ACR Analysis of CY 2019 Hospital Outpatient Prospective Payment System

Table of Contents

Calendar Year 2019 Hospital Outpatient Prospective Payment System Proposed Rule

On July 25th, 2018 the Centers for Medicare and Medicaid Services (CMS) released the proposed rule for changes to the calendar year (CY) 2019 hospital outpatient prospective payment system (HOPPS). This rule provides for a 60-day comment period ending on September 24, 2018. The finalized changes will appear in the final rule in early November and are effective January 1, 2019. A detailed summary of the proposed rule follows.

Conversion Factor (pg. 102)

CMS is proposing to update the conversion factor which payment rates are calculated using geometric mean costs. The proposed OPD fee schedule increase factor of 1.25 percent for CY 2019, the required proposed wage index budget neutrality adjustment of approximately 1.0004, the proposed cancer hospital payment adjustment of 1.0000, and the proposed adjustment of 0.02 percentage point of projected OPPS spending for the difference in the pass-through spending and outlier payments that result in a proposed conversion factor for CY 2019 of $79.546.

CMS is proposing that hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Reporting (OQR) Program would continue to be subject to a further reduction of 2.0 percentage points to the OPD fee schedule increase factor. This would result in a proposed reduced conversion factor of $77.955 for hospitals that fail to meet requirements for the Hospital OQR Program.

Proposed Ambulatory Payment Classification (APC) Group Policies

APC Placement of New Radiology CPT codes

In March 2018, the ACR presented CMS with recommendations for new CPT codes placement within APCs for CY 2019. The table below shows CMS proposed APC placements for CY 2019. CMS proposes to accept ACR's suggested APC placements except for three codes of which ACR will evaluate further.

CMS Proposed APC Placement for New CPT Codes

New Code	Short Descriptor	SI	CMS Proposed APC	ACR APC Recommendation
10X12	Fna bx w/us gdn 1st les	T	5071	5071
10X14	Fna bx w/fluor gdn 1st les	T	5071	5071
10X16	Fna bx w/ct gdn 1st les	T	5071	5072
10X18	Fna bx w/mr gdn 1st les	T	5071	5373
767X1	Use parenchyma	Q3	5522	5522
767X2	Use 1st target lesion	Q3	5522	5522
767X3	Use ea addl target lesion	N		
76X01	Mr elastography	Q3	5523	5523
76X0X	Us trgt dyn mbubb 1st les	S	5571	5571
76X1X	Us trgt dyn mbubb ea addl	N		
77X49	Mri breast c- unilateral	Q3	5523	5523
77X50	Mri breast c- bilateral	Q3	5523	5523
77X51	Mri breast c-+ w/cad uni	B		5571

77X52	Mri breast c-+ w/cad bi	B		5572
50X39	Dilat xst trc ndurlgc px	J1	5373	5374
50X40	Dilat xst trc new access rcs	J1	5374	5374
36X72	Insj picc rs&i <5 yr	T	5181	5181
36X73	Insj picc rs&i 5 yr+	T	5182	5182

Status indicator key in Appendix A

Imaging APCs (pg. 192)

For CY 2019 HOPPS, CMS reviewed the resource costs and clinical coherence of the procedures associated with the four levels of Imagining without Contrast APCs and the three levels of Imaging with Contrast APCs. CMS does not propose any new changes to the APC structure for imaging codes. The seven payment categories remain. However, CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two times rule.

Table 17. Proposed CY 2019 Imagining APCs

CY 2019 APC	CY 2019 APC Title	CY 2018 APC Geometric Mean Cost	Proposed CY 2019 APC Geometric Mean Cost
5521	Level 1 Imaging without Contrast	$62.08	$64.02
5522	Level 2 Imaging without Contrast	$114.39	$115.89
5523	Level 3 Imaging without Contrast	$232.17	$236.05
5524	Level 4 Imaging without Contrast	$486.38	$502.75
5571	Level 1 Imaging with Contrast	$252.58	$206.94
5572	Level 2 Imaging with Contrast	4456.08	$395.84
5573	Level 3 Imaging with Contrast	$681.45	$699.02

Additionally, CMS is requesting public comment on the proposal to maintain the current Imaging APC structure. CMS is specifically interested in receiving comments and recommendations on the proposed code reassignments associated within the Imaging APCs. A thorough analysis of the code movement, cost ranges, and stability within the APCs will be evaluated for development of ACR comments.

Comprehensive APCs

New C-APCs for CY 2019 (pg. 58)

For the CY 2019 OPPS, CMS reviewed and revised the services within each APC group and the APC assignments under the OPPS. A C-APC is defined as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service marked with “J1” status indicator (status indicator key in Appendix A). As a result, CMS is proposing the creation of three new C-APCs for the CY 2019. These three new C-APCs are as follows: C-APC 5163 (Level 3 ENT Procedures), C-APC 5183 (Level 3 Vascular Procedures), and C-APC 5184 (Level 4 Vascular Procedures). The Vascular Procedures C-APCs could possibly include interventional radiology procedures which will be reviewed further for impacts and comments.

Proposed Changes to New Technology APCs (pg 179)

CMS continues to propose the use of 52 New Technology APC levels, ranging f APC 1491 (New Technology - Level 1A ($0-$10)) through APC 1908 (New Technology - Level 52 ($145,001-$160,000)).

New Technology APC group policies allow CMS to move a service from a New Technology APC in less than 2 years if sufficient data are available.

For CY 2019, CMS is proposing to establish a different payment methodology for services assigned to New Technology APCs with fewer than 100 claims. This new methodology would allow CMS to use up to 4 years of claims data to establish a payment rate for applicable services.

Proposed Changes to MRgFUS APCs (pg. 177)

In CY 2018, there are four CPT/HCPCS codes that describe magnetic resonance image-guided, high-intensity focused ultrasound (MRgFUS) procedures. CMS is proposing to continue assigning three to standard APCs. However, CMS is proposing use their equitable adjustment authority to estimate the proposed payment rate for the procedures described by CPT code 0398T by calculating the arithmetic mean of the three paid claims for the procedures in CY 2016 and CY 2017, and reassigning CPT code 0398T from APC 1576 (New Technology – Level 39 ($15,001-$20,000) to APC 1575 (New Technology - Level 38 ($10,001-$15,000)) with a proposed payment rate of $12,500.50.Table 13, below, describes changes to MRgFUS Procedures. CMS also solicits comments on the change in statistical methodology from geometric mean to arithmetic mean. Due to the limited number of claims and high variability of costs, the calculated geometric mean cost is lower that the reported cost on the claim.

Table 13. Proposed CY 2019 Status Indicators, APC Assignment, and Payment Rate for MRgFUS Procedures

CPT/ HCPCS Code	Long Descriptor	CY 2018 OPPS SI	CY 2018 OPPS APC	CY 2018 OPPS Payment Rate	Proposed CY 2019 OPPS SI	Proposed CY 2019 OPPS APC	Proposed Payment CY 2019 OPPS Payment Rate
0071T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume less than 200 cc of tissue.	J1	5414	$2,272.77	J1	5414	$2,366.22
0072T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume greater or equal to 200 cc of tissue.	J1	5414	$2,272.77	J1	5414	$2,366.22
0398T	Magnetic	S	1576	$17,500.50	S	1575	$12,500.50

	resonance image guided high intensity focused ultrasound (mrgfus), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed.						
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance.	J1	5115	$5,606.42	J1	5115	$10,738.55

Endovascular Revascularization (pg. 188)

In August 2017, the HOP Panel recommended that CMS review endovascular revascularization APC placement to determine whether further granularity was warranted. CMS also is soliciting comments on expanding the C-APCs for endovascular revascularization from 4 levels to as many as 6. CMS acknowledged that previous stakeholder comments stated that certain procedures, such as angioplasty procedures with use of a drug-coated balloon in addition to a non-coated balloon, resource cost are significantly higher than the geometric mean cost for all angioplasty procedures combined. The higher levels may allow for more accurate payments for more complex cases that use more expensive devices.

Brachytherapy (pg. 55)

CMS is proposing to use the costs derived from CY 2017 claims data to set the proposed CY 2019 payment rates for brachytherapy. Additionally, CMS is proposing to assign status indicator "E2" (Items and Services for Which Pricing Information and Claims Data Are Not Available) to HCPCS code C2644 (Brachytherapy cesium-131 chloride) because this code was not reported on CY 2017 claims. CMS continues to request stakeholder recommendations for new codes to describe new brachytherapy sources.

Stereotactic Radio Surgery

CMS is proposing to continue making separate payment 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.

CT and MR Cost Centers (pg. 42)

In the CY 2018 HOPPS Final Rule CMS finalized a policy to extend the transition policy for 1 additional year and continued to remove claims from providers that use a cost allocation method of "square feet" to calculate CT and MR CCRs for the CY 2018 OPPS. In CY 2019, CMS was due to terminate the transition period for its policy on the use of CT and MR cost data and would estimate the imaging APC relative payment weight using cost data from all providers regardless of cost allocation statistic employed (i.e. direct, dollar or square foot method). The ACR has raised concerns regarding using claims from all providers to calculate CT and MR cost-to-charge ratios (CCRs) because many providers continue to use the "square feet" cost allocation method and that including claims from such providers would cause significant reductions in imaging APC payment rates. Table 1, below, describes the relative effect on imaging APC payments after removing cost data for providers that report CT and MRI standard cost centers using "square feet" as the cost allocation method. Currently the radiology-related APCs financially benefit from CMS delaying the use of all hospital cost allocation data, including the "square foot" data, in their analysis. If CMS finalized the full use of data in 2020, it is projected that these positive changes shown in table 1 will in turn be negative.

Table 1. Percentage Change in Estimate Cost for CT and MRI APCs when Excluding Claims from Provider Using "Square Feet" as the Cost Allocation Method

APC	APC Descriptor	Percentage Change
5521	Level 1 Imaging without Contrast	-3.6%
5522	Level 2 Imaging without Contrast	5.5%
5523	Level 3 Imaging without Contrast	4.3%
5524	Level 4 Imaging without Contrast	4.7%
5571	Level 1 Imaging with Contrast	7.7%
5572	Level 2 Imaging with Contrast	8.4%
5573	Level 3 Imaging with Contrast	2.8%
8005	CT and CTA without Contrast Composite	13.9%
8006	CT and CTA with Contrast Composite	11.4%
8007	MRI and MRA without Contrast Composite	6.6%
8008	MRI and MRA with Contrast Composite	7.4%

In a meeting with CMS earlier this year, ACR requested that the CT and MR cost centers be deleted and that hospitals be allowed to report these costs under the standard diagnostic imaging cost center. Instead, CMS is proposing to continue the transition period in CY 2019, providing flexibility for hospitals to improve their cost allocation methods. This would be the sixth year transition year, and it is unlikely CMS will further extend the transition period past CY 2019. Beginning in CY 2020, CMS proposes to determine the imaging APC relative payment weights for CY 2020 cost data from all providers, regardless of the cost allocation method employed.

CT Lung Cancer Screening

In the CY 2019 OPPS Proposed Rule, CMS is proposing to continue placing G0297 (Low Dose CT for Lung Cancer Screening) in the lowest Imaging without Contrast APC (5521), with an increased payment for the service from $59.17 to $62.86. In addition, CMS has proposed to place G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a minor payment increase for the service from $68.92 to $73.02.

The ACR has raised concerns about the inadequate payments for CT lung screening based on flawed hospital data in the past few rules and the need for this screening benefit to be more readily available to the millions of Americans who would benefit from early detection of lung cancer.

Off Campus Site-Neutral Policies (pg. 393)

CMS proposes to continue to pay Off-campus sites that are more than 250 yards from the main campus and began providing services on or after November 2, 2015 at 40% of the HOPPS rate. A detailed discussion of this proposal appears in the physician fee schedule proposed rule.

Starting in 2019 CMS deems they have the authority to expand the site-neutral payment policy to not only to new services provided in non-excepted off-campus sites* but also to the entire clinical family. In addition, CMS seeks comments on additional items and services paid under the OPPS that may represent redundant increases in outpatient department's utilization and also examples of when it might be appropriate for higher payments to a hospital outpatient site versus other sites-of-service.

Table 32. Proposed Clinical Families of Services for Purposes of Section 603 Implementation

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

*This expansion would apply to excepted off-campus provider-based departments that did not furnish an item or service during a baseline period from November 1, 2014 through November 1, 2015 (and subsequently bill under the OPPS for that item or service)

Other HOPPS Payment Policies

Proposed Payment Adjustments to Cancer Hospital (pg.125)

For CY 2019, CMS is proposing to provide additional payments to the 11 specified cancer hospitals so that each cancer hospital's final payment-to-cost ratio (PCR) is equal to the weighted average PCR (or "target PCR") for the other OPPS hospitals using the most recent cost report data available. Nonetheless, Section 16002(b) of the 21st Century Cures Act requires that this weighted average PCR be reduced by 1.0 percentage point. Based on the data and the required 1.0 percentage point reduction, CMS is proposing that a target PCR of 0.88 be used to determine the CY 2019 cancer hospital payment adjustment to be paid at cost report settlement. Table 6 below specifies the proposed estimated percentage increase in OPPS payments to each cancer hospital for CY 2019 due to the proposed cancer hospital payment adjustment policy.

Table 6. Proposed Estimated Cy 2019 Hospital-Specific Payment Adjustment for Cancer Hospitals to be Provided at Cost Report Settlement

Provider Number	Hospital Name	Estimated Percentage Increase in OPPS Payments for CY 2019 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	37.1%
050660	USC Norris Cancer Hospital	13.4%
100079	Sylvester Comprehensive Cancer Center	21.0%
100271	H. Lee Moffitt Cancer Center & Research Institute	22.3%
220162	Dana-Farber Cancer Institute	43.7%
330154	Memorial Sloan-Kettering Cancer Center	46.9%
330354	Roswell Park Cancer Institute	16.2%
360242	James Cancer Hospital & Solove Research Institute	22.6%
390196	Fox Chase Cancer Center	8.4%
450076	M.D. Anderson Cancer Center	53.6%
500138	Seattle Cancer Care Alliance	54.3%

Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals (pg. 303)

Per the CY 2018 OPPS Final Rule, CMS began paying ASP minus 22.5 percent for non-pass through drugs or biologicals that are acquired by a non-excepted hospital through the 340B Program paid under the OPPS. This policy affected outpatient facilities physically connected to 340B hospitals but not those offsite. For CY 2019, CMS proposes to continue the ASP minus 22.5 percent payment policy and extend it to affect off-campus 340B providers as well.

Furthermore, CMS is proposing to continue paying for drugs and therapeutic radiopharmaceuticals at ASP + 6% as set forth in the CY 2010 OPPS/ASC Final Rule. The proposed threshold payment for therapeutic radiopharmaceuticals is $125 where CMS will package those that are priced less or equal to $125 into the APC payments and pay separately for those that meet or exceed this threshold amount.

Proposed Measure Changes within the Hospital OQR Program (pg. 515)

CMS is proposing to remove a total of 10 measures from the Hospital OQR Program measure set across the CY 2020 and CY 2021 payment determinations. Of interest to ACR, CMS is proposing to remove the following measures for CY 2021 payment determinations: OP-9: Mammography Follow-up Rates (no NQF number); OP-11: Thorax Computed Tomography (CT) – Use of Contrast Material (NQF #0513); and OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT (no NQF number).

CMS is proposing to remove OP-9: Mammography Follow-up Rates from CY 2021 payment determinations under measure removal Factor 3, meaning the measure does not align with current clinical guidelines or practice. Furthermore, CMS is proposing to remove OP-11: Thorax Computed Tomography (CT) – Use of Contrast Material (NQF #0513) and OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT (no NQF number) under removal Factor 1, stating the measures performance among providers is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

CMS is proposing additional changes to the Appropriate Use Criteria program. The AUC program applies to the Medicare Physician Fee Schedule (MPFS), the Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgical Center rules. More details on this proposal are included in the ACR summary of the CY 2019 MPFS proposed rule.

Request for Information (pg. 626)

The CY 2019 OPPS Propose Rule included three distinct RFIs for public feedback:

- Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers
- Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information
- Potential Model to Leverage the Authority under the CAP for Part B Drugs and Biologicals: Request for Information

The ACR's HOPPS Committee and staff will review these changes and will draft comments during the 60-day comment period. Those comments are due to CMS by September 24th.

Appendix A: Status Indicator Key

CY 2019 Proposed Status Indicators

Status Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS	Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E1	Items, Codes, and Services: • Not covered by any Medicare outpatient benefit category • Statutorily excluded by Medicare • Not reasonable and necessary	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
E2	Items, Codes, and Services: • For which pricing information and claims data are not available	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; separate APC payment.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
J1	Hospital Part B Services Paid Through a Comprehensive APC	Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; all preventive

		services; and certain Part B inpatient services.
J2	Hospital Part B Services That May Be Paid Through a Comprehensive APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. 1. Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. 2. Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1". 3. In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
K	Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals	Paid under OPPS; separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the MAC	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; per diem APC payment.
Q1	STV-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable.

		1. Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “S”, “T”, or “V". 2. Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. 3. In other circumstances, payment is made through a separate APC payment.
Q2	T-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. 1. Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “T”. 2. In other circumstances, payment is made through a separate APC payment.
Q3	Codes That May Be Paid Through a Composite APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. 1. Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. 2. In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Q4	Conditionally Packaged Laboratory Tests	Paid under OPPS or CLFS. 1. Packaged APC payment if billed on the same claim as a HCPCS code assigned published

		status indicator “J1",“J2”, “S”, “T” ,“V”, “Q1” ,“Q2”, or “Q3”. 2. In other circumstances, laboratory tests should have a status indicator of "A" and payment is made under the CLFS.
R	Blood and Blood Products	Paid under OPPS; separate APC payment.
S	Procedure or Service, Not Discounted When Multiple	Paid under OPPS; separate APC payment.
T	Procedure or Service, Multiple Procedure Reduction Applies	Paid under OPPS; separate APC payment.
U	Brachytherapy Sources	Paid under OPPS; separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to a DME MAC.