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Reimbursement Bulletin

Summary of 2019 Proposed Payment Rules

For the Hospital Outpatient Prospective Payment System & Medicare Physician Fee Schedule

Earlier this month, the Centers for Medicare and Medicaid Services (CMS) issued the proposed payment rules for both the Medicare Physician Fee Schedule (MPFS) and the Medicare Hospital Outpatient Prospective Payment System (OPPS).[1] Below is a preliminary analysis of the proposed policies affecting radiation oncology payments as well as estimates of proposed total reimbursement per course of care. Varian will be working with oncology care providers and other industry stakeholders to provide comments on the proposed policies prior to the release of the final rules.

MEDICARE PHYSICIAN FEE SCHEDULE (PHYSICIANS AND FREESTANDING CENTERS)

CMS issued the proposed rule for the Medicare Physician Fee Schedule for physicians and freestanding centers for CY 2019 on July 12, 2018. The proposed rules offers updates to Medicare payment policies, payment rates, and beginning this year changes to the Quality Payment Program (QPP) for 2019, Year 3. **Comments to the proposed rule are due September 10, 2018. The Final Rule will be issued on or around November 25, 2018 with an effective date of January 1, 2019.**

The proposed conversion factor for 2019 is $36.05. This reflects the 0.25 percent update adjustment factor specified under the Bipartisan Budget Act of 2018 and a budget neutrality adjustments of -0.12 percent. This is a slight increase over the 2018 PFS conversion factor of $35.99. Within the proposed rule, CMS proposes modifications to pricing for Direct Practice Expense Inputs for supplies and equipment, as well as a new coding and valuation system for Evaluation and Management Codes that result in rate reductions across services. **Overall, the proposed rule estimated impact to radiation oncologists and radiation therapy centers is -2%.**

Practice Expense (PE): Market-Based Supply and Equipment Pricing Update

CMS is proposing to adopt updated PFS direct practice expense (PE) input prices for supplies and equipment developed by an outside contractor. CMS is proposing to phase in use of the new direct PE input pricing of equipment over a 4-year period beginning in 2019 in order to lessen the impact of the new reduced equipment prices which will lead to significantly reduced reimbursement. The final updated prices and payments will be fully transitioned by CY 2022. The recommended price changes impact more than 1,300 supplies and 750 equipment items, including several radiation oncology equipment items. As a result of legislation passed at the end of 2017, payment rates for conventional and IMRT treatment delivery payments remain at their current rates through CY 2019, and, therefore, intensity-modulated radiation therapy (IMRT) and 3DCRT payments should not be affected by this policy in CY 2019. The legislation passed at the end of 2017 does not apply to stereotactic body radiation therapy (SBRT) and stereotactic radiosurgery (SRS) treatment delivery codes. As a result of the outside contractor's recommendations, CMS is proposing to decrease the equipment price of the SBRT system from $4,000,000 to $931,965. This is causing a significant reduction in the SBRT treatment delivery code. This is likely due to some confusion and misinformation gathered from outside sources, so Varian will be working on a strategy with stakeholders to better educate CMS on the equipment prices of our devices to mitigate inappropriate price reductions in radiotherapy codes as a result of this policy. It is important to note that this proposed policy change does not directly affect the payment rate for the SBRT G-codes, which are locally carrier priced, billed by many providers utilizing appropriate Varian devices.

[1] Proposed payment rules can be found at https://www.cms.gov/Medicare/Medicare.html

Site of Service/ Off-Campus Provider-Based Hospitals Departments

As a result the Bipartisan Budget Act (BBA) of 2015, CMS no longer reimburses for certain items and services, including radiotherapy, furnished by certain off-campus hospital outpatient provider-based departments under the Hospital Outpatient Prospective Payment System (OPPS) unless the new hospital outpatient provider is within 300 yards of the main hospital campus. Instead, since CY 2017 payment for these items and services have been made under the PFS using a PFS relativity adjuster based on a percentage of the OPPS payment rate. CMS is proposing to maintain the payment rate for non-excepted off-campus provider-based hospital departments at 40 percent of the Physician Fee Schedule. This proposal does not impact providers that were billing under the Hospital Outpatient Prospective Payment System prior to enactment of BBA.

Quality Payment Program

The proposed rule also establishes update to the Quality Payment Program for 2019, Year 3. For the 2019 performance period (payment in 2021), CMS proposes modifications to three of the MIPS performance categories: Quality, Cost, and Improvement Activities. In addition to renaming the "Advancing Care Information" to "Promoting Interoperability" performance category, CMS proposes a new scoring methodology based on a combination of measures instead of the current base, performance and bonus score methodology. For the 2019 performance year final score, CMS proposes the following weights: 45 percent for quality, 15 percent for cost, 15 percent for improvement activities, and 25 percent for improving interoperability.

Below are total estimated reimbursement payments by course of care based on our preliminary analysis.

Estimated MPFS Per Course National Average Medicare Reimbursement									
Modality	2018 Final Professional Medicare Payment	2018 Final Technical Medicare Payment	2018 Final Global Medicare Payment	2019 Proposed Professional Medicare Payment	2019 Proposed Technical Medicare Payment	2019 Proposed Global Medicare Payment	Professional % Change 2018 Final - 2019 Proposed Rule	Technical % Change 2018 Final - 2019 Proposed Rule	Global % Change 2018 Final - 2019 Proposed Rule
2D (10 fractions)	$1,089	$3,988	$5,077	$1,140	$3,859	$4,999	5%	-3%	-2%
3D with IGRT (35 fractions)	$3,247	$13,517	$16,765	$3,200	$13,091	$16,291	-1%	-3%	-3%
3D without IGRT (35 fractions)	$2,591	$12,059	$14,650	$2,542	$11,679	$14,221	-2%	-3%	-3%
IMRT (35 fractions)	$3,327	$17,295	$20,622	$3,279	$17,184	$20,463	-1%	-1%	-1%
SRS	$1,431	$2,329	$3,759	$1,388	$2,250	$3,638	-3%	-3%	-3%
SBRT (3 fractions)	$1,649	$5,606	$7,255	$1,606	$4,778	$6,385	-3%	-15%	-12%
SBRT (5 fractions)	$1,649	$8,324	$9,973	$1,606	$6,977	$8,584	-3%	-16%	-14%
APBI HDR	$3,014	$7,340	$10,354	$2,959	$7,078	$10,037	-2%	-4%	-3%
Prostate HDR	$3,950	$2,659	$6,608	$3,871	$2,538	$6,409	-2%	-5%	-3%
GYN tandem and ovoid HDR	$2,254	$3,386	$5,640	$2,215	$3,288	$5,504	-2%	-3%	-2%
Skin HDR (2 cm lesion)	$674	$1,277	$1,951	$636	$1,260	$1,896	-6%	-1%	-3%

Conversion Factor(CF) used to calculate payment rates is 35.9996 for CY 2018 final rates and 36.0463 for CY 2019 proposed rates.

MEDICARE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

CMS issued the proposed rule for the Medicare Hospital Outpatient Prospective Payment System (OPPS) for CY 2019 on July 25, 2018. The proposed rule updates OPPS payment policies that apply to outpatient services provided to Medicare beneficiaries by general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals, as well as for partial hospitalization services in community mental health centers (CMHCs). **Comments to the proposed rule are due September 24, 2018. The Final Rule will be issued on or around November 25, 2018 with an effective date of January 1, 2019.**

CMS proposes to update and increase overall hospital payment rates by 1.25 percent for 2019. This update is based on the projected hospital market basket increase of 2.8 percent minus both a 0.8 percentage point adjustment for multi-factor productivity (MFP) and a 0.75 percentage point adjustment required by law. The increase of this rate update is largely offset by the proposal to pay for visits at certain off-campus hospital outpatient provider-based departments (PBDs) at the freestanding center equivalent rate, which is projected to reduce hospital payments by 1.2 percent. However, our initial analysis shows a 1-3% increase in typical radiotherapy course of treatment.

Site of Service/ Off-Campus Provider-Based Hospitals Departments

CMS is proposing to reduce hospital outpatient department spending with an expansion of existing site neutrality policies. As a result the Bipartisan Budget Act of 2015, CMS no longer reimburses for certain items and services, including radiotherapy, furnished by certain off-campus hospital outpatient provider-based departments (PBD) under the Hospital Outpatient Prospective Payment System (OPPS) unless the new hospital outpatient provider is within 300 yards of the main hospital campus. Instead, since CY 2017, payment for these items and services have been made under the Medicare Physician Fee Schedule (PFS) based on a percentage of the OPPS payment rate. CMS is proposing to pay for certain new services, that were not provided at the excepted off-campus PBD prior to the date of the enactment of the Bipartisan Budget Act of 2015, including radiotherapy services, under the PFS instead of the OPPS after reevaluating the policy from CY 2017 OPPS rulemaking. CMS does not believe it was congressional intent to allow hospital based off-campus providers to be paid higher rates for types of services they were not performing prior to enactment of the law. This proposed change in policy could affect radiotherapy payments for certain hospital based providers who may have acquired new services since 2015.

Proton Therapy

CMS did not propose changes to proton payment policy, however, CMS is proposing an increase in payment rates. Hospital outpatient department payment rates are set based on cost report data reported by hospitals billing two years prior. As a reminder, many of Varian's proton facilities negotiate rates individually with the Medicare carriers since they bill as freestanding facilities and are not subject to these rates.

CPT® Code	CPT Code Descriptor	APC Group	2018 Final Medicare Rate	2019 Proposed Medicare Rate	% Change 2018 Final-2019 Proposed
77520	Proton treatment simple without compensation	5623	$522	$530	1.6%
77522	Proton treatment simple with compensation	5625	$1,053	$1,081	2.7%
77523	Proton treatment intermediate	5625	$1,053	$1,081	2.7%
77525	Proton treatment complex	5625	$1,053	$1,081	2.7%

Below are total estimated reimbursement payments by course of care based on our preliminary analysis.

ESTIMATED OPPS PER COURSE NATIONAL AVERAGE MEDICARE REIMBURSEMENT			
Modality	2018 Final Payment	2019 Proposed Payment	% Change 2018 Final-2019 Proposed Payment
2D (10 fractions)	$4,303	$4,398	2%
3D (With or without IGRT, 35 fractions)	$12,634	$12,941	2%
IMRT (Simple or complex, 35 fractions)	$21,229	$21,549	2%
SRS (Comprehensive APC)	$9,200	$9,446	3%
SBRT (3 fractions)	$8,376	$8,495	1%
SBRT (5 fractions)	$11,730	$11,900	1%
Proton (25 fractions)	$29,358	$30,086	2%
Prostate HDR (3 fractions)	$12,001	$12,198	2%
GYN tandem and ovoid HDR (3 fractions)	$7,702	$7,968	3%
Skin HDR (10 fractions)	$7,606	$7,648	1%

The information provided herein has been gathered from third-party sources which include, but are not limited to government and commercially available coding guides, professional societies and research conducted by coding and reimbursement consultants, and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules and policies. This information should not be construed as authoritative and is presented for illustrative and informational purposes only. It does not constitute either reimbursement or legal advice. The entity billing Medicare, other government programs and/or third-party payers is solely responsible for determining medical necessity, the proper site for delivery of any services and to submit accurate and appropriate codes, charges, and modifiers for services that are rendered and reflected in a patient's medical record. Varian does not have access to medical records, and therefore cannot recommend codes for specific cases. Varian recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters. Varian's products have been cleared for use by the FDA as set forth in our Instructions for Use and nothing in this document should be construed as promoting any use outside of those instructions.

Intended Use Summary

Varian Medical Systems' linear accelerators are intended to provide stereotactic radiosurgery and precision radiotherapy for lesions, tumors, and conditions anywhere in the body where radiation treatment is indicated.

Safety Statement

Radiation treatments may cause side effects that can vary depending on the part of the body being treated. The most frequent ones are typically temporary and may include, but are not limited to, irritation to the respiratory, digestive, urinary or reproductive systems, fatigue, nausea, skin irritation, and hair loss. In some patients, they can be severe. Treatment sessions may vary in complexity and time. Radiation treatment is not appropriate for all cancers.

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