

2018 Hospital Outpatient Prospective Payment System Proposed Rule Summary

On July 13, 2017, the Centers for Medicare & Medicaid Services (CMS) released the 2018 Hospital Outpatient Prospective Payment System (HOPPS) [proposed rule](#). Comments on the proposed rule are due September 11, 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 OPSS 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 proposes increasing the payment rates under the OPSS by an Outpatient Department (OPD) fee schedule increase factor of 1.75 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 0.4 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 2018 will be approximately \$70 billion, an increase of \$5.7 billion compared to 2017 HOPPS payments.

Comprehensive Ambulatory Payment Classifications (APCs)

CMS is not proposing to 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 (SRS and IORT)

In the 2018 HOPPS proposed rule, CMS proposes to continue the policy for the payment of Stereotactic Radiosurgery (SRS) treatment as described in the 2016 HOPPS final rule. This policy removes claims reporting for the 10 planning and preparation services for SRS treatment

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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.

In the 2017 HOPPS final rule, CMS finalized the requirement that providers append a “CT” modifier to claims for cranial single session SRS patients. Based on preliminary data collected with modifier “CP”, CMS had identified additional services that are adjunctive to the primary “J1” SRS treatment service and reported on a different claim outside of the 10 SRS planning and preparation codes that were removed from SRS C-APC cost calculations. The analysis also demonstrates that the modifier was not always appended correctly. The “CP” modifier is set to expire at the end of 2017.

For 2018, CMS is proposing to continue to make separate payments for the 10 planning and preparation services adjunctive to the delivery of SRS treatment. The Agency believes this will allow for additional claims data analysis that will determine if repackaging all adjunctive services (planning, preparation, and imaging, among others) back into cranial single session SRS is appropriate in future rule making.

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

The proposed payment rate is set at \$7,335 for 2018, compared to the 2017 payment rate of \$7,456. This is a 1.6 percent decline in payment. Since the 2016 policy was implemented, the APC has experienced a 25 percent overall reduction in payment.

C-APCs 5113, 5165, 5165, 5302, 5341 and 5414 - Brachytherapy Insertion

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 announces 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 proposes to address the issue by establishing a code edit that requires a brachytherapy treatment code when a brachytherapy insertion code is billed, which should lead to more correctly coded claims

The brachytherapy insertion codes that will be required to be billed with a brachytherapy treatment code are listed below:

Proposed Brachytherapy Insertion Procedures Assigned to Status Indicator “J1”

HCPCS CODE	Long Descriptor
19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
19298	Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, including image guidance
19499	Unlisted procedure, breast
20555	Placement of needles or catheters into the muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)
31643	Bronchoscopy, rigid, or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application
41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube catheter
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
58346	Insertion of Heyman capsules for clinical brachytherapy

Ambulatory Payment Classifications (APC)

Composite APC 8001 LDR Prostate Brachytherapy

In the 2018 HOPPS proposed rule, CMS proposes to delete Composite APC 8001. The Agency proposes to assign a “J1” status indicator to CPT Code 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy*. Payment for this procedure will be made through the C-APC payment methodology similar to the payment methodology for other brachytherapy insertion procedures. CMS proposes to assign CPT Code 55875 to C-APC 5375 Level 5 *Urology and Related Services*. As described previously, the code edit for claims with brachytherapy services will require the brachytherapy treatment code, CPT Code 77778 *Interstitial radiation source application; complex*, to be included on the claim with CPT Code 55875.

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The deletion of Composite APC 8001 and the transition of CPT Code 55875 to APC 5375 results in a 42 percent increase in payment. In 2017, the payment rate was set at \$2,543. The proposed rate for 2018 is \$3,598.

CPT Code 55X87 Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed

In 2016, the CPT Editorial Panel deleted CPT Category III code 0438T and created new CPT Code 55X87 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed*. In the proposed 2018 HOPPS, CMS proposes to assign the new code to APC 5375 Level 5 *Urology and Related Services* which is proposed to be reimbursed at \$3,598 for 2018.

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. This reduction comes one year after the APC suffered a 14 percent payment rate reduction due to lower charges than anticipated for CPT code 77522 *Proton Treatment, simple with compensation*.

APC 5624 Level 4 Radiation Therapy – HDR Brachytherapy

CMS is proposing a 6 percent decrease in payment for APC 5624 Level 4 Radiation Therapy. The following chart depicts the HDR codes impacted by this proposed change:

HCPCS Code	Short Descriptor	2017 Payment Rate	2018 Proposed Payment Rate
77605	Hyperthermia, external, deep	\$739	\$694
77763	Apply intracavitary radation, complex	\$739	\$694
77770	HDR Intracavitary Brachytherapy, Simple	\$739	\$694
77771	HDR Intracavitary Brachytherapy, Intermediate	\$739	\$694
77772	HDR Intracavitary Brachytherapy, Complex	\$739	\$694
77778	Interstitial radiation source application, complex	\$739	\$694
0395T	HDR Electronic Brachytherapy, Interstitial or Intracavitary	\$739	\$694

Brachytherapy Sources

The 2018 HOPPS proposed rule uses payment rates based on costs derived from 2016 claims data. CMS is proposing to base the payment rates for brachytherapy sources on the geometric mean unit costs for each source, consistent with the methodology that they are proposing for other items and services paid under the OPSS.

Stranded/Non-Stranded

CMS is proposing to pay for the stranded and nonstranded not otherwise specified (NOS) codes, HCPCS codes C2698 and C2699, at a rate equal to the lowest stranded or nonstranded prospective payment rate for such sources, respectively, on a per source basis, which is based on

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the policy the Agency established in 2008.

No Claims Data

For CY 2018 and subsequent years, CMS is proposing to continue the policy they 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

CMS is proposing to assign status indicator “E2” (Items and Services for Which Pricing Information and Claims Data Are Not Available) to HCPCS code C2645. This code was not reported on CY 2016 claims. Therefore, the Agency is unable to calculate a proposed payment rate based on the general OPSS rate-setting methodology described earlier. Although HCPCS code C2645 became effective January 1, 2016, and CMS expects that if a hospital furnished a brachytherapy source described by this code in CY 2016, HCPCS code C2645 should appear on the CY 2016 claims, there are no CY 2016 claims reporting this code. In addition, unlike new brachytherapy sources HCPCS codes, CMS will not consider external data to determine a proposed payment rate for HCPCS code C2645 for 2018.

C2644 Brachytherapy cesium 131 chloride

CMS is proposing to assign status indicator “U” to HCPCS code C2644. Payment rates for HCPCS code C2644 will be based on this information. In the review of CY 2016 claims, CMS found that one hospital submitted one claim reporting HCPCS code C2644.

CMS assigned status indicator “E2” to HCPCS code C2644 (Brachytherapy cesium-131 chloride) because this code was not reported on any CY 2015 claims (that is, there were no Medicare claims submitted by any hospitals in 2015 that reported this HCPCS code).

New Brachytherapy Source Codes

CMS continues to invite hospitals and other parties to submit recommendations for new codes to describe new brachytherapy sources.

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

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- Code fragmentation

Based on 2016 claims data available for the 2018 proposed rule, CMS is proposing exceptions to 12 APCs found to violate the two-times rule, including APC 5611 Level 1 Therapeutic Radiation Treatment Preparation. CMS states that the proposed APCs on the exemption list meet one or more of the exemption criteria listed.

Bypass List for 2018

Each year CMS issues a list of bypass codes. The proposed list of bypass codes contains codes that were reported on claims for services in 2016, but were deleted for 2017. The codes are included on the bypass list because they were covered outpatient provider department services in that period and 2016 claims data are used to calculate 2018 payment rates. For 2018, CMS proposes to remove CPT Codes 77305 through 77315 *Teletherapy isodose plan; simple through complex* from the bypass list.

Packaging of Items and Services Under the HOPPS

The prospective payment system relies on the concept of packaging multiple interrelated services into a single payment. This involves averaging, where the payment may be more or less than the estimated costs of providing a service or package of services for a particular patient, but with the exception of outlier cases, the concept is designed to provide access to appropriate care. Decisions about packaging and bundling payment involve a balance between ensuring separate payment for individual services or items, while also establishing incentives to drive efficiencies through larger bundles of payment.

In the 2018 HOPPS proposed rule, CMS states that it continues to monitor the impact packaging policies, as the HOPPS continues to move towards prospectively-determined, encounter-based payments and away from separate fee-for-service payments. The Agency acknowledges that it frequently hears from stakeholders regarding concerns about how these policies are impacting patient access or are resulting in other negative consequences. However, CMS has not observed significant fluctuations in data that indicate an adverse effect from implementing the packaging policies. The Agency is seeking comments particularly with regard to clinical scenarios involving currently packaged HCPCS codes for which stakeholders believe packaged payment is not appropriate under the HOPPS.

Expansion of Excepted Off-Campus Provider Based Department Services

For CY 2018, CMS is proposing to revise the PFS Relativity Adjuster for nonexcepted items and services furnished by nonexcepted off-campus PBDs to be 25 percent of the OPSS payment rate. More information about the PFS Relativity Adjuster for 2018 can be found in ASTRO's 2018 MPFS proposed rule summary.

In the 2017 HOPPS final rule, CMS did not finalize its proposal to limit service line expansion for excepted off-campus provider based departments (PBDs). Excepted off-campus PBDs are those departments that billed for items and services under HOPPS prior to November 2, 2015. In

the 2018 HOPPS proposed rule, the Agency seeks to continue this policy for another year as it continues to monitor claims data for changes in billing patterns and utilization.

Enforcement Instruction for Supervision of Outpatient Therapeutic Services in Critical Access Hospitals (CAHs) and Certain Small 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 non-enforcement 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 proposed rule, CMS seeks to reinstate 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.

Cancer Hospitals

CMS is proposing to continue to provide additional payments to cancer hospitals so that the cancer hospital's payment-to-cost ratio (PCR) after the additional payments equals the weighted average PCR for the other OPSS hospitals using the most recently submitted or settled cost report data. However, beginning CY 2018, section 16002(b) of the 21st Century Cures Act requires this weighted average PCR be reduced by 1.0 percentage point. Based on the data and the required 1.0 percentage point reduction, a proposed target PCR of 0.89 would be used to determine the CY 2018 cancer hospital payment adjustment to be paid at cost report settlement. That is, the proposed payment adjustments would be the additional payments needed to result in a PCR equal to 0.89 for each cancer hospital.

Ambulatory Surgical Center (ASC) Payment Reform

Ambulatory Surgical Center (ASC) payment rates are tied to data derived from the OPSS. Similar to efforts to address payment differentials between the Medicare Physician Fee Schedule and HOPPS, CMS is also concerned about the difference between HOPPS payments and ASC payments. Average ASC payment rates have declined relative to HOPPS payment rates over the past 10 years, from 65 percent of average HOPPS rates in 2008 to 56 percent of average HOPPS rates in 2018. CMS is soliciting comments on ways to improve payment accuracy to ASCs, as well as on the collection of ASC cost data.

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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/public-inspection/current>

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-1678-P.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>

A fact sheet on this proposed rule is available at:
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13.html>