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Reimbursement Bulletin

Summary of 2019 Final Medicare Payment Rules

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

On November 1 and 2, 2018, the Centers for Medicare and Medicaid Services (CMS) issued the final payment rules for both the Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Physician Fee Schedule (PFS). Below is an analysis of the key provisions of the final rules and estimated payment changes for specific radiation therapy codes and typical courses of treatment.

2019 MEDICARE PHYSICIAN FEE SCHEDULE (PHYSICIANS AND FREESTANDING CENTERS)

The Medicare Physician Fee Schedule final rule updates Physician Fee Schedule (PFS) payment policies that apply to services furnished in all sites by physicians and other practitioners, in addition to other entities like freestanding radiation therapy centers. The PFS final conversion factor for 2019 is $36.0391. This reflects the 0.25 percent update adjustment factor specified under the Bipartisan Budget Act of 2018 and a budget neutrality adjustment of -0.14 percent. This is a slight increase over the 2018 PFS conversion factor of $35.9996. Overall, the final rule impact to radiation oncologists and radiation therapy center payments is -1%. Below are some highlights from the final rule along with an estimate of total reimbursement per course of care.

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

The PFS proposed rule included a proposal to modify how CMS calculates the cost of medical equipment and supplies to set payment rates. CMS proposed to update PFS direct practice expense (PE) input prices for approximately 1,300 supplies and 750 pieces of equipment following recommendations developed by an outside contractor. The supply and equipment prices were last systematically developed in 2004-2005. Three radiotherapy devices, in particular, were identified for significant reductions: The stereotactic body radiation therapy (SBRT) system, HDR afterload system, and intensity-modulated radiation therapy (IMRT) treatment planning system. As a result of the proposed reductions, Varian worked with other vendors through AdvaMed, the medical device trade association, to have an outside firm collect invoices from three manufacturers and recommend more appropriate pricing for the three pieces of equipment. Varian also met with CMS to provide invoices and express concern that the proposed prices did not accurately reflect, particularly in the case of the SBRT device, the cost of the complete device.

CMS is finalizing their proposal to update the prices of identified equipment and supplies with slight modifications. For all three radiotherapy devices, CMS is finalizing slight increases to the proposed equipment price reductions. CMS will be phasing the reductions of pricing in over a four-year period beginning in 2019 to lessen the impact of the new reduced equipment prices which will lead to reduced reimbursement. In the case of the SBRT device, due to the error in pricing the linac used to perform SBRT, the SBRT treatment delivery code was proposed to receive a reduction of 18%. While still not optimal, CMS is today finalizing only a 7% reduction in the SBRT treatment delivery code after revising the proposed pricing data. Varian will continue to work with CMS to ensure that accurate data is being considered in equipment pricing updates. The below chart shows the previous, proposed, recommended, and final prices for all three devices.

Equipment	CY 2018 Input Price	Proposed CY 2022 Input Price	Median Price Based on Submitted Invoices	Final CY 2022 Price
SBRT system	$4,000,000.00	$931,965.48	$4,081,731.43	$2,973,721.836
HDR afterload system	$375,000.00	$111,425.88	$256,413.03	$132,574.780
Treatment planning system, IMRT	$350,545.00	$157,392.84	$281,869.38	$197,247.000

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

As a result of enactment of 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 has been made under the Physician Fee Schedule (PFS) using a PFS relativity adjuster based on a percentage of the OPPS payment rate. CMS finalized their proposal to maintain the payment rate for non-excepted off-campus provider-based hospital departments at 40% of the Physician Fee Schedule. This provision does not impact providers that were billing under the Hospital Outpatient Prospective Payment System prior to enactment of the BBA.

Potential Alternative Payment Model for Radiation Therapy

Due to the Patient Access and Medicare Protection Act (PAMPA) enacted at the end of 2017, payment rates for conventional and IMRT treatment delivery payments remain frozen at their current rates through CY 2019. PAMPA also required the Secretary of Health and Human Services to submit to Congress a report on the development of an episodic alternative payment model (APM) for payment under the Medicare program for radiation therapy (RT) services. In the Report to Congress, delivered in November 2017, CMS discussed the current status of RT services and payment, and reviewed model design considerations for a potential APM for RT services. The review of the applicable evidence in the Report to Congress demonstrated that episode payment models could be a tool for improving care and reducing expenditures. In the final rule, CMS briefly acknowledges that they believe that radiation oncology is a promising area of health care for bundled payments, in part, based on the findings in the Report to Congress. CMS goes on to say that the CMS Innovation Center will continue to use public information regarding commercial initiatives, as well as stakeholder feedback to help inform the development, implementation, and refinement of design and testing of a potential model that tests payment for RT services.

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

MPFS PER COURSE NATIONAL AVERAGE REIMBURSEMENT									
Modality	2018 Final Professional Payment	2018 Final Technical Payment	2018 Final Global Payment	2019 Final Professional Payment	2019 Final Technical Payment	2019 Final Global Payment	Professional % Change 2018 Final - 2019 Final Rule	Technical % Change 2018 Final - 2019 Final Rule	Global % Change 2018 Final - 2019 Final Rule
2D (10 fractions)	$1,089	$3,988	$5,077	$1,101	$3,873	$4,974	1%	-3%	-2%
3D with IGRT (25 fractions)	$2,656	$10,029	$12,685	$2,686	$9,753	$12,438	1%	-3%	-2%
3D without IGRT (25 fractions)	$2,209	$9,146	$11,355	$2,230	$8,893	$11,124	1%	-3%	-2%
IMRT (30 fractions)	$3,594	$15,578	$19,173	$3,629	$15,617	$19,246	1%	0%	0%
SRS*	$1,431	$2,329	$3,759	$1,442	$2,260	$3,701	1%	-3%	-2%
SBRT (3 fractions)*	$1,649	$5,606	$7,255	$1,662	$5,255	$6,917	1%	-6%	-5%
SBRT (5 fractions)*	$1,649	$8,324	$9,973	$1,662	$7,767	$9,429	1%	-7%	-5%
APBI HDR	$3,014	$7,340	$10,354	$3,045	$7,178	$10,223	1%	-2%	-1%
Prostate HDR	$3,950	$2,659	$6,608	$3,965	$2,581	$6,545	0%	-3%	-1%
GYN tandem and ovoid HDR	$2,254	$3,386	$5,640	$2,277	$3,336	$5,613	1%	-1%	0%
Skin HDR (2 cm lesion)	$674	$1,277	$1,951	$678	$1,268	$1,946	1%	-1%	0%

Conversion Factor(CF) used to calculate payment rates is 35.9996 for CY 2018 final rates and 36.0391 for CY 2019 final rates.
Number of fractions assumed for 3D, IMRT, SRS, SBRT, and Proton courses of care are in line with assumptions made by the Advisory Board in years past. 2D and HDR courses codes as per education from billing and coding seminars.

* Payments calculated using 77372 and 77373, since G0339 and G0340 are carrier priced and there are no national average rates available.

2019 MEDICARE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

In the Medicare Hospital Outpatient Prospective Payment System final rule, CMS finalized policies to update and increase overall hospital payment rates by 1.35 percent for 2019. This is consistent with our initial analysis showing about a 1% increase in typical radiotherapy treatments overall. Below are some highlights along with a preliminary estimate of total reimbursement per course of care.

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

CMS did not finalize a proposal to reduce hospital outpatient department spending with an expansion of existing site neutrality policies. As a result of enactment of 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 (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 has been made under the Medicare Physician Fee Schedule (PFS) based on a percentage of the OPPS payment rate. CMS proposed to pay for certain new services, that were not provided at the excepted off-campus PBD before 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 did not move forward with this new policy which could have negatively affected radiotherapy payments for certain hospital-based providers who may have acquired new services since 2015.

Applying 340B Drug Payment Policy to Off-Campus Provider-Based Departments

CMS finalized a proposal to expand last year's cuts to 340B drug discounts given to outpatient facilities. Last year, the agency cut 340B drug payments by $1.6 billion, or 22.5% less than the average sales price. CMS is expanding the 340B cut to off-campus provider-based departments to prevent hospitals from moving their drug administration services for 340B-acquired drugs to an off-campus facility to receive a higher payment amount for these drugs.

Proton Therapy

CMS did not make changes to proton payment policy; however, CMS finalized 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.

CPT® Code	CPT Code Descriptor	APC Group	2018 Final Rate	2019 Final Rate	% Change 2018 Final-2019 Final
77520	Proton treatment simple without compensation	5623	$522	$520	-0.4%
77522	Proton treatment simple with compensation	5625	$1,053	$1,079	2.5%
77523	Proton treatment intermediate	5625	$1,053	$1,079	2.5%
77525	Proton treatment complex	5625	$1,053	$1,079	2.5%

Below are the total estimated reimbursement payment by course of care based on our analysis.

OPPS ESTIMATED PER COURSE NATIONAL AVERAGE REIMBURSEMENT			
Modality	2018 Final Payment	2019 Final Payment	% Change 2018 Final-2019 Final Payment
2D (10 fractions)	$4,303	$4,341	1%
3D (25 fractions)	$10,185	$10,286	1%
IMRT (30 fractions)	$18,492	$18,413	0%
SRS (Comprehensive APC)	$9,200	$9,282	1%
SBRT (3 fractions)	$8,376	$8,409	0%
SBRT (5 fractions)	$11,730	$11,791	1%
Proton (25 fractions)	$29,358	$29,990	2%
Prostate HDR (3 fractions)	$12,001	$12,934	8%
GYN tandem and ovoid HDR (3 fractions)	$7,702	$7,956	3%
Skin HDR (10 fractions)	$7,606	$7,595	0%

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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