbursement reductions for services provided to patients in which traditional film is used under HOPPS (outlined similar rules under MPFS)
- Proposing 20% reduction to reimbursement for any service in CY 2017 where X-ray films were used
- Starting 2018 – 2022 X-rays taken using computed radiography reduced 7%
- CY 2023 and beyond 10% reduction
- Proposing modifier to be applied to all services where X-ray films were taken – No specific modifier proposed for HOPPS

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Meaningful Use

- Typically outlined in separate rules release, CMS addressed in OPPS
- CMS proposed changes to objectives and measures used for Modified Stage 2 in 2017 and Stage 3 in 2017 and 2018
  - Eliminate Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures and lower reporting thresholds for a subset of remaining objectives and measures
- Proposing a one-time significant hardship exemption from the 2018 payment adjustment for certain eligible professionals who are new participants to the EHR Incentive Program in 2017 and transitioning to the Merit-Based Incentive Payment System (MIPS) in 2017

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2016-2017 Hospital Outpatient Prospective Payment System Course Example Impacts				
Type	HOPPS 2016 Course Medicare Allowable	HOPPS 2017 Course Medicare Allowable	2016 - 2017 Final Rule Variance	2016- 2017 Final Rule % Change
2D - 10 fxs	$4,100.72	$4,245.61	$144.89	3.53%
3D - w/ imaging (28 fxs)	$11,646.47	$12,060.69	$414.22	3.56%
3D - w/out imaging (33 fxs)	$11,927.28	$12,338.19	$410.91	3.45%
IMRT - Simple 42 fxs	$25,227.05	$24,838.17	-$388.88	-1.54%
IMRT - Complex 30 fxs	$18,623.93	$18,340.89	-$283.04	-1.52%
SRS- Linac Frameless	$9,180.54	$9,314.84	$134.30	1.46%
SRS- Cobalt Headframe	$8,888.77	$9,007.10	$118.33	1.33%
SRS- Cobalt Frameless	$8,888.77	$9,007.10	$118.33	1.33%
SBRT Linac 5 Fractions	$13,676.20	$13,834.75	$158.55	1.16%
SBRT - Cobalt 5 Fractions	$15,947.80	$15,229.10	-$718.70	-4.51%
Proton - 25 Fractions	$33,237.41	$32,443.11	-$794.30	-2.39%
Prostate - HDR	$14,092.93	$15,076.65	$983.72	6.98%
Prostate - LDR	$9,442.13	$9,454.53	$12.40	0.13%
GYN - T&O - HDR	$12,946.00	$13,717.44	$771.44	5.96%
GYN - Cylinder 1 Chan- HDR	$8,260.60	$8,257.25	-$3.35	-0.04%
GYN - Cylinder Multi Chan - HDR	$8,444.97	$8,448.47	$3.50	0.04%

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National Correct Coding Initiative (NCCI)

- Developed to promote correct coding and control improper coding resulting in inappropriate payments
- Based on coding conventions defined by the CPT® Manual
- Updated Quarterly
- Practitioner versus hospital outpatient publications
- Edits include:
  - Procedure to Procedure (PTP)
  - Medically Unlikely Edits (MUE)

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/

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NCCI Edit 77295 & 77300 Deleted!

- CPT® code 77300 is now considered billable with 77295
- Deletion is retroactive to January 1, 2016, the implementation date of the edit

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Column1/Column 2 Edits						
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date	Modifier	PTP Edit Rationale
				*=no data	0=not allowed	
					1=allowed	
					9=not applicable	
77295	77300		20160101	20160101	9	Misuse of column two code with column one code

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NCCI Policy Manual

- Per letter to ASTRO - CMS will also revise the *National Correct Coding Initiative Policy Manual for Medicare (Medicaid) Services*, Chapter IX (Radiation Oncology), subsection 17 of the 2017 version of the Manual
- Current Language (2016)

14. Calculations described by CPT code 77300 are integral to the procedure described by CPT code 77295 (three-dimensional radiotherapy plan, including dose volume histograms). CPT code 77300 should not be reported with CPT code 77295.

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QUESTIONS

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