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2018 Hospital Outpatient Prospective Payment System
Final Rule Summary

On November 1, 2017, the Centers for Medicare & Medicaid Services (CMS) released the 2018 Hospital Outpatient Prospective Payment System (HOPPS) final rule. Comments on the proposed rule are due December 31, 2017.

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 HOPPS 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

CMS is increasing the payment rates under the OPPS by an Outpatient Department fee schedule increase factor of 1.35 percent. This increase factor is based on the hospital inpatient market basket percentage increase of 2.7 percent for inpatient services paid under the hospital inpatient prospective payment system, minus a 0.6 percentage point adjustment for multifactor productivity, and a 0.75 percentage point adjustment required by the Affordable Care Act. Based on this update, CMS estimates that total payments to HOPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for 2018 will be approximately $70 billion, an increase of $5.8 billion compared to 2017 HOPPS payments.

Comprehensive Ambulatory Payment Classification (C-APC)

CMS did not create any new C-APCs for 2018 or make any extensive changes to the already established methodology used for C-APCs. There will be a total of 62 C-APCs as of January 1, 2018. 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.

C-APC 5627 Level 7 Radiation Therapy

CMS will continue its policy for the payment of Stereotactic Radiosurgery (SRS) treatment as described in the 2016 HOPPS final rule through the end of 2018. This policy removes claims reporting for the 10 planning and preparation services for SRS treatment from the geometric mean cost calculation for the 2018 payment rate for C-APC 5627 *Level 7 Radiation Therapy* and

pays separately for the planning and preparation services. The Agency will also continue to require that providers append a "CP" modifier to claims for cranial single session SRS patients. This policy will also expire on December 31, 2018.

In 2017, CMS added CPT Codes 77424 and 77425 *Intraoperative Radiation Therapy* to C-APC 5627. The Agency retains these codes in this C-APC again for 2018.

The final payment rate for C-APC 5627 is set at $7,565 for 2018, compared to the 2017 payment rate of $7,456, a 1.46 percent increase in payment.

Brachytherapy Insertion C-APCs 5165, 5302, and 5414

In the 2017 HOPPS final rule, CMS finalized six new C-APCs that described procedures for inserting brachytherapy catheters/needles and other related brachytherapy procedures, such as the insertion of tandem and/or ovoids and the insertion of Heyman capsules. In written comments, ASTRO expressed concern that claims for several of the brachytherapy device/insertion codes (CPT Codes 57155, 20555, 31643, 41019, 43241, 55920, and 58346) did not contain a brachytherapy treatment delivery code (CPT Codes 77750 through 77799). As a result, brachytherapy delivery charges are underrepresented in rate setting under the C-APC methodology. In response to ASTRO's concerns, CMS stated that the Agency would continue to examine the claims for these brachytherapy insertion codes and determine if any future adjustment to the methodology (or possibly code edits) would be appropriate.

In the 2018 HOPPS proposed rule, CMS announced that the Agency analyzed claims that included brachytherapy insertion codes assigned to status indicator "J1" and that received payment through a C-APC. The analysis validated ASTRO's concerns and, as a result, the Agency proposed to address the issue by establishing a code edit that requires a brachytherapy treatment code when a brachytherapy insertion code is billed.

CMS did not proceed with its proposal to require a code edit for brachytherapy treatment delivery when a brachytherapy insertion code is billed. However, the Agency did confirm that it will continue to utilize the C-APC methodology for brachytherapy insertion codes. CMS believes that the C-APC methodology is appropriately applied to the brachytherapy insertion procedures because they are primary services that are typically the focus of the hospital outpatient stay. CMS welcomes comments on how to improve the payment methodology for the brachytherapy insertion C-APCs given the concerns raised regarding variation in hospital billing practices.

Overall the Brachytherapy Insertion C-APCs experienced an increase in reimbursement for 2018. Below is chart comparing the 2017 and 2018 payment rates:

C-APC	Title	2017 Rate	2018 Rate	% Change
5165	Level 5 ENT Procedures	$4,131	$4,338	5%
5302	Level 2 Upper GI Procedures	$1,335	$1,427	7%
5414	Level 4 Gynecologic Procedures	$2,085	$2,273	9%

Composite APC 8001 LDR Prostate Brachytherapy

CMS finalized its decision to delete Composite APC 8001 *LDR Prostate Brachytherapy Composite*. CPT code 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* will be assigned to a C-APC 5375 *Level 5 Urology and Related Procedures* with a status indicator of J1. This increases the payment rate from $2,543 in 2017 to $3,706 in 2018, a 46 percent increase.

Also included in C-APC 5375 is the new CPT Code 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed*.

CPT Code 20555 Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)

In the final 2018 HOPPS, CMS made the decision to move CPT Code 20555 from C-APC 5113 *Level 3 Musculoskeletal Procedures* to C-APC 5112 *Level 2 Musculoskeletal Procedures*. This was not an item addressed in the proposed 2018 HOPPS. In 2017, the payment rate for C-APC 5113 was $2,438. Under its new assignment to C-APC 5112, CPT Code 20555 will be paid at $1,350 in 2018, a 45 percent reduction from the 2017 payment amount.

CPT Code 55920 Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application

In the proposed 2018 HOPPS, CMS proposed to retain CPT Code 55920 in C-APC 5341 *Abdominal/Peritoneal/Bilary and Related Procedures*. ASTRO urged CMS to modify the C-APC assignment noting that radiation therapy is an important adjuvant therapy for gynecological malignancies and that the vignette for CPT Code 55920 describes a gynecological implant. The Agency has agreed to move the code to C-APC 5415 *Level 5 Gynecologic Procedures*. CMS considered the geometric mean cost of CPT Code 55290, which is $4,791. This geometric mean cost is similar to the geometric mean cost of C-APC 5415 $4,109, compared to the geometric mean cost for C-APC 5341 which is $2,909.

The decision to move CPT Code 55920 from C-APC 5341 to C-APC 5415 increases the payment rate by 44 percent from $2,862 in 2017 to $4,112 in 2018.

C-APC 5092 Level 2 Breast/Lymphatic Surgery and Related Procedures

CMS is finalizing its decision to retain CPT Code 19298 *Placement of radiotherapy afterloading brachytherapy catheters into breast for interstitial; radioelement application* in C-APC 5092 *Level 2 Breast/Lymphatic Surgery and Related Procedures*. ASTRO argued that payment in this C-APC is inadequate because it does not recognize the costs associated with the placement of the breast brachytherapy catheter or brachytherapy treatment delivery and related planning and preparation codes. However, the Agency decided to retain CPT Code 19298 in C-APC 5092 because the geometric mean cost of $5,944 is similar to the geometric mean cost of C-APC 5092 of $4,809 rather than the geometric mean cost of C-APC 5093, which has a geometric mean cost of $7,383.

C-APC 5092 will experience a 9 percent increase in payment for 2018. The 2017 payment rate was set at $4,419. The 2018 rate is set at $4,812.

Ambulatory Payment Classifications (APCs)

APC 5625 Level 5 Radiation Therapy - Proton Therapy
In the 2018 HOPPS proposed rule, CMS proposes to decrease the reimbursement rate for APC 5625 by 5 percent. In the final rule that decision was reversed. The Agency has approved a 6 percent increase in payment from $994 in 2017 to $1,053 in 2018. This is welcome news given that APC 5625 took a 14 percent cut between 2016 and 2017.

APC 5624 Level 4 Radiation Therapy – HDR Brachytherapy
CMS has finalized a 3 percent decrease in payment for APC 5624 Level 4 Radiation Therapy. The following chart depicts the HDR codes impacted by this reduction:

HCPCS Code	Short Descriptor	2017 Payment Rate	2018 Payment Rate
77605	Hyperthermia, external, deep	$739	$714
77763	Apply intracavitary radiation, complex	$739	$714
77770	HDR Intracavitary Brachytherapy, Simple	$739	$714
77771	HDR Intracavitary Brachytherapy, Intermediate	$739	$714
77772	HDR Intracavitary Brachytherapy, Complex	$739	$714
77778	Interstitial radiation source application, complex	$739	$714
0395T	HDR Electronic Brachytherapy, Interstitial or Intracavitary	$739	$714

Enforcement of Supervision of Outpatient Therapeutic Services in Critical Access Hospitals (CAHs) and Rural Hospitals

In the 2009 HOPPS final rule, CMS finalized supervision requirements in hospital outpatient settings. Specifically, the Agency requires the direct supervision of hospital outpatient therapeutic services covered by Medicare that are furnished in hospitals, as well as in provider-based departments (PBDs) of hospitals. In 2010, CMS confirmed that this standard also applied to Critical Access Hospitals (CAHs). That same year, in response to concerns expressed by CAHs and small rural hospitals regarding their ability to meet the requirement, CMS issued a notice of nonenforcement to Medicare administrative contractors. This nonenforcement policy was amended to include rural hospitals with fewer than 100 beds and was extended through 2013. Separate Congressional legislative action extended nonenforcement through December 2016.

Stakeholders have petitioned CMS to continue the nonenforcement policy, and CMS noted that radiation oncology is a critical specialty service where it is particularly difficult to furnish direct supervision. In the 2018 HOPPS final rule, CMS reinstated the nonenforcement of direct supervision enforcement instruction for outpatient therapeutic services for CAHs and small rural

hospitals with 100 or fewer beds for 2018 and 2019. The agency said this will allow CAHs and small rural hospitals more time to comply with the supervision requirements for outpatient therapeutic services and give all parties time to submit specific services to be evaluated by the Advisory Panel on Hospital Outpatient Payment for recommended change in supervision level.

Additional information about the 2018 HOPPS final rule can be found at the following links:

A display copy of the final rule can be found at:
https://www.federalregister.gov/documents/2017/11/13/2017-23932/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

The Addenda relating to the HOPPS final rule are available at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

A fact sheet on this final rule is available at:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-01.html