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FINAL RULES FOR 2015 HOSPITAL OPPS:
CMS Sets the Stage for New Episodes of Care

The 2015 final rules for the hospital outpatient prospective payment (OPPS) and ambulatory surgical center (ASC) payment include, as always, changes to the amounts and factors used to determine the payment rates for services paid under these systems. Even more importantly, the Centers for Medicare & Medicaid Services (CMS) have expanded the packaging policy and moved forward on its plan to connect quality measures with payments.

On the hospital outpatient side, CMS estimates an average payment increase of 2.3 percent for all services. An update factor of 1.4 percent will be applied to ASC services for 2015. Any hospital not reporting the required quality measures will see a 2-percent reduction in the 2015 conversion factor (CF) used to determine payments.

Like recent years, CMS has updated requirements related to the Hospital Outpatient Quality Reporting (OQR) Program as well as the ASC QR Program, and this year is no different. In fact, each year CMS provides "incentives for facilities to deliver more efficient, higher quality care," according to a statement in a related fact sheet.

Most of the new and revised policies included in the final rule take effect on January 1, 2015.

Packaged Payments

In addition to an increased focus on the quality-payment connection, a key goal that CMS has established for the OPPS relates to packaging. The 2015 final rule "furthers the agency's goal of delivery system reform by moving the OPPS toward making payments for larger packages of items and services rather than making separate payments for each individual service."

Currently and until December 31, 2014, CMS will separately reimburse ancillary services with a status indicator (SI) of X, which has been deleted for 2015. Beginning January 1, 2015, ancillary services (usually minor diagnostic tests and possibly therapeutic services) that are "integral, supportive, dependent, or adjunctive to a primary service" will be "conditionally" packaged. When these ancillary services are furnished alone (not connected to another procedure), separate payments will be made.

To establish an initial set of "conditionally" packaged ancillary service ambulatory payment classifications (APCs), CMS will use a geometric mean cost of $100 or less as the criterion. Exceptions to the ancillary services packaging policy include drug-administration services, preventive services, and psychiatry-related services.

Comprehensive APCs

In 2015, CMS will implement the policy it refined and updated in the 2014 OPPS final rule related to comprehensive ambulatory payment classifications (C-APCs)—a high-cost primary service that "accounts for a higher percentage of the total costs of the hospital encounter." CMS states that C-APCs will give hospitals "improved incentives" to provide efficient and high-quality care at lower cost.

In 2015, there will be 25 C-APCs within 12 clinical families. The following services fall under the C-APC payment-packaging policy:

- Drugs, biologicals, and radiopharmaceuticals (except those receiving pass-through status)
- Diagnostic procedures
- Laboratory tests
- Other diagnostic tests and treatments that assist in the delivery of the primary procedure

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- Visits and evaluations performed in association with the procedure
- Durable medical equipment as well as prosthetic and orthotic items and supplies when provided as part of the outpatient service.

As stated above, CMS deleted the "X" SI (ancillary services) from the OPPS SI list, and beginning in 2015, the hospital Part B services that will be paid by a C-APC are identified by the following SI:

J1 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 SI=F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services

Exclusions include charges that must receive (according to statute) separate payment, which includes brachytherapy seeds, pass-through drugs and devices, self-administered drugs, and the annual wellness visit providing personalized prevention-plan services.

A single payment will be made for all related or adjunctive hospital items and services provided to a patient receiving certain primary procedures that are either:

- Largely device dependent, such as insertion of a pacemaker or
- Represent single-session services with multiple components.

According to the American College of Radiology (ACR) analysis of the final rule, "The implementation of the comprehensive device-dependent APCs is important because it sets the foundation by which CMS will begin to pay for new episodes-of-care under HOPPS."

Modifier for Off-Campus PBDs

Because of the growth in the frequency and type of services furnished in off-campus provider-based departments (PBD), CMS will launch a new data-collection requirement in 2015 that will impact both physician and hospital reporting.

In 2015, hospitals may *voluntarily* report the following modifier on the UB-04 claim for services furnished in their off-campus PBDs. Beginning January 1, 2016, the modifier is *mandatory* for every code for outpatient hospital services furnished in an off-campus PBD of a hospital.

PO Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments

Physicians and other eligible practitioners will be required to report their professional services on the CMS-1500 with one of two new place-of-service (POS) codes. These will replace the current POS code 22 (hospital outpatient). CMS states that it will retain separate POS code 23 (emergency room, hospital).

According to CMS, the new POS codes will be required for professional claims "as soon as it is available," but not before January 1, 2016. Additional instruction and provider education will be forthcoming from CMS.

Information Source: The final rules and other supporting documents can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html?DLPage=1&DLSort=2&DLSortDir=descending*

2015 FINAL RULES FOR MEDICARE PFS:
Minimal Payment Impact for Nuclear Medicine

In the 2015 final rules for the Medicare physician fee schedule (MPFS), published in the November 13 issue of the *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) report that the current conversion factor (CF) of $35.8228 will continue to be used for claims with dates of service (DOS) between January 1 and March 31, 2015, as mandated by section 101 of the Protecting Access to Medicare Act (PAMA).

For claims with DOS on and after April 1, 2015, the CF will change to $28.22 (based on the sustainable growth rate [SGR] formula), which is a decrease of 21.2 percent from the current CF. However, Congress could take action to over-ride this decrease, which it has done for the last several years.

CMS spends close to half of the final MPFS rule addressing the methodology used to determine the national relative value units (RVUs) it has assigned to all CPT and HCPCS codes. Various types of RVUs are combined to determine MPFS payment: work, practice expense (PE), and malpractice (MP). An estimated impact table provided in the final rule lists the impacts of each of these and the combined impact.

The combined impacts for radiology specialties are provided below.

Specialty	Combined Impact	Cause of Change
Diagnostic testing facility	-2%	Decrease in PE RVUs
Interventional radiology	0%	1 percent increase in PE RVUs (no affect on total)
Nuclear medicine	0%	--
Radiation oncology	0%	--
Radiation therapy centers	0%	--
Radiology	-1%	1 percent decrease in PE RVUs

In addition to addressing the updated RVUs, CMS discusses "potentially misvalued services," which includes several radiology and interventional radiology codes with high Medicare expenditures.

Quality Provisions

In the final MPFS rule, CMS discusses the following quality-reporting initiatives that are associated with MPFS payments: Physician Quality Reporting System (PQRS), Medicare Shared Savings Program, Medicare Electronic Health Record (EHR) Incentive Program, and Physician Compare website.

It also discusses the continuance of the phased-in implementation of the physician value-based payment modifier (value modifier), created by the Affordable Care Act, that would base payment on the quality and cost of care that eligible professionals (EPs) furnish to beneficiaries enrolled in the traditional Medicare fee-for-service program. Through this program, CMS will provide physicians with comparative performance information so they can improve the care they deliver.

Information Source: The 2015 MPFS final rules can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html?DLPage=1&DLSort=2&DLSortDir=descending.*

UPDATE ON REPORTING RADIOPHARMACEUTICALS:
New and Continuing Codes for 2015

Although the American Medical Association (AMA) made no revisions to the nuclear medicine CPT codes for 2015, the Centers for Medicare & Medicaid Services (CMS) did change the HCPCS level II codes below

New Codes	Descriptors	Notes
•A9606	Radium Ra-223 dichloride, therapeutic, per microcurie	**Type:** Therapeutic radiopharmaceutical **FDA approved:** May 15, 2013 **Common Name:** Radium-223 **Trade Name:** Xofigo™ **National drug code (NDC):** 50419-0208-01 for Xofigo™ **Billing Tip:** Note that the code description is "per microcurie." Billing units should be consistent with costs of radiotracer.
•J0153	Injection, adenosine, 1 mg	This code replaces diagnostic and therapeutic codes J0150 and J0151, which CMS terminated.
•A9599	Radiopharmaceutical, diagnostic, for beta-amyloid PET imaging, per study dose (Use unlisted code pending specific code)	**Type:** Diagnostic PET radiopharmaceutical **FDA Approved:** October 25, 2013, and CMS established this code in 2014. **Common Name:** Beta amyloid imaging agent **Trade Name:** Vizamyl™ G.E. **NDC:** 17156-067-10 or 17156-067-30
		Type: Diagnostic PET radiopharmaceutical **FDA Approved:** March 20, 2014 **Common Name:** Beta amyloid imaging agent **Trade Name:** NeuraCeq™ Piramal (See below for billing tip.) **NDC:** 54828-001-30

In addition to the above, the two radiopharmaceuticals below will continue to receive pass-through status.

2015 HCPCS Codes	Long Descriptors	Notes	2015 APC Rate
A9520	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	**Type:** Diagnostic radiopharma¬ceutical **Common Name:** None **NDC:** 52579-1600-05 for Lym¬phoSeek™	$240
A9586	Florbetapir F18, diagnostic, per study dose, up to 10 millicuries	**Common Name:** Beta amyloid imaging **Trade Name:** Amyvid™ **NDC:** #00002-1200-01	$2,756

Billing Tips

- On claims with dates of service March 20, 2014, and until CMS implements a pass-through code, hospital outpatient departments, independent diagnostic testing facilities (IDTFs), physician offices, and third-party payers should use the following HCPCS Level II code to report NeuraCeq™:

  A9599 Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (PET) imaging, per study dose

- For claims with DOS on or after January 1, 2015, report the following for Xofigo:

  A9606 Radium Ra-223 dichloride, therapeutic, per microcurie dose

BILLING EDITS FOR FDG PET SCANS: Implementation Now Complete

On October 6, 2014, the Centers for Medicare & Medicaid Services (CMS) and its Medicare administrative contractors (MACs) completed the third of the three-phase implementation of billing edits that relate to coverage of 18 fluorodeoxyglucose positron emission tomography (FDG PET), PET/CT and PET/magnetic resonance imaging (MRI) for solid tumors.

As required by the billing instructions accompanying the NCD, providers must append one of the following two modifiers, as appropriate, to FDG PET or PET/CT claims for the same cancer diagnosis:

Modifier PI—to inform the initial treatment strategy of tumors that are biopsy-proven or strongly suspected of being cancerous based on other diagnostic testing

Modifier PS—to inform subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that a PET study is needed.

Beginning with services performed on or after June 11, 2013, MACs pay for up to three FDG PET scans when they are used to

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guide subsequent management of an anti-tumor treatment strategy (modifier -PS) after completion of initial anti-cancer therapy (modifier -PI) for the exact same cancer diagnosis.

MACs will determine coverage of the fourth FDG PET scan, and the provider must append modifier KX to one of following CPT codes, as appropriate. The modifier indicates that the coverage criteria have been met for use of four or more FDG PET scans for subsequent treatment strategy for the same cancer diagnosis.

78608 Brain imaging, PET; metabolic evaluation

78811 PET imaging; limited area (e.g., chest, head/neck)

78812 skull base to mid-thigh

78813 whole body

78814 PET with concurrently acquired CT for attenuation correction and anatomical localization imaging; limited area (e.g., chest, head/neck)

78815 skull base to mid-thigh

78816 whole body

To report the radiopharmaceutical for the above codes, report the following level II code:

A9552 F-18 FDG, diagnostic, per study dose, up to 45 millicuries

According to CMS, a different cancer diagnosis, whether submitted with a -PI or a -PS modifier, will begin the count again. That is, the count of one initial FDG PET scan and three subsequent FDG PET scans, which do not require the -KX modifier, and the fourth scan or more for subsequent treatment strategy for the same cancer diagnosis that do require the -KX modifier.

Information Sources: Comprehensive details and links about the above can be found in *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8739.pdf.*

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