

## CY 2018 OPPTS Final Rule Initial Summary

On November 1, 2017 the Centers for Medicare and Medicaid Services (CMS) released its final rule with 60-day comment period for changes to the calendar year (CY) 2018 hospital outpatient prospective payment system (HOPPS).

In this rule, CMS finalized a number of changes that affect radiology including the delayed implementation of the CT and MR cost centers and the implementation of two modifiers for use on claims for plain film and computed radiography X-ray services. CMS elected not to finalize its proposal to add a level to the Imaging without Contrast APC. These changes are effective January, 1, 2018.

CMS will delay full implementation of its transitional CT and MR cost center policy until January 1, 2019 to provide added flexibility for hospitals to improve their cost allocation methods during CY 2018 OPPTS. Earlier this year ACR raised concerns regarding using claims from all providers to calculate CT and MRI cost-to-charge ratios (CCRs) because many providers continue to use the “square feet” cost allocation method and future use of these claims would cause significant reductions in imaging APC payment rates. The ACR requested in its meeting with CMS and in writing for the CT and MR cost centers to be deleted since the intended purpose has been met by other HOPPS policies. The ACR advised that full implementation of this policy would be an overreach with many negative consequences to radiology payments in various practice settings. The ACR will continue to work with CMS to remedy this payment issue.

In response to public comments, CMS has elected to forego the addition of a fifth Imaging without Contrast APC. The additional APC would have split the previous Level 4 Imaging APC to include higher volume lower cost services and placed low frequency services with higher costs in the new Level 5 Imaging without contrast APC, however CMS states that maintaining the four level Imaging without Contrast APC family will minimize fluctuations in payments rates and lead to payment stability from CY 2017 to CY 2018. CMS accepted some of ACR’s suggestions which will be outlined in a future detailed summary.

CMS is finalize its proposal to keep G0297 (Low Dose CT for Lung Cancer Screening) in the lowest level Imaging without Contrast APC (5521), however, while the CY 2018 proposed rule set the payment rate for 5521 at \$59.17, CMS finalized a payment rate of \$62.11, which would represent an increase from the CY 2017 Payment rate of \$59.84. Similarly, CMS has elected to keep G0296 (visit to determine lung LDCT eligibility) in APC 5822 but rather than decrease the payment rate from \$70.23 to the proposed \$68.92, will finalize an increased payment rate of \$71.94.

CMS finalized its proposal not to implement any new comprehensive APCs (C-APCs) for CY 2018. CMS will continue to pay separately for the 10 planning and preparation services adjunctive to the delivery of Stereotactic Radio Surgery (SRS) treatments using Cobalt-60-based or LINAC-based technology when these services are furnished to beneficiaries within 30 days of SRS treatment. CMS has finalized its proposal to conclude the data collection period for SRS claims with the “CP” modifier on December 31, 2017 and will discontinue its required use for CY 2018 and future years. The ACR very much supports this decision because it helps to further stabilize payments for SRS and its ancillary services.

For CY2018 CMS is moving forward with its proposal to establish a new modifier (“FY”) to be reported on claims including codes that describe X-rays taken using computed radiography. Payments for x-ray services using computed radiography furnished between CY 2018 and CY 2021 will be reduced by 7 percent and in subsequent years payment will be reduced by a further 10 percent. This policy is a

response to provisions in the Consolidated Appropriations act of 2016 incentivizing the transition from traditional X-ray imaging to digital radiography.

CMS is finalizing its proposal to increase the conversion factor by 1.75 percent bringing it up to \$76.483 for CY 2018. Additionally, CMS finalized its proposal to set the reduced conversion factor for hospitals failing to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements at \$74.953.

ACR staff is preparing a detailed analysis of the proposed rule and will provide additional information in the coming week. Limited comments on the final rule are due to CMS by December 31, 2018. Discussion of CMS' final decisions on the site-neutral policy for off-campus providers is found in the Medicare Physician Fee Schedule summary.