American College of Radiology Detailed Summary of the CY 2017 Final Rule for the Hospital Outpatient Prospective Payment System

The Centers for Medicare and Medicaid Services (CMS) released its final rule for calendar year (CY) 2017 changes to the Hospital Outpatient Prospective Payment System (HOPPS) on November 1, 2016. This final rule has a 60-day comment period closing on December 31, 2016. These changes will become effective January 1, 2017. The following is a detailed summary of the final rule.

HOPPS Conversion Factor

CMS finalized a 1.65 percent increase to the HOPPS conversion factor bringing it up to $75.001. Additionally, the CMS reduced conversion factor for hospitals failing to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements is $73.411 (-1.498 percent).

Finalized Comprehensive APCs (C-APCs) for CY 2017

In the CY 2014 HOPPS Final Rule CMS finalized a comprehensive payment policy that packages payment for adjunctive and secondary items, services and procedures into the most costly primary procedure payable under the OPPS at the claim level. These most costly primary procedures are given a "J1" status indicator. With very specific exception, when such a primary ("J1") service is reported on a claim, CMS considers all other items and services reported on that claim as integral, ancillary supportive, dependent and adjunctive and packages payment into that of the primary service. Similar to previous year's expansion of the C-APC methodology, for (CY) 2017 CMS is implementing 25 new C-APCs as proposed, bringing the total number of C-APC's to 62 as of January 1, 2017. Many of the new C-APCs are major surgery APCs within the various existing C-APC clinical families. CMS is also proposing three new clinical families to accommodate new C-APCs including nerve procedures, excision, biopsy, incision and drainage procedures, as well as airway endoscopy procedures.

See the table below for a list of C-APC's which include codes pertaining to radiology:

APC	Group Title	Relative Weight	Payment Rate
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	16.4811	$1,236.10
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	33.3118	$2,498.42
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	58.9005	$4,417.60
5153	Level 3 Airway Endoscopy	16.9231	$1,269.25
5154	Level 4 Airway Endoscopy	32.4023	$2,430.20
5155	Level 5 Airway Endoscopy	58.1474	$4,361.11
5302	Level 2 Upper GI Procedures	17.7900	$1,334.27
5303	Level 3 Upper GI Procedures	33.4614	$2,509.64
5341	Abdominal/Peritoneal/Biliary and Related Procedures	38.1532	$2,861.53
5373	Level 3 Urology and Related Services	21.9192	$1,643.96
5414	Level 4 Gynecologic Procedures	27.7941	$2,084.59
5431	Level 1 Nerve Procedures	20.8365	$1,562.76

APC Restructure for Diagnostic Imaging

Despite heavy opposition, CMS elected to move forward with a restructure of the 17 imaging ambulatory payment classifications (APCs) that exist for CY 2016 down to 7 for CY 2017. The seven include four APCs for imaging without contrast and three for imaging with contrast and consist of cardiology, echocardiography, radiology and any other specialty that would provide imaging services. Within this consolidation, CMS has also chosen to calculate a geometric mean cost of each study based on its most current data and sort them into the corresponding pricing categories purely by cost. This means that the original Congressional intent that studies be place in categories according to clinically similarity is of little consideration.

TABLE 21.—FINAL CY 2017 IMAGING APCs

CY 2017 APC	CY 2017 APC Title
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5572	Level 2 Imaging with Contrast
5573	Level 3 Imaging with Contrast

As a result, the ACR is extremely disappointed that G0297 (Low dose CT scan (LDCT) for lung cancer screening) which is currently priced at $112.49 will be cut to $59.84 for CY 2017. ACR and the Lung Cancer Screening Coalition pointed out to CMS that this new code has had little time to be priced in HOPPS and has only 40 single claims identified in the 2015 OPPS claims data. This is most likely due to the fact that facilities had to hold claims for the first coverage year and wait for CMS guidance on coding and claims submission. Once the claims were submitted, there were many claims denials due to the implementation of ICD-10 and many of the held claims included ICD-9 coding. New studies need at least two full years for hospitals to establish the

programs and report appropriate costs. The ACR argued that CMS did not have enough claims data to justify the cut. CMS did stabilize the payment rates for the Shared Decision Making code (G0296) at $70.23.

In addition, CMS is finalizing the placement of MR and MRA codes into lower payment categories which price them in the $225.00 to $265.00 payment categories which will undoubtedly have negative effects on their technical component payments in the physician fee schedule for CY 2017. CMS also refused to budge on ACR's recommendations to stabilize payment for many other imaging studies and only made exceptions for a few. Although ACR has not determined specific impacts below in Table 19 of the final rule are examples of where ACR commented to stabilize payments for imaging studies and CMS disagreed.

TABLE 19.--SERVICES REQUESTED TO BE REASSIGNED TO THE NEXT HIGHER LEVEL IMAGING APC

CPT Code	Long Descriptor	Proposed CY 2017 SI	Proposed CY 2017 APC	CMS Response (Agree or Disagree with Commenter)	Final CY 2017 SI	Final CY 2017 APC
70545	Magnetic resonance angiography, head; with contrast material(s)	S	5571	Disagree	S	5571
70548	Magnetic resonance angiography, head; with contrast material(s)	S	5571	Disagree	S	5571

CPT Code	Long Descriptor	Proposed CY 2017 SI	Proposed CY 2017 APC	Response (Agree or Disagree with Commenter)	Final CY 2017 SI	Final CY 2017 APC
70557	Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material	S	5523	Disagree	S	5523
71270	Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections	Q3	5571	Disagree	Q3	5571
76010	Radiologic examination from nose to rectum for foreign body, single view, child	Q1	5521	Disagree	Q1	5521
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	S	5521	Disagree	S	5521
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Q1	5521	Agree	Q1	5522
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when	Q1	5521	Disagree	Q1	5521

CPT Code	Long Descriptor	Proposed CY 2017 SI	Proposed CY 2017 APC	CMS Response (Agree or Disagree with Commenter)	Final CY 2017 SI	Final CY 2017 APC
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus	Q1	5521	Agree	Q1	5522
76821	Doppler velocimetry, fetal; middle cerebral artery	Q1	5521	Agree	Q1	5522
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	Q3	5521	Agree	Q3	5522
C8903	Magnetic resonance imaging with contrast, breast; unilateral	Q3	5571	Disagree	Q3	5571
C8918	Magnetic resonance angiography with contrast, pelvis	Q3	5571	Disagree	Q3	5571

Proposal to Change the Beginning Eligibility Date for Device Pass-Through Payment Status

CMS has decided to move forward with their proposal to allow for quarterly expiration of pass-through status for devices, drugs, biologicals and radiopharmaceuticals without modification. The reasoning they put forth is that quarterly expiration will ensure better data for placement of these new products into their final APC placement once the pass-through period has expired. For new devices, biologicals and drugs payment will be made under the OPPS temporarily via the use of transitional pass-through payments for at least two but no more than three years. The pass-through period for new drugs and devices will begin in the quarter that the application is approved by CMS. Therefore drugs and devices with pass-through status beginning in the first quarter of the year will receive the full three years of eligibility in the regulatory cycle; those that went into effect in the third quarter will be priced on two and a half years-worth of data. Allowing the pass-through period to expire quarterly will grant a period of time closer to the statutory limit of 3 years for each item on pass-through status. CMS estimates pass-through totals to equal approximately 0.24 percent of the total OPPS spending.

Payment of Devices, Drugs, Biologicals and Radiopharmaceuticals

CMS will continue to pay for devices, drugs, biologicals and radiopharmaceuticals that do not have pass-through status and are paid separately at the statutory default of average sales price (ASP) plus 6 percent.

Packaging Threshold

CMS is moving forward with their proposal to raise the packaging threshold for therapeutic radiopharmaceuticals to $110. CMS will package drugs with a per-day cost less than or equal to $110 and identify those with a per-day cost greater than $110 for separate payment. All non-pass-through, separately payable therapeutic radiopharmaceuticals will be paid at ASP plus 6 percent.

Final Changes to Packaged Items and Services

CMS packages many radiology items and services into surgical primary services. For example, all interventional radiology radiologic supervision and interpretation codes (75600-75989) are considered packaged into their corresponding surgical code(s) where costs are captured off of a claim from multiple codes billed and one consolidated payment is made. However, CMS recognizes that there are times when a radiology S&I code may be billed separately and allows for their separate payment under those conditions. The status indicators CMS use to identify these codes with multiple payment conditions are Q1 and Q2. CMS is finalizing their packaging logic for status indicators Q1 and Q2 to make the decision to package or pay separately at the claim level rather than based on the date of service. CMS believes this new packaging logic will result in a greater volume of conditionally packaged costs (and thus data) of items and services.

Final Treatment of New and Revised CY 2016 Category I and III CPT Codes That Will Be Effective January 1, 2017

In the 2015 proposed rule, CMS began the process of assigning new and revised Category I and III CPT Codes to APCs with status indicators for comment in the proposed rule cycle which are then considered final in the final rule and effective January 1 of the calendar year immediately to follow. The new and revised Category I and III CPT Codes are found in OPPS Addendum B and assigned the new comment indicator "NP" to indicate that it is a new or substantially revised code for the next calendar year (CY). For CY 2017 CMS has finalized an additional comment indicator "NC" to identify that the new or revised code has received a final APC assignment and status indicator in the final rule and that no further comments will be accepted. There are some new and revised CPT codes that do not make it into the proposed rule in time for consideration, the APC placement and payment status indicators for these new codes may be discussed in the final rule, are then open for comment in its 60-day comment period and considered interim for the CY immediately to follow. The payment status indicators tell stakeholders whether or not a service represented by a code is payable under the OPPS or any other payment system and to which OPPS policies these codes apply. Below are the new 2017 codes for radiology.

CY 2017 OPPS/ASC FINAL RULE 5-Digit CPT Code	Long Descriptor	CY 2017 OPPS/ASC Final Rule Comment Indicator (CI)	APC Assignment
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	NC	
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	NC	
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	NC	5182

36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report	NC	5181
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	NC	5192
36903	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s) peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	NC	5193
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)	NC	5192
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	NC	5193

36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of an intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	NC	5194
36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	NC	NA
36908	Transcatheter placement of an intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	NC	NA
36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	NC	NA
37246	Transluminal balloon angioplasty (except lower extremity artery(s) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	NC	5192
37247	Transluminal balloon angioplasty (except lower extremity artery(s) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)	NC	NA

37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein	NC	5192
37249	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)	NC	NA
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	NC	5442
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	NC	5442
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	NC	5442
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	NC	5442
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	NC	5443

62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	NC	5443
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	NC	5443
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	NC	5443
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	NC	5522
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	NC	NA
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	NC	NA
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	NC	NA
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral	NC	5722
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older	NC	NA

99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)	NC	NA
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older	NC	
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient younger than 5 years of age	NC	NA
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older	NC	NA
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)	NC	NA

Changes for Payment for Film X-Ray

CMS has finalized the development of a new FX modifier to be used by hospitals to be appended to X-ray services on the claims that are taken using film. A quick review found that fluoroscopy and mammography studies will be affected by this policy. Effective January 1, the use of this proposed modifier will result in a 20-percent payment reduction for the film-based X-ray services. CMS clarifies however that when payment for applicable X-ray services are packaged into the payment for another item or service under the OPPS, no separate payment for the X-ray service taken using film is made and so no payment reduction occurs.

Appropriate Use Criteria for Advanced Diagnostic Imaging

Section 218(b) of the Protecting Access of Medicare Act of 2014 (PAMA, Pub. L. 113-93) directs the Secretary to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. Last year's MPFS final rule with comment period

addressed the initial component of the Medicare AUC program, including specifying applicable AUC and establishing CMS authority to identify clinical priority areas for making outlier determinations. The program's criteria and requirements were established and are being updated as appropriate through the Medicare Physician Fee Schedule (MPFS) rulemaking process. Effective January 1, 2018, ordering practitioners are required to consult AUC at the time of ordering advanced diagnostic imaging, and imaging suppliers will be required to report information related to such consultations on claims, for all applicable advanced diagnostic imaging services paid under the MPFS, the OPPS, and the Ambulatory Surgical Center payment system. The CY 2017 MPFS final rule includes requirements and processes for the second component of the Medicare AUC program, which is the specification of qualified clinical decision support mechanisms (CDSMs) under the program. The CDSM is the electronic tool through which the ordering practitioner consults AUC. The application deadline for submission to qualify as a Medicare approved CDSM has been extended until March 1, 2017. CMS plans to announce the approved CDSMs by June 30, 2017. It also finalized specific clinical priority areas and exceptions to the AUC consultation and reporting requirements. Read ACR's detailed summary on the MPFS final rule for more details.

Implementation of Section 603 of the Bipartisan Budget Act of 2015 Relating to Payment for Certain Items and Services Furnished by Certain Off-Campus Departments of a Provider

CMS is moving forward with its proposal to make site neutral payments to new off-campus sites which provide items and services to outpatients based on the Medicare Physician Fee Schedule technical component rate and denying their eligibility for payment under HOPPS. This proposal stems from Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74) which requires that certain items and services furnished by certain off-campus sites shall not be considered covered outpatient department services for purposes of OPPS payment and shall instead be paid "under the applicable payment system" beginning January 1, 2017. CMS has chosen to move forward with its requirement that items and services must continue to be furnished and billed at the same physical address of the off campus site that was in place as of November 2, 2015, in order for the off campus site to be considered excepted from Section 603 requirements. CMS imposes new payment schedules on those sites that choose to relocate only providing exception for those instances that are proven to be of dire circumstances. However, CMS chose to not move forward with imposing site neutral payments for service expansions on existing sites.

CMS establishes an interim final rule with 60-day comment period for stakeholders to provide comments on the specific rates that will be paid under the Medicare Physician Fee Schedule (MPFS) for the technical component of all non-excepted items and services. Hospitals will be paid under the MPFS at these newly established MPFS rates which will be billed on the institutional claim and must be billed with a new claim line modifier "PN" to indicate that an item or service is a non-excepted item or service. For CY 2017, the payment rate for these services will generally be 50 percent of the OPPS rate. Packaging, and certain other OPPS policies, will continue to apply to such services. CMS is seeking public comments on the new payment mechanisms and rates detailed in this interim final rule with comment period and, based on these comments, will make adjustments as necessary to the payment mechanisms and rates through rulemaking that could be effective in CY 2017.

Radiation Oncology (APCs 5092, 5611, and 5627)

Despite many comments from stakeholders to not cut the payment rate, CMS finalized its reassignment of CPT code 19298 (Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance) to APC 5092 (Level 2 Breast/Lymphatic Surgery and Related Procedures), with a payment rate of approximately $4,395 for CY 2017. The geometric mean cost for CPT code 19298 decreased from approximately $6,269 in CY 2016 to approximately $5,128 for CY 2017 which caused a change from the Level 3 APC to Level 2.

CMS received comments suggesting that CMS reassign CPT codes 77424 (Intraoperative radiation treatment delivery, x-ray, single treatment session) and 77425 (Intraoperative radiation treatment delivery, electrons, single treatment session) to an APC in the radiation therapy series other than APC 5093 (Level 3 Breast/Lymphatic Surgery and Related Procedures) because these radiation treatment services are not clinically similar to the breast procedures that are assigned to APC 5093. CMS agreed, that the assignment of these codes to APC 5093 was intended to be temporary until more claims data for these codes was available. Based on these codes being radiation treatment delivery codes and their geometric mean costs for CPT codes 77424 (approximately $8,701) and 77425 (approximately $7,172), CMS reassigned these services to the recommended APC 5627 (Level 7 Radiation Therapy), with a geometric mean cost of approximately$7,664. However, CMS notes that if planning and preparation and imaging services are repackaged into the single session cranial SRS codes (that are assigned to APC 5627) in the future, this could cause the geometric mean cost for the single session cranial SRS codes to increase such that it may no longer be appropriate to group CPT codes 77424 and 77425 with the single session SRS codes in the same APC. However, for CY 2017, APC 5627 is the most appropriate APC for CPT codes 77424 and 77425, both clinically and from a resource-cost perspective.

CMS also received requests to create a fourth level in the Therapeutic Radiation Treatment Preparation APC series and assign CPT code 77301 (Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications) to this new APC instead of reassigning it to a lower payment under APC 5613 at $1065.79. The commenters believed that the costs from the claims data for CPT code 77301 are lower than the actual current costs because the AMA CPT Editorial Panel bundled simulation services (that used to be separately coded) into the payment for CPT code 77301. CMS decided to not move forward with these requests but instead will wait for the actual claims data before reassigning this code because the cost of a new bundled code is often difficult to predict as well as significantly less than the sum of the costs of the individual codes that contribute to the bundle. For CY 2017, CMS finalized our proposal to reassign CPT code 77301 to APC 5613.

A few stakeholders also requested that CMS not reassign CPT codes 77370, 77280, and 77333 to APC 5611 (Level 1 Therapeutic Radiation Treatment Preparation) for CY 2017. These codes are currently assigned to the Level 2 Therapeutic Radiation Treatment Preparation APC (APC 5612) in CY 2016. The payment would decrease from $167 in CY 2016 to $117 in CY 2017. CMS

reviewed these APCs and noticed that the difference in the geometric mean costs between Level 1 and 2 was not significant. Therefore, CMS proposed to consolidate these two APCs into a single APC and reduce the number of levels in the Therapeutic Radiation Treatment Preparation APC series from four to three. The range of geometric mean costs for significant services in the proposed CY 2017 APC 5611 (Level 1 Therapeutic Radiation Treatment Preparation) is $101 to $197, which comports with the 2 times rule. Therefore, CMS finalized its proposed APC structure to consolidate the Therapeutic Radiation Treatment Preparation APC down to three and assign CPT codes 77370, 77280, and 77333 to APC 5611 for CY 2017.