2018 Coding & Documentation Updates
Part I & II

2018 Radiation Oncology Conference for Therapists & Dosimetrists
September 9, 2016
Presenter

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Consulting Manager
Questions

- If you are a Revenue Cycle Inc. Client Resource Center member, please ask your question via your Q & A Forum.
- If you are not a Client Resource Center member, email us at info@revenuecycleinc.com and one of our experienced consulting associates will promptly respond.
Disclaimer

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Presentation Objectives

- Basic Review of Reimbursement Settings
- Discuss the HOPPS Proposed Rule Items
- Review HOPPS Reimbursement Impact for 2019
- Discuss the MPFS Proposed Rule Items
- Review MPFS Reimbursement Impact for 2019
HOPPS & MPFS Payment Systems

**HOPPS**
- Hospitals and ASCs
- 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**
- Physicians and Office Settings
- 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
Billing Scenarios

Hospital Outpatient
- Technical Services
  - UB04
- Physician Services (-26)
  - CMS 1500

Freestanding Facility
- Global Billing
  - Pro & Tech Services
    - CMS 1500
  - Physician Services (-26)
    - CMS 1500
  - Technical Services (TC)
    - CMS 1500

Split Billing
Federal Register

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

Hospital Outpatient Prospective Payment System (HOPPS)

Medicare Physician Fee Schedule (MPFS)
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
HOPPS Proposed Rule CY 2019

Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model

HOPPS Payment Rates

- Proposed 1.25% increase to Outpatient Department (OPD) fee schedule
  - Based on 2.8% increase for inpatient services paid under inpatient prospective payment system (IPPS), multifactor productivity (MFP) adjustment -0.8% & Affordable Care Act adjustment of -0.75%
- Payments in CY 2019 are expected to be ~$74.6 billion, increase of ~$4.9 billion from CY 2018 OPPS payments
- Conversion Factor (CF) to increase from CY 2018 to equal $79.546
- Proposed 2.0% reduction for hospitals failing to meet outpatient quality reporting requirements (CF = $77.955)
Wage Index

- In a hospital setting the wage index is used to identify per the geographic location, urban or rural, the factor used to calculate reimbursement for each code
- **CMS proposing** to continue apply the 1.000 frontier state wage index
- To not extend the imputed floor for all urban-states (currently 3, DE, NJ and RI)
- To add new urban CBSA Twin Falls, Idaho (CBSA 46300) – rural designation in CY 2018
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2D - 10 fxs</td>
<td>$4,303.49</td>
<td>$4,398.40</td>
<td>$94.91</td>
<td>2.21%</td>
</tr>
<tr>
<td>3D - w/ imaging (33 fxs)</td>
<td>$12,698.12</td>
<td>$12,991.08</td>
<td>$292.96</td>
<td>2.31%</td>
</tr>
<tr>
<td>3D - w/out imaging (33 fxs)</td>
<td>$12,698.12</td>
<td>$12,991.08</td>
<td>$292.96</td>
<td>2.31%</td>
</tr>
<tr>
<td>IMRT - Simple 44 fxs</td>
<td>$27,456.10</td>
<td>$27,858.45</td>
<td>$402.35</td>
<td>1.47%</td>
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<tr>
<td>IMRT - Complex 30 fxs</td>
<td>$19,391.66</td>
<td>$19,678.35</td>
<td>$286.69</td>
<td>1.48%</td>
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<tr>
<td>SRS- Linac</td>
<td>$9,567.24</td>
<td>$9,950.01</td>
<td>$382.77</td>
<td>4.00%</td>
</tr>
<tr>
<td>SRS- Cobalt (Same Day)</td>
<td>$9,244.15</td>
<td>$9,622.83</td>
<td>$378.68</td>
<td>4.10%</td>
</tr>
<tr>
<td>SRS- Cobalt Frameless</td>
<td>$9,567.24</td>
<td>$9,950.01</td>
<td>$382.77</td>
<td>4.00%</td>
</tr>
<tr>
<td>SBRT Linac 3 Fractions</td>
<td>$12,881.80</td>
<td>$13,051.16</td>
<td>$169.36</td>
<td>1.31%</td>
</tr>
<tr>
<td>SBRT Linac 5 Fractions</td>
<td>$16,236.24</td>
<td>$16,456.62</td>
<td>$220.38</td>
<td>1.36%</td>
</tr>
<tr>
<td>SBRT – Lung</td>
<td>$15,590.06</td>
<td>$15,802.26</td>
<td>$212.20</td>
<td>1.36%</td>
</tr>
<tr>
<td>SBRT - Cobalt 5 Fractions</td>
<td>$13,651.52</td>
<td>$13,839.18</td>
<td>$187.66</td>
<td>1.37%</td>
</tr>
<tr>
<td>Proton - 25 Fractions</td>
<td>$29,361.22</td>
<td>$30,088.23</td>
<td>$727.01</td>
<td>2.48%</td>
</tr>
<tr>
<td>Prostate – HDR</td>
<td>$9,226.42</td>
<td>$9,358.03</td>
<td>$131.61</td>
<td>1.43%</td>
</tr>
<tr>
<td>Prostate – LDR</td>
<td>$9,112.63</td>
<td>$9,314.49</td>
<td>$201.86</td>
<td>2.22%</td>
</tr>
<tr>
<td>GYN - T&amp;O – HDR</td>
<td>$13,472.80</td>
<td>$13,926.79</td>
<td>$453.99</td>
<td>3.37%</td>
</tr>
<tr>
<td>GYN - Cylinder Single Channel HDR</td>
<td>$5,740.08</td>
<td>$5,760.40</td>
<td>$20.32</td>
<td>0.35%</td>
</tr>
<tr>
<td>GYN - Cylinder Multi Channel HDR</td>
<td>$5,740.08</td>
<td>$5,760.40</td>
<td>$20.32</td>
<td>0.35%</td>
</tr>
<tr>
<td>APBI Single Channel - HDR</td>
<td>$10,969.63</td>
<td>$10,977.07</td>
<td>$7.44</td>
<td>0.07%</td>
</tr>
<tr>
<td>APBI Multi Channel - HDR</td>
<td>$10,969.63</td>
<td>$10,977.07</td>
<td>$7.44</td>
<td>0.07%</td>
</tr>
<tr>
<td>Skin Single Channel - HDR</td>
<td>$6,927.78</td>
<td>$6,971.97</td>
<td>$44.19</td>
<td>0.64%</td>
</tr>
</tbody>
</table>
Additional Payment Adjustments

- Rural adjustment of 7.1% to the OPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs)
  - Excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy
- Ambulatory Surgical Center (ASC) payment to increase by 1.3% that meet quality reporting under ASCQR program
- Cancer Hospital Payment Adjustment
  - Target PCR of 0.88 would be used to determine the CY 2019 cancer hospital payment adjustment to be paid at cost report settlement
<table>
<thead>
<tr>
<th>Provider Number</th>
<th>Hospital Name</th>
<th>Estimated Percentage Increase in OPPS Payments for CY 2019 due to Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>050146</td>
<td>City of Hope Comprehensive Cancer Center</td>
<td>37.1%</td>
</tr>
<tr>
<td>050660</td>
<td>USC Norris Cancer Hospital</td>
<td>13.4%</td>
</tr>
<tr>
<td>100079</td>
<td>Sylvester Comprehensive Cancer Center</td>
<td>21.0%</td>
</tr>
<tr>
<td>100271</td>
<td>H. Lee Moffitt Cancer Center &amp; Research Institute</td>
<td>22.3%</td>
</tr>
<tr>
<td>220162</td>
<td>Dana-Farber Cancer Institute</td>
<td>43.7%</td>
</tr>
<tr>
<td>330154</td>
<td>Memorial Sloan-Kettering Cancer Center</td>
<td>46.9%</td>
</tr>
<tr>
<td>330354</td>
<td>Roswell Park Cancer Institute</td>
<td>16.2%</td>
</tr>
<tr>
<td>360242</td>
<td>James Cancer Hospital &amp; Solove Research Institute</td>
<td>22.6%</td>
</tr>
<tr>
<td>390196</td>
<td>Fox Chase Cancer Center</td>
<td>8.4%</td>
</tr>
<tr>
<td>450076</td>
<td>M.D. Anderson Cancer Center</td>
<td>53.6%</td>
</tr>
<tr>
<td>500138</td>
<td>Seattle Cancer Care Alliance</td>
<td>54.3%</td>
</tr>
</tbody>
</table>
Outlier Payments

- Established by CMS to help mitigate the financial risk associated with some high cost procedures and services
- Services which meet specific criteria set up by CMS, an additional payment is made to the hospital to assist in off-setting the cost and potential loss of revenue due to the ambulatory payment classification (APC) established rate.
- CY 2019
  - Threshold at 1.75 times APC payment and exceeds $4,600 APC payment
  - 50% of the 1.75 times APC adjustment made
Standardizing APC Payment Weights

- APCs group services which are considered clinically comparable to each other with respect to the resources utilized and the associated cost.
- Ancillary services or items which are necessary components of the primary service are packaged into the APC rates and not separately reimbursed.
- Code G0463, clinic visit, was used as standardization for weighting APCs, assigned a weight of 1.00 again for CY 2019.
Comprehensive APCs (C-APCs)

- C-APC’s package payments for ancillary and secondary items, services and procedures into the most costly primary procedure under HOPPS at the claim level
- Three new C-APCs proposed for CY 2019, not related to oncology
- No changes proposed for C-APC SRS Treatment Course, 10 separately paid ancillary codes appear to continue for CY 2019
APC 2 Times Rule Exceptions

- CMS identified 16 APCs in which the 2 times rule violation was found – one specific to radiation oncology
- APC 5612 (Level 2 Therapeutic Radiation Treatment Preparation) and includes HCPCS codes 77285, 77290, 77306, 77307, 77316, 77317, 77318, 77321, 77334 or 77338
- CMS proposing to make exceptions for all 16 APCs in violation of the 2 times rule for CY 2019
Brachytherapy Sources

- CMS used costs derived from CY 2017 claims data to set the proposed CY 2019 payment rates
  - Base the payment rates for brachytherapy sources on the geometric mean unit costs for each source
- Brachytherapy sources, unless otherwise noted, are assigned status indicator (SI) “U”
  - Codes with SI “U” are not packaged into C-APCs
- Sources with no claims data assigned SI “E2” (Items and Services for Which Pricing Information and Claims Data Are Not Available) – proposing C2644, no claims data from CY 2017
- **CMS proposing** HCPCS C2645 assigned “U” for CY 2019
New Brachytherapy Sources

- Recommendations for new brachytherapy sources can be submitted to:
  Division of Outpatient Care
  Mail Stop C4-01-26
  Centers for Medicare and Medicaid Services
  7500 Security Boulevard
  Baltimore, MD 21244

- CMS will continue to update quarterly any new source codes and descriptors
Therapeutic Radiopharmaceuticals

- New drugs, biologicals and radiopharmaceuticals are granted pass-through status by Medicare
  - Establishes transitional payment until enough data is acquired to determine if the new agent is to be paid separately or packaged into an APC
- Therapeutic radiopharmaceuticals with nonpass-through status paid at average sales priced (ASP) +6%
  - If no ASP data, then use mean unit costs data from CY 2017 claims for payment rates
- Therapeutic radiopharmaceuticals with pass-through status paid at average sales priced (ASP) +6%
  - If no ASP data, then WAC+3% proposed
New Category III Code

- Category III code effective July 1, 2018, code C9031 (Lutetium Lu 177, dotatate, therapeutic, 1 mCi).
- Used for the treatment of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors in adults.
  - Recommended treatment course is to give 200 mCi by IV infusion over 30 minutes every 8 weeks for a total of 4 doses.
- **CMS proposes** assignment of SI “G” (Pass-Through Drugs and Biologicals), APC 9067 national average payment of $251.75
- **CMS seeking comments** regarding this and the other Category III codes which were included in the proposed assignments for CY 2019
Application for Device Pass-Through

- Augmenix, Inc. submitted application for the SpaceOAR® System for new device category for transitional pass-through payment status
- 3 major criterion must meet
  - No other category the device included in
  - Device will substantially improve diagnosis or treatment of illness, etc.
  - Cost of device is not insignificant
- CMS believes it meets criterion 1 & 3, concerns about criterion 2
- **CMS seeking comments** about granting pass-through status
Site Neutral Payments Clinic Visit

- Neutralizing payments began CY 2008 – IGRT packaging was one of seven categories, ring a bell?
  - Continued with C-APCs in CY 2015
- HOPPS is the fastest growth sector of Medicare payments out of all of the payment systems under Part A and B
  - Growth approximately 8% a year! Approximately twice the estimated spending of a decade ago in CY 2008
- Code G0463 most widely reported code under HOPPS
  - Concerns about “unnecessary increases in the volume of covered outpatient department services”
Clinic Visit in Excepted PBDs

• **CMS proposing** to pay code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) in an excepted off-campus PBD at 40% of the HOPPS rate
  - Same payment rate for nonexcepted off-campus PBDs
  - Both entities still report modifiers on codes
    • Excepted = PO
    • Nonexcepted = PN
• HOPPS proposed rate CY 2019 = $115.76, 40% of rate would =$46.30
Expansion of Clinical Families

- Concerns about services in excepted off-campus PBDs – incentivizing hospitals to transition new services and acquired practices or nonexcepted non-campus PBDs services due to reimbursement

- **CMS proposing** CY 2019 & subsequent years
  - Services performed from 11/1/14 – 11/1/15 are covered and paid as excepted
    - Depts. open after 11/1/14 but before 11/2/15 will start year on first billed date, same as mid-construction sites
  - Any new services in 19 clinical families added after baseline year, paid under MPFS at 40% of HOPPS rate

- **CMS seeking comments** on proposed families
<table>
<thead>
<tr>
<th>Clinical Families</th>
<th>APCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway Endoscopy</td>
<td>5151–5155</td>
</tr>
<tr>
<td>Blood Product Exchange</td>
<td>5241–5244</td>
</tr>
<tr>
<td>Cardiac/Pulmonary Rehabilitation</td>
<td>5771; 5791</td>
</tr>
<tr>
<td>Diagnostic/Screening Test and Related Procedures</td>
<td>5721–5724; 5731–5735; 5741–5743</td>
</tr>
<tr>
<td>Drug Administration and Clinical Oncology</td>
<td>5691–5694</td>
</tr>
<tr>
<td>Ear, Nose, Throat (ENT)</td>
<td>5161–5166</td>
</tr>
<tr>
<td>General Surgery and Related Procedures</td>
<td>5051–5055; 5061; 5071–5073; 5091–5094; 5361–5362</td>
</tr>
<tr>
<td>Gastrointestinal (GI)</td>
<td>5301–5303; 5311–5313; 5331; 5341</td>
</tr>
<tr>
<td>Gynecology</td>
<td>5411–5416</td>
</tr>
<tr>
<td>Major Imaging</td>
<td>5523–5525; 5571–5573; 5593–5594</td>
</tr>
<tr>
<td>Minor Imaging</td>
<td>5521–5522; 5591–5592</td>
</tr>
<tr>
<td>Musculoskeletal Surgery</td>
<td>5111–5116; 5101–5102</td>
</tr>
<tr>
<td>Nervous System Procedures</td>
<td>5431–5432; 5441–5443; 5461–5464; 5471</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>5481, 5491–5495; 5501–5504</td>
</tr>
<tr>
<td>Pathology</td>
<td>5671–5674</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>5611–5613; 5621–5627; 5661</td>
</tr>
<tr>
<td>Urology</td>
<td>5371–5377</td>
</tr>
<tr>
<td>Vascular/Endovascular/Cardiovascular</td>
<td>5181–5184; 5191–5194; 5200; 5211–5213; 5221–5224; 5231–5232</td>
</tr>
<tr>
<td>Visits and Related Services</td>
<td>5012; 5021–5025; 5031–5035; 5041; 5045; 5821–5823</td>
</tr>
</tbody>
</table>
Submitting Comments

- Comments to CMS regarding the MPFS proposed rule must refer to file code **CMS-1695-P**
- Received no later than 5 pm EST September 24, 2018.
- Electronic submission is encouraged by CMS, [http://www.regulations.gov](http://www.regulations.gov)
- Follow the instructions under the “submit a comment” tab
MPFS Proposed Rule CY 2019

Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; etc.

Conversion Factor Update

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) put into law April 16, 2015
  - CF to increase 0.5% each year through 2019…BUT
    • Bipartisan Budget Act of 2018 changed to 0.25%!
  - CF 0% increase 2020 – 2025, additional payments based on Quality Payment Program (MIPS)
  - 2026 and beyond payments on participation in APMs
    • 0.75% update for qualifying APMs
    • 0.25% update for non-qualifying APMs
- Proposed Conversion Factor for 2019 = $36.0463
  - Proposed Increase from 2018 ($35.9996)
Calculating Conversion Factor

- Budget neutrality factor to maintain budget within +/- $20 million

### TABLE 92: Calculation of the Proposed CY 2019 PFS Conversion Factor

<table>
<thead>
<tr>
<th>CY 2018 Conversion Factor</th>
<th>35.9996</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Update Factor</td>
<td>0.25 percent (1.0025)</td>
</tr>
<tr>
<td>CY 2019 RVU Budget Neutrality Adjustment</td>
<td>-0.12 percent (0.9988)</td>
</tr>
<tr>
<td>CY 2019 Conversion Factor</td>
<td>36.0463</td>
</tr>
</tbody>
</table>
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
## MPFS Payment Impact Table

### TABLE 94: CY 2019 PFS Estimated Impact on Total Allowed Charges by Specialty

<table>
<thead>
<tr>
<th>(A) Specialty</th>
<th>(B) Allowed Charges (mil)</th>
<th>(C) Impact of Work RVU Changes</th>
<th>(D) Impact of PE RVU Changes</th>
<th>(E) Impact of MP RVU Changes</th>
<th>(F) Combined Impact**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncology and Radiation Therapy Centers</td>
<td>$1,750</td>
<td>0%</td>
<td>-2%</td>
<td>0%</td>
<td>-2%</td>
</tr>
</tbody>
</table>

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

- CY 2016 review MP RVUs yearly to better represent mix of specialties billing codes
- CY 2018 CMS did not finalize changes to updated MP values prior to the 5-year update
- **CMS Seeking Comments**
  - Related to next update required by CY 2020
  - Improvements on crosswalking specialties in state-level raw rate filings to categorize specialty codes to develop risk factors and MP RVUs
Direct Practice Expense

- Practice expense (PE) accounts for the resources provided by the physician and practitioner such as office rent and personnel wages, but exclude expense for malpractice
  - Direct = clinical labor, medical supplies and medical equipment
  - Indirect = administrative labor, office expenses and all other expenses
- Proposed adjustments to nearly every radiation oncology CPT® code
- Proposed changes to G-codes which by law cannot change
  - Must use the 2016 values until 12/31/19
<table>
<thead>
<tr>
<th>HCPCS</th>
<th>SERVICE DESCRIPTION</th>
<th>2018 Final RVU Totals</th>
<th>2019 Proposed RVU Totals</th>
<th>Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>77014</td>
<td>Ct scan for therapy guide</td>
<td>3.4</td>
<td>3.38</td>
<td>(0.02)</td>
</tr>
<tr>
<td>77263</td>
<td>Radiation therapy planning</td>
<td>4.74</td>
<td>4.71</td>
<td>(0.03)</td>
</tr>
<tr>
<td>77290</td>
<td>Set radiation therapy field</td>
<td>14.96</td>
<td>14.35</td>
<td>(0.61)</td>
</tr>
<tr>
<td>77295</td>
<td>3-d radiotherapy plan</td>
<td>14.14</td>
<td>13.77</td>
<td>(0.37)</td>
</tr>
<tr>
<td>77300</td>
<td>Radiation therapy dose plan</td>
<td>1.91</td>
<td>1.86</td>
<td>(0.05)</td>
</tr>
<tr>
<td>77301</td>
<td>Radiotherapy dose plan imrt</td>
<td>56.48</td>
<td>54.29</td>
<td>(2.19)</td>
</tr>
<tr>
<td>77307</td>
<td>Teiletx isodose plan cplx</td>
<td>8.31</td>
<td>8.13</td>
<td>(0.18)</td>
</tr>
<tr>
<td>77316</td>
<td>Brachytx isodose plan simple</td>
<td>5.43</td>
<td>5.70</td>
<td>0.27</td>
</tr>
<tr>
<td>77318</td>
<td>Brachytx isodose complex</td>
<td>10.23</td>
<td>10.77</td>
<td>0.54</td>
</tr>
<tr>
<td>77334</td>
<td>Radiation treatment aid(s)</td>
<td>3.69</td>
<td>3.61</td>
<td>(0.08)</td>
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<tr>
<td>77336</td>
<td>Radiation physics consult</td>
<td>2.3</td>
<td>2.24</td>
<td>(0.06)</td>
</tr>
<tr>
<td>77338</td>
<td>Design mlc device for imrt</td>
<td>14.65</td>
<td>13.90</td>
<td>(0.75)</td>
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<tr>
<td>77370</td>
<td>Radiation physics consult</td>
<td>3.54</td>
<td>3.49</td>
<td>(0.05)</td>
</tr>
<tr>
<td>77372</td>
<td>Srs linear based</td>
<td>31.07</td>
<td>30.10</td>
<td>(0.97)</td>
</tr>
<tr>
<td>77373</td>
<td>Sbtr delivery</td>
<td>39.52</td>
<td>32.25</td>
<td>(7.27)</td>
</tr>
<tr>
<td>77427</td>
<td>Radiation tx management x5</td>
<td>5.31</td>
<td>5.28</td>
<td>(0.03)</td>
</tr>
<tr>
<td>77432</td>
<td>Stereotactic radiation trmt</td>
<td>11.95</td>
<td>11.90</td>
<td>(0.05)</td>
</tr>
<tr>
<td>77435</td>
<td>Sbtr management</td>
<td>18.02</td>
<td>17.95</td>
<td>(0.07)</td>
</tr>
<tr>
<td>77470</td>
<td>Special radiation treatment</td>
<td>3.89</td>
<td>3.69</td>
<td>(0.20)</td>
</tr>
<tr>
<td>77770</td>
<td>Hdr rdncl ntrsl/icav brchtx</td>
<td>9.29</td>
<td>9.21</td>
<td>(0.08)</td>
</tr>
<tr>
<td>77771</td>
<td>Hdr rdncl ntrsl/icav brchtx</td>
<td>17.27</td>
<td>16.73</td>
<td>(0.54)</td>
</tr>
<tr>
<td>77778</td>
<td>Apply interstit radiat compl</td>
<td>23.62</td>
<td>23.81</td>
<td>0.19</td>
</tr>
<tr>
<td>G6002</td>
<td>Stereoscopic x-ray guidance</td>
<td>2.18</td>
<td>2.13</td>
<td>(0.05)</td>
</tr>
<tr>
<td>G6012</td>
<td>Radiation treatment delivery</td>
<td>7.63</td>
<td>7.38</td>
<td>(0.25)</td>
</tr>
<tr>
<td>G6013</td>
<td>Radiation treatment delivery</td>
<td>7.63</td>
<td>7.39</td>
<td>(0.24)</td>
</tr>
<tr>
<td>G6015</td>
<td>Radiation tx delivery imrt</td>
<td>9.96</td>
<td>9.99</td>
<td>0.03</td>
</tr>
<tr>
<td>G6016</td>
<td>Delivery comp imrt</td>
<td>9.93</td>
<td>9.97</td>
<td>0.04</td>
</tr>
</tbody>
</table>
### CY 2019 Proposed Rule MPFS Global Non-Facility Course Compare

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2D 10 fxs</td>
<td>$5,179.26</td>
<td>$5,010.44</td>
<td>-$168.83</td>
<td>-3%</td>
</tr>
<tr>
<td>3D w/IGRT 33 fxs</td>
<td>$17,165.33</td>
<td>$16,743.51</td>
<td>-$421.82</td>
<td>-2%</td>
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<tr>
<td>3D - w/out IGRT 33 fxs</td>
<td>$11,046.48</td>
<td>$10,712.24</td>
<td>-$334.24</td>
<td>-3%</td>
</tr>
<tr>
<td>IMRT 44 fxs</td>
<td>$25,348.04</td>
<td>$25,157.07</td>
<td>-$190.97</td>
<td>-1%</td>
</tr>
<tr>
<td>IMRT 30 fxs</td>
<td>$19,866.38</td>
<td>$19,710.84</td>
<td>-$155.54</td>
<td>-1%</td>
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<tr>
<td>SRS - Linac</td>
<td>$5,699.10</td>
<td>$5,533.47</td>
<td>-$165.63</td>
<td>-3%</td>
</tr>
<tr>
<td>SBRT Linac 5 Fractions</td>
<td>$12,131.87</td>
<td>$10,685.57</td>
<td>-$1,446.30</td>
<td>-12%</td>
</tr>
<tr>
<td>APBI Single Channel HDR</td>
<td>$7,435.00</td>
<td>$7,294.33</td>
<td>-$140.67</td>
<td>-2%</td>
</tr>
<tr>
<td>APBI Multi-Channel HDR</td>
<td>$10,367.16</td>
<td>$10,068.81</td>
<td>-$298.35</td>
<td>-3%</td>
</tr>
<tr>
<td>Prostate - HDR</td>
<td>$5,561.22</td>
<td>$5,350.71</td>
<td>-$210.51</td>
<td>-4%</td>
</tr>
<tr>
<td>Prostate - LDR</td>
<td>$3,219.08</td>
<td>$3,154.05</td>
<td>-$65.03</td>
<td>-2%</td>
</tr>
<tr>
<td>GYN T&amp;O - HDR</td>
<td>$8,230.23</td>
<td>$8,049.50</td>
<td>-$180.73</td>
<td>-2%</td>
</tr>
<tr>
<td>GYN Cylinder Single Channel HDR</td>
<td>$3,616.88</td>
<td>$3,554.53</td>
<td>-$62.35</td>
<td>-2%</td>
</tr>
<tr>
<td>GYN Cylinder Multi-Channel HDR</td>
<td>$4,538.11</td>
<td>$4,431.53</td>
<td>-$106.58</td>
<td>-2%</td>
</tr>
</tbody>
</table>
Values of Code Specific to Rad Onc

- CMS addresses comments regarding CPT\textsuperscript{®} code 77401 (Radiation treatment delivery, superficial and/or ortho voltage, per day)

- **CMS Seeking Comments**
  - Possibility of creating multiple G-codes specific to the services associated with SRT
  - Codes would cover clinical treatment planning, initial simulation, treatment device design, SRT management and medical physics consultation

- Codes would be interim approach until addressed fully by CPT\textsuperscript{®} Editorial Panel and the RUC
Evaluation & Management (E/M)

- E/M visits account for approximately 40% of allowed charges for MPFS services, 20% are office/outpatient E/M visits
  - Considerable financial aspect for CMS
- CY 2018 CMS sought comments and feedback on how to change
- Longstanding stakeholder comments that 1995 & 1997 E/M guidelines are outdated and administratively burdensome
- CMS proposing changes to office/outpatient E/M codes only
  - New patient visit codes (99201-99205)
  - Established patient visit codes (99211-99215)
- **CMS is proposing several changes outlined on next slides**
Lifting Restrictions Multiple Visits

- Currently more than one visit is not billable by same physician or physician specialty group for same patient on same date of service
- Physicians are cross-training creating scenarios where could be supported
- **CMS is seeking comments** eliminating the provision that does not allow for more than one visit by same physician or specialty group on same date of service
Choices in E/M Documentation

- **CMS proposing** physicians and NPPs would have option on how to document E/Ms
  - Use 1995 or 1997 E/M guidelines
  - Medical Decision-Making (MDM) framework
  - Time-based framework
- Reimbursement based on two levels of E/M
  - Level 1 codes 99201 and 99211 each with rate
  - Levels 2-5 all paid same amount
    - Ex. 99202-99205 all paid exact same and 99212-99215 all paid exact same
Current ’95 or ’97 Framework

- Per CMS the scenario of this framework would be:
- Level 1 would be based on outlined ‘95 or ‘97 guidelines
- Practitioners selecting to continue following current framework of 1995 or 1997 guidelines the proposed minimum documentation for levels 2-5 would be:
  - A problem-focused history that does not include a review of systems or a past, family, or social history;
  - A limited examination of the affected body area or organ system; and
  - Straightforward medical decision making measured by minimal problems, data review, and risk (two of these three).
Medical Decision Making Framework

- Practitioners selecting the framework of MDM alone would be required to provide the following minimum documentation:
  - Straightforward medical decision-making measured by minimal problems, data review, and risk (two of these three).
  - CMS is proposing the MDM documentation requirements would follow the current guidelines but are seeking comments on how to change in subsequent years.
Time-based Framework

- Practitioners selecting the framework of time or duration of visit would be required to provide the following minimum documentation:
  - A statement of medical necessity for the visit and document the amount of time personally spent by the billing practitioner face-to-face with the patient.
  - CMS is seeking comments on the typical time expected per the newly proposed payment system for outpatient E/M visits.
- CMS used 38 minutes as the average for a new patient visit and 31 minutes for an established patient visit when setting up the proposed payment values.
Easing Burden of Documentation

• **CMS is proposing** key components of History and Exam for established patients, only the items changed or not changed since last visit would be documented
  – Replaces need to document all items of each component
• Practitioners would still be required to conduct medically necessary inquiries and exams, but repetitive components no need to repeat
• **CMS seeking comments** how to apply similar logic to new patients
## Proposed E/M Reimbursement

### TABLE 19: Preliminary Comparison of Payment Rates for Office Visits New Patients

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>CY 2018 Non-facility Payment Rate</th>
<th>CY 2018 Non-facility Payment Rate under the proposed Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>$45</td>
<td>$44</td>
</tr>
<tr>
<td>99202</td>
<td>$76</td>
<td></td>
</tr>
<tr>
<td>99203</td>
<td>$110</td>
<td>$135</td>
</tr>
<tr>
<td>99204</td>
<td>$167</td>
<td></td>
</tr>
<tr>
<td>99205</td>
<td>$211</td>
<td></td>
</tr>
</tbody>
</table>

Rates in far right column reflect CY 2019 proposed payment rates, not CY 2018

### TABLE 20: Preliminary Comparison of Payment Rates for Office Visits Established Patients

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Current Non-facility Payment Rate</th>
<th>Proposed Non-facility Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>$22</td>
<td>$24</td>
</tr>
<tr>
<td>99212</td>
<td>$45</td>
<td>$93</td>
</tr>
<tr>
<td>99213</td>
<td>$74</td>
<td>$30</td>
</tr>
<tr>
<td>99214</td>
<td>$109</td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>$148</td>
<td></td>
</tr>
</tbody>
</table>
Additional E/M Measures

- Due to significant impact to some specialties CMS is proposing several additional billing measures
  - An E/M multiple procedure payment adjustment to account for duplicative resource costs when E/M visits and procedures with global periods are furnished together;
  - HCPCS G-code add-ons to recognize additional relative resources for primary care visits and inherent visit complexity that require additional work beyond that which is accounted for in the single payment rates for new and established patient levels 2 through level 5 visits;
  - An additional prolonged face-to-face services add-on G code; and
  - A technical modification to the PE methodology to stabilize the allocation of indirect PE for visit services
E/M Multiple Procedure Payment Adjustment

- When an E/M is billed on same date as another service and the -25 modifier is applied, CMS is proposing to reduce the lesser paid code by 50%
  - Similar to current multiple procedure payment reduction (MPPR) policy
- Ex. Billing E/M on same date as 77263
  - Proposed CY 2019 rate for CPT® code 77263 is $169.78 and proposed rate new patient E/M (level 2-5) proposed to be $134.45 in an office setting.
  - The reimbursement for the E/M is the lower of the two codes, rate cut by 50% to ~$67.23 and code 77263 would not be reduced
G-codes for Specialties

- CMS is proposing to create two new G-codes for specialties which bill high volume of E/Ms based-on services and practice patterns, hit hard by proposed changes
  - Primary Care
  - Endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care
  - No code for radiation oncology
High Complexity Add-on Code

- Only applies for Hematology/Oncology, not radiation oncology

- **CMS proposes** - add-on G-code GCG0X (Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit)
Prolonged Services E/M Add-on Code

- **CMS proposing** new prolonged services code
  - GPRO1 (Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; 30 minutes (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)
  - Would be in addition to the current prolonged services codes 99354 & 99355
  - Could be billed by radiation oncologists & medical oncologists could bill this with E/M & specialty add-on code
# Proposed Impact w/out Added Codes

**TABLE 21: Unadjusted Estimated Specialty Impacts of Proposed Single RVU Amounts for Office/Outpatient E/M 2 through 5 Levels**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (mil)</th>
<th>Estimated Potential Impact of Valuing Levels 2-5 Together, Without Additional Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistant</td>
<td>$2,253</td>
<td>Less than 3% estimated increase in overall payment</td>
</tr>
<tr>
<td>Radiation Oncology and Radiation Therapy Centers</td>
<td>$1,776</td>
<td>Minimal change to overall payment</td>
</tr>
<tr>
<td>Radiology</td>
<td>$4,898</td>
<td></td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>$1,813</td>
<td>-7%</td>
</tr>
</tbody>
</table>
# Proposed Impact w/ Added Codes

## TABLE 22: Specialty Specific Impacts Including Payment Accuracy Adjustments

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (mil)</th>
<th>Estimated Potential Impact of Valuing Levels 2-5 Together, With Additional Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistant</td>
<td>$2,253</td>
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<td>Radiation Oncology and Radiation Therapy Centers</td>
<td>$1,776</td>
<td>Less than 3% estimated decrease in overall payment</td>
</tr>
<tr>
<td>Hematology/Oncology*</td>
<td>$1,813</td>
<td></td>
</tr>
</tbody>
</table>

*CMS assumes hematology/oncology utilized the G-code for visit complexity with every E/M office/outpatient visit code.
E/M Teaching Documentation

- **CMS proposing** to eliminate duplicative documentation and proposing changes to how participation of teaching physician is documented
- **Proposing** presence of teaching physician during E/M service may be documented note in medical record made by a physician, resident or nurse
- **CMS proposing** delete requirement the teaching physician document extent of participation in review of direction of services.
  - New paragraph would be added allow for documentation of a note in medical record made by a physician, resident or nurse
Nonexcepted Off-Campus PBDs

- Nonexcepted provider-based departments (PBDs) are outside 250 yards of main building of hospital and started billing services on or after 11/2/15
- CY 2017 paid at 50% of HOPPS rate for services performed
- CY 2018 paid at 40% of HOPPS rate, decrease from CY 2017
- CY 2019 and beyond proposed to be paid at 40% of HOPPS rate – no change from 2018
- Packaging and bundling of services (C-APCs and MPPR) incorporated into PFS Relativity Adjuster
- Outlier payments, the rural sole community hospital (SCH) adjustment and the cancer hospital adjustments not applied – only for hospitals
Billing for Services in PBDs

- Nonexcepted off-campus PBDs radiation TXs billed using G-codes (G6003 – G6016) and IGRT using codes G6001, G6002, G6017 and 77014
  - Reimbursement is full nonfacility MPFS rate per locale
  - G-codes used through December 31, 2019
- Possible APM for reimbursement in 2020
  - ASTRO working on one for Rad Onc
  - All services billed on UB04 w/”PN” modifier on every line item
- Continue following hospital supervision and facility guidelines
AUC Advanced Diagnostic Imaging

• Mandated by MACRA & PAMA to promote appropriate use criteria for advanced diagnostic services
• Appropriate Use Criteria (AUC) program begins January 1, 2020
  – Any physician or practitioner (includes Radiation Oncologists) ordering advanced diagnostic imaging must follow the AUC program
    • Includes Ultrasounds, CTs, Nuclear Medicine PET and MRIs
• Ordering physician must consult AUC through Clinical Decision Support Mechanism (CDSM)
  – Assists ordering physician in making the appropriate treatment decision for the patient, based on their specific clinical condition
• Current sites - physician’s office, a hospital outpatient department (including an emergency department), an ASC and any other provider-led outpatient setting determined appropriate by the Secretary
AUC Sites

- Currently set to be implemented in following sites:
  - Physician’s office, hospital outpatient department (including an emergency department), ASC and any other provider-led outpatient setting determined appropriate by the Secretary

- **CMS is proposing** to add independent diagnostic testing facility (IDTF)
  - Services provided in an IDTF require physician supervision and written orders must be furnished
  - CMS belief it is provider-led outpatient setting
Billing for Advanced Imaging

- CMS proposing to establish G-codes and modifiers to be reported by furnishing physician and imaging facility
- Each claim will be required to document the following three items for each billed service:
  - Which qualified CDSM was consulted by the ordering professional;
  - Whether the service ordered adhered to specified applicable AUC, did not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered;
  - The NPI of the ordering professional (if different from the furnishing professional)
- Paper and electronic orders must be accounted for and part of AUC
- Volunteer reporting July 1, 2018 – December 31, 2019
- QQ modifier reported on claims during volunteer reporting period
  - Joint effort by ordering and furnishing physicians and facilities needed
Who Can Perform Consultation?

- After many comments and requests for clarification CMS is proposing
  - Consultation may be performed by auxiliary personnel incident to the ordering physician or NPP
  - Ordering professional delegates to appropriate personnel, but still responsible for order as NPI of ordering professional reported on claim
  - Inappropriate ordering could mean tagged as ordering outlier
Ordering Outliers

- An ordering outlier is physician or NPP in which the ordering patterns etc. are outside the norm
- May be subjected to prior authorization requirements based on ordering patterns
- **CMS is seeking comments** on how to best measure methodology for determining ordering outlier professionals
  - Specific data elements and thresholds used to identify
  - Will not use data from testing period, only data beginning January 1, 2020
  - Ordering outliers will be more fully addressed in rulemaking of CY 2022 or 2023
AUC Outlier Scans for Ordering

- Providers ordering advanced diagnostic imaging services for the following will be required to follow AUC program initially:
  - Coronary artery disease (suspected or diagnosed)
  - Suspected pulmonary embolism
  - Headache (traumatic and non-traumatic)
  - Hip pain
  - Low back pain
  - Shoulder pain (to include suspected rotator cuff injury)
  - Cancer of the lung (primary or metastatic, suspected or diagnosed)
  - Cervical or neck pain
AUC Hardship Exceptions

- **CMS proposing** adjust significant hardship exception requirements
- Any ordering professional experiencing following not required to consult AUC with qualifying CDSM
  - Insufficient internet access;
  - EHR or CDSM vendor issues; or
  - Extreme and uncontrollable circumstances
- **Proposing** ordering professional self-attest if significant hardship at time of advanced diagnostic imaging order
- **CMS requesting comments on**
  - Circumstances which could be considered significant hardships
  - Posing particular real-time difficulty
  - Challenge to the ordering professional in consulting AUC
Submitting Comments

- Comments to CMS regarding the MPFS proposed rule must refer to file code **CMS-1693-P**
- Received no later than 5 pm EST September 10, 2018.
- Electronic submission is encouraged by CMS, [http://www.regulations.gov](http://www.regulations.gov)
  - Follow the instructions under the “submit a comment” tab
Questions

- If you are a Revenue Cycle Inc. Client Resource Center member, please ask your question via your Q & A Forum.

- If you are not a Client Resource Center member, email us at info@revenuecycleinc.com and one of our experienced consulting associates will promptly respond.