American College of Radiology of CY 2019 HOPPS Final Rule Detailed Summary

On November 2nd, 2018 the Centers for Medicare and Medicaid Services issued the calendar year (CY) 2019 Hospital Outpatient Prospective Payment System (HOPPS) final rule. Any comments on the payment classifications assigned to the interim APC assignments and/or status indicators of new or replacement Level II HCPCS codes in this final rule with comment period must be received no later than 5 p.m. EST on December 3, 2018. The finalized changes are effective January 1, 2019.

Conversion Factor

CMS is finalizing a 1.35 percent increase of the conversion factor, bringing the conversion factor up to $79.490 for CY 2019. CMS also finalized 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 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' finalized APC placements for CY 2019.

CMS Proposed APC Placement for New CPT Codes

New CPT Code	Short Descriptor	SI	CY 2019 CMS Proposed APC	ACR APC Recommendation	CY 2019 APC Placement
10004	Fna bx w/us gdn 1st les	T	5071	5071	5071
10007	Fna bx w/fluor gdn 1st les	T	5071	5071	5071
10009	Fna bx w/ct gdn 1st les	T	5071	5072	5071
10011	Fna bx w/mr gdn 1st les	T	5071	5373	5071
76981	Use parenchyma	Q3	5522	5522	5522
76982	Use 1st target lesion	Q3	5522	5522	5522
76391	Mr elastography	Q3	5523	5523	5523
76978	Us trgt dyn mbubb 1st les	S	5571	5571	5571
77046	Mri breast c- unilateral	Q3	5523	5523	5523
77047	Mri breast c- bilateral	Q3	5523	5523	5523
50436	Dilat xst trc ndurlgc px	J1	5373	5374	5373
50437	Dilat xst trc new access rcs	J1	5374	5374	5374
36568	Insj picc rs&i <5 yr	T	5181	5181	5181
36569	Insj picc rs&i 5 yr+	T	5182	5182	5182

Despite ACR's comments on the CY 2019 HOPPS proposed rule, CMS did not agree with several of ACR's proposed CPT placements in APCs for CY 2019 including; 10009 (Fna bx w/ct gdn 1st les), and 10011 (Fna bx w/mr gdn 1st les), and 50436 (Dilat xst trc ndurlgc px). CMS responded to ACR's comments stating they believe that 10009 and 10011 are appropriately described by APC 5071. The ACR will continue to advocate for appropriate CPT code placement based on clinical similarity and cost data.

Imaging APCs

CMS did not propose any changes to the APC structure for imaging codes, and will maintain the seven payment categories for CY 2019. However, CMS has moved codes within these payment categories of which would cause price changes for 2019. CMS stated it will except the two-times rule violations present in 7 APCs, including APCs 5521, 5522, 5523, and 5571. CMS finalized these code movements for CY 2019. Table 33, below, shows the final geometric mean costs for imaging APCs for CY 2019. The ACR will continue to work with CMS to help stabilize the seven imaging APCs.

Table 33 - Final CY 2019 Imaging APCs

CY 2019 APC	CY 2019 APC Title	CY 2018 APC Geometric Mean Cost	Proposed CY 2019 APC Geometric Mean Cost	Final CY 2019 Geometric Mean Cost
5521	Level 1 Imaging without Contrast	$62.08	$64.02	$62.84
5522	Level 2 Imaging without Contrast	$114.39	$115.89	$113.48
5523	Level 3 Imaging without Contrast	$232.17	$236.05	$232.56
5524	Level 4 Imaging without Contrast	$486.38	$502.75	$501.79
5571	Level 1 Imaging with Contrast	$252.58	$206.94	$203.48
5572	Level 2 Imaging with Contrast	4456.08	$395.84	$389.22
5573	Level 3 Imaging with Contrast	$681.45	$699.02	$697.73

New Comprehensive APCs for CY 2019

A comprehensive APC (C-APC) is the OPPS version of an episode-of- care where 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) are paid to hospitals in one bundled payment. In CY 2019 CMS is creating 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 new vascular C-APCs are of interest to ACR. Refer below to Appendix A for all codes that are held within the 5183, and Appendix B lists out codes held with in 5184.

New Technology APCs

CMS will continue the use of 52 New Technology APC levels, ranging 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 finalized policy to establish a different payment methodology for services assigned to New Technology APCs with fewer than 100 claims. This new methodology permits CMS to use up to 4 years of claims data to establish a payment rate for services assigned New Technology with fewer than 100 claims. CMS will use a “smoothing methodology” based on multiple years of claims data to establish a more stable payment rate for these services. With this new policy, CMS will calculate the geometric mean costs, the median costs, and the arithmetic mean costs for these procedures and adopt through annual rulemaking the most appropriate payment rate for the services using one of the methodologies. In addition, CMS will exclude services assigned to New Technology APCs from bundling into C-APCs.

Magnetic Resonance-Guided Focused Ultrasound Surgery (MRgFUS) APCs

For CY 2018, there are four CPT/HCPCS codes that describe magnetic resonance image-guided, high-intensity focused ultrasound (MRgFUS) procedures. CMS will continue assigning three to standard APCs. After public comments, CMS finalized their use of the equitable adjustment authority to estimate the 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 payment rate of $12,500.50. CMS responded to stakeholder comments that requested CPT code 0398T be placed in APC APC 1576 (New Technology – Level 39 ($15,001-$20,000)) instead of APC 1575 (New Technology - Level 38 ($10,001-$15,000)) stating the payment reduction is based on 14 claims that have been billed for CPT code 0398T since CMS first received claims for this procedure in CY 2016. Table 17, below, describes CMS’ finalized changes to MRgFUS Procedures.

Table 17. 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	CY 2019 OPPS SI	CY 2019 OPPS APC	CY 2019 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	$2,361.27
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	$2,361.27

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0398T	Magnetic resonance image guided high intensity focused ultrasound (mrgfus), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed.	S	1576	$17,500.50	S	1575	$12,500.50
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance.	J1	5115	$5,606.42	J1	5115	$10,713.88

Endovascular Revascularization

In August 2017, the HOP Panel recommended that CMS review endovascular revascularization APC placement to determine whether further granularity was warranted. CMS solicited comments on expanding the C-APCs for endovascular revascularization from four levels to as many as six. CMS' analysis found no two-times rule violations within the current endovascular revascularization APC structure. CMS maintains the four levels of C-APCs for endovascular revascularization and will continue to review APC structure to determine if additional granularity is necessary in the future.

Table 24, below, describes the C-APCs structure for CY 2019 for endovascular revascularization.

Table 24. CY 2019 C-APC Structure for Endovascular Revascularization

C-APC	Geometric Mean Cost
5191 – Level 1 Endovascular Procedures	$2,834
5192 – Level 2 Endovascular Procedures	$4,719
5193 – Level 3 Endovascular Procedures	$9,752
5194 – Level 4 Endovascular Procedures	$15,487

Brachytherapy

CMS reiterated its belief that the HOPPS prospective payment methodology is appropriate for brachytherapy. CMS used cost data derived from CY 2017 claims data to set the CY 2019 payment rates for brachytherapy. CMS will 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 define new brachytherapy sources.

Stereotactic Radiosurgery (SRS)

CMS replied to public comments suggesting CMS discontinue the C-APC payment policy for SRS, stating that they believe it is still an appropriate payment policy for SRS. CMS reiterated that in the CY 2018 HOPPS final rule, when they analyzed the separately payable codes that were then assigned to C-APCs, they observed an increase in claim line frequency, units billed, and Medicare payment for those procedures, which suggests to CMS that the C–APC payment policy did not negatively affect access to care or decrease payments to hospitals. CMS stated that commenters did not offer empirical evidence to suggest the C-APC payment policy does not sufficiently pay for SRS procedures.

In addition, CMS will continue making separate payment for the 10 planning and preparation services adjunctive to the administration of 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

CMS finalized policy to extend the transition period CT and MR cost center policies for CY 2019, providing flexibility for hospitals to improve their cost allocation methods. 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 begin to 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.

CMS reiterated that beginning in 2020, they will determine the imaging APC relative payment weights for CY 2020 cost data from all providers, regardless of the cost allocation method employed. In the CY 2019 HOPPS proposed rule comment letter, the 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. However, CMS’ response to public comments was to add one final year to allow hospitals to transition to a direct or dollar cost allocation method making this a 6-year transition period.

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	-4.0%
5522	Level 2 Imaging without Contrast	5.6%
5523	Level 3 Imaging without Contrast	4.2%
5524	Level 4 Imaging without Contrast	5.3%
5571	Level 1 Imaging with Contrast	7.8%
5572	Level 2 Imaging with Contrast	8.3%
5573	Level 3 Imaging with Contrast	2.8%
8005	CT and CTA without Contrast Composite	14.1%

8006	CT and CTA with Contrast Composite	11.5%
8007	MRI and MRA without Contrast Composite	6.5%
8008	MRI and MRA with Contrast Composite	6.8%

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. CMS responded to stakeholder comments stating the CMS has increasing packaging policies, including creation of C-APCs, to make the HOPPS a more prospective payment system. Additionally, CMS encouraged hospitals to use more precise cost reporting methods through cost reporting instructions and communication with Medicare contractors regarding the approval of hospitals' request to switch from the square feet statistical allocation method. CMS will continue the transition period in CY 2019, providing flexibility for hospitals to improve their cost allocation methods. Beginning in CY 2020, CMS states it will 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

CMS finalized its proposal to continue placing G0297 (Low Dose CT for Lung Cancer Screening) in the lowest Imaging without Contrast APC (5521), at a payment level of $62.84. In addition, CMS has finalized to place G0296 (visit to determine lung LDCT eligibility) in APC 5822 paying this service at $76.39.

The ACR has raised concerns about the inadequate payments for CT lung screening based on flawed hospital data. ACR also noted that the payment rate for this study would be priced closer to $100 if the CT cost center was deleted and the payment rate was instead calculated using the diagnostic radiology cost center. CMS responded to comments stating that they believe G0297 is appropriately described by APC 5521. CMS stated they will continue to monitor payment for these imaging services and will consider the most appropriate methodology for rate-setting in future rulemaking.

Off Campus Site-Neutral Policies

CMS will 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. CMS stated that they believe the shift in site of service is due to payment incentives, and finds it unnecessary for shift in site of service from the physician office to a hospital outpatient department if the beneficiary can safely receive the same care at a lower cost. A detailed discussion of this proposal appears in the physician fee schedule final rule.

Additionally, CMS did not finalize the proposed policy that off-campus provider based departments (PBDs) excepted from Section 603 of the Bipartisan Budget Act of 2015 could continue to be paid at OPPS rates for items and services in each of 19 proposed "clinical families of services" if a PBD furnished and billed for a service in that clinical family of services prior to November 2, 2015. CMS stated they will continue to monitor the expansion of services in these departments.

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Other HOPPS Payment Policies

Payment Adjustments to Cancer Hospitals

For CY 2019, CMS will 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 determined 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 10 below specifies the proposed estimated percentage increase in OPPS payments to each cancer hospital for CY 2019 due to the cancer hospital payment adjustment policy.

Table 10. 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	46.4%
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%

OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals

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 will continue the ASP minus 22.5 percent payment policy and extend it to affect off-campus 340B providers as well.

Furthermore, CMS will continue paying for drugs and therapeutic radiopharmaceuticals at ASP + 6% as set forth in the CY 2010 OPPS/ASC final rule. CMS addressed commenters that did not support the inclusion

of radiopharmaceuticals in the proposal to utilize a 3 percent add-on, instead of a 6 percent add-on, for drugs paid based on WAC, stating there was no evidence to support a 3 percent add-on instead of a 6 percent add-on would negatively affect access to radiopharmaceuticals.

CMS responded to public comments that requested pass-through payment status for HCPCS code A9515 (Choline c-11, diagnostic, per study dose up to 20 millicuries) be extended until March 2019 to allow for the three full years of pass-through payment status. CMS responded stating that A9515 is covered under the pass-through payment expiration policy in effect in CY 2016, which stated that drugs and biologicals receive at least 2 years and no more than 3 years of pass-through payment status, with the pass-through payment period expiring at the end of a calendar year. CMS maintained that pass-through payment status for A9515 will end on December 31, 2018.

Moreover, the threshold payment for therapeutic radiopharmaceuticals is $125. 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.

Measure Changes within the Hospital OQR Program

CMS will 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 will 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 will remove these measures based on several measures including; the costs associated with a measure outweigh the benefit of its continued use in the program; the measure does not align with current clinical guidelines or practice, measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made; or because performance or improvement on a measure does not result in better patient outcomes. CMS responded to stakeholders who recommended that the measures be removed prior to 2021, and begin in 2020. CMS stated it intended to implement the removals in 2021 to be sensitive to facilities' planning and operational procedures.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

CMS finalized a January 1, 2020 as the implementation date for the Appropriate Use Criteria (AUC) program in the 2018 Physician Fee Schedule final rule. This delay allows time to further develop claims processing instructions. Due to the complex nature of the AUC program, CMS finalized an "educational and operations testing period" of one year that will begin on January 1, 2020. During this period, ordering professionals will consult AUC and furnishing providers will report without penalty. CMS also finalized the use of G-codes to report the CDS mechanism and modifiers to reflect the level of adherence to the AUC. The AUC program applies to the Medicare Physician Fee Schedule, the Outpatient Prospective Payment System, Independent Diagnostic Testing Facilities and the Ambulatory Surgical Centers. Further details are outlined in ACR's initial summary of the CY 2019 Physician Fee Schedule final rule.

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Appendix A: C-APC 5183

HCPCS Code	Short Descriptor
37600	Ligation of neck artery
37606	Ligation of neck artery
35261	Repair blood vessel lesion
36835	Artery to vein shunt
37188	Ven mechnl thrmbc repeat tx
30915	Ligation nasal sinus artery
37212	Thrombolytic venous therapy
36810	Insertion of cannula
30920	Ligation upper jaw artery
37197	Remove intrvas foreign body
33226	Reposition l ventric lead
36821	Av fusion direct any site
37722	Ligate/strip long leg vein
36570	Insert picvad cath
35903	Excision graft extremity
35761	Exploration of artery/vein
36565	Insert tunneled cv cath
37735	Removal of leg veins/lesion
36595	Mech remov tunneled cv cath
37193	Rem endovas vena cava filter
37700	Revise leg vein
37760	Ligate leg veins radical
37607	Ligation of a-v fistula
37650	Revision of major vein
36582	Replace tunneled cv cath
36475	Endovenous rf 1st vein
0388T	Leadless c pm remove ventr
34530	Leg vein fusion
35231	Repair blood vessel lesion
36561	Insert tunneled cv cath
36558	Insert tunneled cv cath
36585	Replace picvad cath
36560	Insert tunneled cv cath

36571	Insert picvad cath
35184	Repair blood vessel lesion
37766	Phleb veins - extrem 20+
36478	Endovenous laser 1st vein
33215	Reposition pacing-defib lead
37765	Stab phleb veins xtr 10-20
37718	Ligate/strip short leg vein
93505	Biopsy of heart lining
37192	Redo endovas vena cava filtr
36473	Endovenous mchnchem 1st vein
35206	Repair blood vessel lesion
34490	Removal of vein clot
36581	Replace tunneled cv cath
36578	Replace tunneled cv cath
37785	Ligate/divide/excise vein
35860	Explore limb vessels
36640	Insertion catheter artery
35207	Repair blood vessel lesion
34421	Removal of vein clot
37605	Ligation of neck artery

Appendix B: C-APC 5185

HCPCS Code	Short Descriptor
36260	Insertion of infusion pump
35881	Revise graft w/vein
35236	Repair blood vessel lesion
35876	Removal of clot in graft
34520	Cross-over vein graft
35256	Repair blood vessel lesion
34203	Removal of leg artery clot
37211	Thrombolytic art therapy
35879	Revise graft w/vein
36830	Artery-vein nonautograft
35883	Revise graft w/nonauto graft
36833	Av fistula revision
36861	Cannula declotting

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35266	Repair blood vessel lesion
36838	Dist revas ligation hemo
35321	Rechanneling of artery
34201	Removal of artery clot
35875	Removal of clot in graft
34101	Removal of artery clot
36825	Artery-vein autograft
35884	Revise graft w/vein
35188	Repair blood vessel lesion
37619	Ligation of inf vena cava
37200	Transcatheter biopsy
34501	Repair valve femoral vein
36482	Endoven ther chem adhes 1st
37202	Transcatheter therapy infuse
34111	Removal of arm artery clot
36831	Open thrombect av fistula
36819	Av fuse uppr arm basilic
36832	Av fistula revision open
37191	Ins endovas vena cava filtr
34510	Transposition of vein valve
35286	Repair blood vessel lesion
35011	Repair defect of artery
37500	Endoscopy ligate perf veins
36800	Insertion of cannula
36820	Av fusion/forearm vein
35190	Repair blood vessel lesion
35045	Repair defect of arm artery
36818	Av fuse uppr arm cephalic
36583	Replace tunneled cv cath
36566	Insert tunneled cv cath
35201	Repair blood vessel lesion
49419	Insert tun ip cath w/port
36815	Insertion of cannula
36557	Insert tunneled cv cath
36563	Insert tunneled cv cath