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2019 Hospital Outpatient Prospective Payment System
Final Rule Summary

On November 2, 2018, the Centers for Medicare & Medicaid Services (CMS) released the 2019 Hospital Outpatient Prospective Payment System (HOPPS) final rule. In the Medicare hospital outpatient environment, hospital reimbursement is based on Ambulatory Payment Classifications or APCs. CMS assigns CPT codes to an APC based on clinical and resource use similarity. All services in an APC are reimbursed at the same rate. Cost data collected from OPPS claims are used to calculate rates. Certain services are considered ancillary and their costs are packaged into the primary service. Packaged services do not receive separate payment. For example, in the hospital outpatient environment imaging is not paid separately when reported with treatment delivery services. Below is a summary of key issues impacting radiation oncology.

Update

In accordance with Medicare law, CMS is updating the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 1.35 percent. This increase factor is based on the hospital inpatient market basket percentage increase of 2.9 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus a 0.8 percentage point adjustment for multifactor productivity (MFP), and a 0.75 percentage point adjustment required by the Affordable Care Act. Based on this update, CMS estimates that proposed total payments to HOPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for 2019 will be approximately $74.1 billion, an increase of $5.8 billion compared to 2018 HOPPS payments.

Comprehensive Ambulatory Payment Classifications (C-APCs)

CMS finalized the expansion of the Comprehensive Ambulatory Payment Classification (C-APC) methodology by adding new C-APCs for ears, nose, and throat (ENT) services and vascular procedures. The addition of these new C-APCs increases the total number of C-APCs to 65. Under the C-APC policy, CMS provides a single payment for all services on the claim regardless of the span of the date(s) of service. Conceptually, the C-APC is designed so there is a single primary service on the claim, identified by the status indicator (SI) of "J1". All adjunctive services provided to support the delivery of the primary service are included on the claim.

While ASTRO supports policies that promote efficiency and the provision of high-quality care, we have long expressed concern that the C-APC methodology lacks the appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC. In the 2019 HOPPS final rule, CMS recognizes ASTRO's concerns regarding the C-APC methodology; however, the Agency remains committed to the methodology and does not intend to modify the methodology for radiation oncology services. ASTRO is disappointed by this and will continue to educate CMS on the impact the C-APC methodology has on radiation oncology services, particularly brachytherapy.

Below is a comparison table of the 2018 payment rates and 2019 payment rates for the radiation oncology services in several key C-APCs:

C-APC 5627 Level 7 Radiation Therapy				
CPT Code	Descriptor	2018 Rate	2019 Final Rate	% Change
77371	SRS Multisource	$ 7,566	$ 7,644	1%
77372	SRS Linear Based	$ 7,566	$ 7,644	1%
77424	IORT delivery by x-ray	$ 7,566	$ 7,644	1%
77425	IORT delivery by electrons	$ 7,566	$ 7,644	1%
C-APC 5092 Level 2 Breast/Lymphatic Survery and Related Procedures				
19298	Place breast rad tube/caths	$ 4,812	$ 4,915	2.15%
C-APC 5093 Level 3 Breast/Lymphatic Survery and Related Procedures				
19296	Place po breast cath for rad	$ 7,388	$ 7,449	0.83%
C-APC 5113 Level 3 Musculoskeletal Procedures				
20555	Place ndl musc/tis for rt	$ 1,350	$ 2,623	94%
C-APC 5165 Level 5 ENT Procedures				
41019	Place needles h&n for rt	$ 4,339	$ 4,424	2%
C-APC 5302 Level 2 Upper GI Procedures				
43241	Egd tube/cath insertion	$ 1,427	$ 1,483	4%
C-APC 5375 Level 5 Urology and Related Services				
55875	Transperi needle place pros	$ 3,706	$ 4,021	8%
C-APC 5414 Level 4 Gynecologic Procedures				
57155	Insert uteri tandem/ovoids	$ 2,273	$ 2,361	4%
58346	Insert heyman uteri capsule	$ 2,273	$ 2,361	4%
C-APC 5415 Level 5 Gynecologic Procedures				
55920	Place needles pelvic for rt	$ 4,112	$ 4,126	0.34%

Ambulatory Payment Classifications (APC)

CMS finalized modest changes to the payment rates of traditional radiation oncology APCs in the 2019 HOPPS final rule. Below is a list of radiation oncology APCs with final 2019 payment rates:

Radiation Oncology - Ambulatory Payment Classification Proposed 2019 Payment Rates				
APC	Descriptor	2018 Rate	2019 Final Rate	% Change
5611	Level 1 Therapeutic Radiation Treatment Preparation	$ 125	$ 124	-1.3%
5612	Level 2 Therapeutic Radiation Treatment Preparation	$ 323	$ 322	-0.39%
5613	Level 3 Therapeutic Radiation Treatment Preparation	$ 1,187	$ 1,192	0.44%
5621	Level 1 Radiation Therapy	$ 125	$ 117	-6%
5622	Level 2 Radiation Therapy	$ 220	$ 224	2%
5623	Level 3 Radiation Therapy	$ 522	$ 520	-0.47%
5624	Level 4 Radiation Therapy - HDR Brachytherapy	$ 714	$ 705	-1.3%
5625	Level 5 Radiation Therapy - Proton Therapy	$ 1,054	$ 1,079	3%
5626	Level 6 Radiation Therapy - SBRT	$ 1,677	$ 1,691	0.8%

Brachytherapy Sources

In the 2019 HOPPS final rule, CMS finalized its decision to use costs derived from 2017 claims data to set the proposed 2019 payment rates for brachytherapy services. The payment rates are based on the geometric mean costs for each source, which is consistent with the methodology used for other services under HOPPS.

Stranded/Non-Stranded

CMS finalized payment for HCPCS codes C2698 *Brachytherapy source, stranded, not otherwise specified* and C2699 *Brachytherapy source, non-stranded, not otherwise specified*, at a rate equal to the lowest stranded or nonstranded prospective payment rate for such sources, respectively on a per source basis. For 2019, the final rates are $36.40 for C2698 and $27.12 for C2699. This is an increase of 5 percent and 42 percent over the 2018 rates of $34.73 and $19.16.

New Brachytherapy Sources with No Claims Data

CMS will continue the policy first implemented in 2010 regarding payment for new brachytherapy sources for which they have no claims data. The policy is intended to enable CMS to assign new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on consideration of external data and other relevant information regarding the expected costs of the sources to hospitals.

C2645 *Brachytherapy planar, p-103*

For 2019, CMS is assigning status indicator “U” (Brachytherapy Sources, Paid under HOPPS; separate APC payment) to HCPCS code C2645. The Agency used invoice prices and other relevant information to establish the APC payment rate of $4.69 per mm. This is the same rate that was in effect for 2017 and 2018.

C2644 *Brachytherapy cesium 131 chloride*
For 2019, CMS is assigning status indicator "E2" (Items and Services for Which Pricing Information and Claims Data Are Not Available) to HCPCS code C2644. Although this code became effective January 1, 2014, it was not reported on 2017 claims. Therefore, the Agency is unable to calculate a payment rate based on the general HOPPS rate-setting methodology.

New Brachytherapy Source Codes
CMS continues to invite recommendations for new codes to describe new brachytherapy sources.

New Device Pass-Through Application - SpaceOAR®

CMS establishes specific criteria for hospitals to receive pass-through payments for devices that offer substantial clinical improvement in treatment of Medicare beneficiaries. Devices must meet the following criteria 1) receive FDA approval or clearance 2) the device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part; and 3) the device is an integral part of the service furnished, is used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted, or applied in or on a wound or other skin lesion. Finally, the device must not be an item for which depreciation and financing expenses are recovered and it is not a supply or material furnished incident to a service.

Augmenix, Inc. submitted an application for a new device category for transitional pass-through payment for the SpaceOAR® system. SpaceOAR® is a polyethylene glycol hydrogel spacer that temporarily positions the anterior rectal wall away from the prostate to reduce the radiation delivered to the anterior rectum during prostate cancer radiation therapy. Despite the efforts of ASTRO, as well as other stakeholder groups, CMS determined in the 2019 HOPPS final rule that there is not enough sufficient evidence that SpaceOAR® provides a substantial clinical improvement over other products. Therefore, the Agency is denying the request for a pass thorough payment for CPT code 55874.

Two Times Rule Exception

CMS established two-times rule criteria within the APC methodology that requires that the highest calculated cost of an individual procedure categorized to any given APC cannot exceed two times the calculated cost of the lowest-costing procedure categorized to that same APC. However, the Agency can exempt any APC from the two-times rule for any of the following reasons:

- Resource homogeneity
- Clinical homogeneity
- Hospital concentration
- Frequency of service (volume)
- Opportunity for upcoding
- Code fragmentation

Based on 2017 claims data available for the 2019 proposed rule, CMS has finalized exceptions to

15 of the 16 APCs found to violate the two-times rule, including APC 5612 Level 2 Therapeutic Radiation Treatment Preparation and APC 5113 Level 3 Musculoskeletal Procedures. CMS states that the APCs on the exemption list meet one or more of the exemption criteria listed.

Method to Control Unnecessary Increases in Volume of Outpatient Services

In 2017, CMS implemented section 603 of the Bipartisan Budget Act of 2015. The Agency established "excepted" off-campus provider-based departments (PBDs) as those departments that billed for items and services under HOPPS prior to November 2, 2015. PBDs who were billing for items and services under HOPPS after that date were consider "non-excepted" off-campus PBDs.

Effective January 1, 2017, the "non-excepted" items and services were paid by applying a Physician Fee Schedule (PFS) Relativity Adjuster set at 50 percent of the HOPPS payment. In 2018 the PFS Relativity Adjuster was set at 40 percent of HOPPS and CMS proposes to retain the 40 percent PFS adjuster in the 2019 MPFS proposed rule. The PFS Relativity Adjuster did not apply to "excepted" off-campus PBDs.

In the 2019 HOPPS final rule, CMS did not finalize a proposal that would have paid excepted off-campus PBD's for items and services related to expansion into a new clinical family at the PFS rate. The Agency will continue to monitor the expansion of services in excepted off-campus PBDS.

Payment of Drugs, Biologicals, and Radiopharmaceuticals

For 2019, CMS is finalizing its decision to pay separately payable drugs and biological products that do not have pass-through payment status and are not acquired under the 340-B program at wholesale acquisition price (WAC) plus 3 percent, instead of WAC plus 6 percent. If WAC data are not available, the Agency will continue its policy to pay at 95 percent of Average Wholesale Price (AWP).

Cancer Hospitals

In the 2019 HOPPS final rule, CMS continues its policy to provide cancer hospitals with additional payments. The additional payments are made to ensure that the cancer hospital's payment-to-cost ratio (PCR) are equal to the weighted average PCR for other HOPPS hospitals. A target PCR of 0.88 will be used to determine the 2019 cancer hospital payment adjustment. This reflects the 1 percentage point reduction in the PCR as required by the 21st Century Cures Act.

Hospital Outpatient Quality Reporting Program (OQR)

The Hospital Outpatient Quality Reporting (OQR) Program is a pay-for-reporting program for services rendered in the hospital outpatient setting. The program requires hospital outpatient facilities to meet quality reporting requirements or receive a reduction of 2 percentage points

from their annual payment update, if they fail to meet the requirements. In the 2019 HOPPS final rule, CMS is finalizing payment determinations, measure removal policies, clarification on topped out measures, and updates to participation status for the Hospital Outpatient Quality Reporting (OQR) program. The Agency is also finalizing the removal of 8 of the 10 measures that were proposed for removal in the 2019 HOPPS proposed rule. Despite ASTRO's efforts, the CMS continues to retain use of OP-33: External Beam Radiotherapy (EBRT) for Bone Metastases.

Register now for ASTRO's Final Rules webinar on Wednesday, December 5 at 1:00 p.m. ET. The webinar will cover final decisions impacting radiation oncology, including the G codes for treatment delivery and image guidance, found in the 2019 Medicare Physician Fee Schedule and Hospital Outpatient Prospective Payment System final rules.

A display copy of the final rule can be found at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24243.pdf

The Addenda relating to the HOPPS proposed rule are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html

A fact sheet on this proposed rule is available at: https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center.