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Oncology

Coding Update 2017

Oncology Reimbursement Meetings

Coding Strategies® provides exceptional consulting and educational services designed to improve compliance and ensure appropriate reimbursement for the financial health of your business.

2017 CODE UPDATES

Each year there are new codes, revised codes and updates to coding guidelines. For calendar year 2017, a new procedure code has been created for the application of an on-body injector:

Code	Description
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection

According to code definition, this code differs from code 96372 (therapeutic subcutaneous or intramuscular injection) because it describes the work of preparing and applying the on-body injector, rather than the manual injection of a drug. 96377 bundles into:

Code	Description
96360	IV infusion, hydration, initial" 31 minutes to 1 hour
96365	IV infusion, for therapy, prophylaxis, diagnosis; initial up to 1 hour
96369	SQ infusion for therapy, prophylaxis; initial up to 1 hour
96374	Therapeutic, prophylactic, diagnostic injection; IV push single or initial
96401	Chemotherapy administration, SubQ or IM; non-hormonal antineoplastic
96402	Chemotherapy administration, SubQ or IM; hormonal antineoplastic
96409	Chemotherapy administration; IV push technique, single or initial
96413	Chemotherapy administration; IV infusion, up to 1 hour, single or initial
96416	Chemotherapy administration; IV infusion, prolonged infusion
96420	Chemotherapy administration, intra-arterial; push
96422	Chemotherapy administration, intra-arterial; infusion
96525	Chemotherapy administration, intra-arterial; prolonged infusion
96440	Chemotherapy administration into pleural cavity, requires thoracentesis
96446	Chemotherapy administration into peritoneal cavity via port or catheter
96450	Chemotherapy administration into CNS, includes spinal puncture
96542	Chemotherapy administration, subarachnoid or intraventricular

Procedure code 96377 also bundles into the codes for observation, discharge, emergency department, critical care and nursing home visits.

Procedure code 96377 is mutually exclusive to new patient visits, consultations and established patient visits.

Make certain to follow your local payor guidelines when submitting this code!

Biodegradable Material

Effective June 30, 2016, the following HCPCS Level II code was deleted:

Code	Descriptor
C9743	Injection/implantation of bulking or spacer material (any type) with or without imaging guidance (not to be used if a more specific code applies)

Code C9743 was replaced with a Category III CPT® code, effective July 1, 2016:

Code	Descriptor
0438T	Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance

This new code will be reported by the hospital for the technical service and by the physician for the professional service. Remember that Category III temporary procedure codes may not be reimbursed by all insurers, so check local payor policies for coverage.

Spacer material separates the anterior rectal wall from the prostate by injecting an absorbable hydrogel or saline filled balloon. The goal of utilizing spacer material is to reduce the radiation dose to the rectum. These materials generally maintain shape and position during treatment, and then degrade or break down within 6 months after implantation, after treatment has completed.

Smoking and Tobacco Use Cessation

According to CMS, effective September 30, 2016, HCPCS codes G0436 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and G0437 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) are deleted. The services previously represented by HCPCS codes G0436 and G0437 should be billed under existing CPT® codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) respectively.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9768.pdf

Mobility Assistance/Care Management

There are new HCPCS codes that will be reported for patients that use special mobility equipment or comprehensive care planning:

Code	Descriptor
G0501	Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service)

Code	Descriptor
G0506	Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service)
S0311	Comprehensive management and care coordination for advanced illness, per calendar month

Comprehensive Care Management Definition: The health care professional takes responsibility for the beneficiary's comprehensive care (ALL medical conditions):

- The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making
- Review need for or follow-up on pending diagnostic tests and treatments
- Establish or re-establish referrals, interact and coordinate with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems
- Identify available community and health resources; communicate with/assist scheduling services
- Assist the beneficiary and/or family in accessing needed care and services
- Assess and support treatment regimen adherence and medication management (all conditions)
- Provide education to the beneficiary, family, guardian, and/or caregiver

https://www.federalregister.gov/documents/2016/11/15/2016-26668/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

Additional new HCPCS Level II modifiers include:

Modifier	Description
FX	X-ray taken using film
Q2	Demonstration procedure/service*
V1	Demonstration modifier 1
V2	Demonstration modifier 2
V3	Demonstration modifier 3
ZB	Pfizer/Hospira

* Existing modifier with revised definition.

Biosimilar Products

A biosimilar product has no clinically meaningful differences from a previously-approved reference product, only minor differences in clinically inactive components. The Centers for Medicare & Medicaid Services (CMS) updates coding and billing information under the Outpatient Prospective Payment System (OPPS) on a quarterly basis. The information effective July 1, 2016 included a reminder that OPPS claims for separately paid biosimilar biological products are required to include a modifier that identifies the manufacturer of the product. Current biosimilars codes and modifiers include:

HCPCS Code	Descriptor	SI	APC	Effective Date	Modifier
Q5101	Injection, filgrastim (G-CSF), biosimilar, 1 mcg	G	1822	03/06/2015	ZA – Novartis/Sandoz
Q5102	Injection, infliximab, biosimilar, 10 mg	K	1847	04/01/2016	ZB – Pfizer/Hospira

***CPT® Assistant,* October 2016**

Q: Is it appropriate to report code 77290, *Therapeutic radiology simulation-aided field setting; complex*, for "computer-aided simulation" or "virtual simulation" without a new data set or without a patient present?

A: No, unless another data set is acquired, it is not appropriate to bill another simulation charge. The CPT® definition of simulation states that "simulation is the process of defining relevant normal and abnormal target anatomy, and acquiring the images and data necessary to develop the optimal radiation treatment process for the patient." CPT® -defined simulation codes assume the use of a computed tomography (CT) data set for defining relevant normal and abnormal anatomy. Virtual simulation is an obsolete term used during a time when simulation was performed using radiographic or fluoroscopic-simulation system augmented by a CT data set.

2017 OIG Work Plan

Intensity-Modulated Radiation Therapy

Intensity-modulated radiation therapy (IMRT) is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor. IMRT is provided in two treatment phases: planning and delivery. Certain services should not be billed when they are performed as part of developing an IMRT plan. Prior OIG reviews identified hospitals that incorrectly billed for IMRT services. We will review Medicare outpatient payments for IMRT to determine whether the payments were made in accordance with Federal requirements.

http://oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016.pdf

National Correct Coding Initiative Policy Manual Updates

The 2017 edition of the NCCI Policy Manual includes the following instruction:

> CPT® codes 77280-77290 (simulation-aided field settings) should not be reported for verification of the treatment field during a course of intensity modulated radiotherapy (IMRT) treatment.

This policy is effective January 1, 2017 and will impact physicians, freestanding radiation treatment centers and hospital outpatient departments. An additional manual update states:

> MUE and NCCI PTP [procedure-to-procedure] edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians should not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/

2017 Estimated Impact Table

Since 1992, Medicare has paid for the services of physicians, nonphysician practitioners and certain other suppliers under the Medicare Physician Fee Schedule (MPFS). For reimbursement purposes, relative values are assigned to more than 7000 services to reflect the amount of work, the direct and indirect (overhead) practice expenses and the malpractice expenses typically involved in furnishing that specific service. After applying a geographic practice cost indicator, the resulting relative value units (RVUs) are summed for each service and multiplied by a fixed-dollar conversion factor to establish the payment amount for each visit or procedure. The calendar year 2017 conversion factor (CF) is estimated to be $35.8887, which is slightly higher than the 2016 conversion factor of $35.8043.

Primary Care

Historically, care management and cognitive work has been bundled into the evaluation and management visit codes used by all specialties. This has mean that payment for these services has been distributed equally among all specialties that report visit codes, instead of being targeted toward practitioners who manage care or primarily provide cognitive services. CMS believes the focus of the health care system has shifted to delivery system reforms, such as patient-centered medical homes, clinical practice improvement, and increased investment in primary and comprehensive care management/coordination services for chronic and other conditions. This shift requires more centralized management of patient needs and extensive care coordination among practitioners and providers, often on a non-face-to-face basis across an extended period of time.

For CY 2017, CMS finalized a variety of coding and payment changes as part of an ongoing effort to improve payment for primary care services. These updates include separate payment for codes describing non-face-to-face prolonged evaluation and management services, revalue existing procedure codes describing prolonged face-to-face services, make separate reimbursement for new codes that describe comprehensive assessment and care planning for patients with cognitive impairment, mobility-related impairment and patients with behavioral health conditions. Last, CMS will make separate payments for codes describing chronic care management for patients with greater complexity (refer to HCPCS codes G0501 and G0506).

CMS believes that these coding and payment changes will improve health care delivery for the types of services holding the most promise for healthier people and smarter spending and advance CMS's health equity goals.

The Estimated Impact Table that projects payment increases or decreases by specialty (without considering the potential conversion factor change) includes:

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Hematology/Oncology	$1,751	0%	0%	0%	0%
Radiation Oncology	$1,726	0%	0%	0%	0%
Radiation Therapy Centers	$44	0%	0%	0%	0%

Telehealth Services

CMS finalized the addition of ESRD-related services, advance care planning services and critical care consultation codes to the current telehealth services list. CMS states that although it expects these changes to increase access to care in rural areas, based on recent utilization of similar services already on the telehealth list there will not be a significant impact on PFS expenditures.

CMS also finalized a payment policy regarding the use of a new place of service code (02 – Telehealth), with telehealth defined as the location where health services and health related services are provided or received, through telecommunications technology. Of note, the originating site will not use this place of service code. In addition, place of service code 02 will be used in addition to, not instead of, modifiers GT (Via interactive audio and video telecommunications) and GQ (Via asynchronous telecommunications system).

Phase-In of Significant RVU Reductions

The Protecting Access to Medicare Act of 2014 (PAMA) specified that if the total RVUs for a service would otherwise be decreased by an estimated amount equal to or greater than 20 percent, the adjustments must be phased-in over a two-year period. This requirement applies only to services described by existing codes and not to services described by new or existing codes.

In the 2017 MPFS final rule, CMS finalized the proposal to reconsider in each year whether the total RVUs for the service would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year. Under this policy the 19 percent reduction in total RVUs would continue to be the maximum one-year reduction for all codes (except those considered new or revised), including those codes with phase-in values in the previous year. CMS identified several radiation oncology codes with significant RVU reductions in 2017.

CMS identified procedure code 77470 through the high expenditures by specialty screen, and proposed the RUC-recommended work RVU of 2.03. However, according to CMS the description of service and vignette describe different and unrelated treatments being performed by the physician and clinical staff for a typical patient, and this presents a disparity between the work RVUs and PE RVUs. CMS solicited comments on information that would clarify this apparent disparity to help determine appropriate practice expense (PE) inputs. In addition, they solicited comments to determine if creating two HCPCS G-codes, one that describes the work portion of this service and one that describes the practice expense portion, may be a potentially more accurate method of valuing and paying for the service or services described by this code. In the Final Rule CMS states:

> According to the description of work provided for this service, the physician performs cognitive work such as planning, consideration of test results, and therapeutic treatment contingency planning that is in addition to what he or she would typically be performing for most radiation treatments. Meanwhile, the radiation therapist handles the treatment devices, performs tasks such as positioning the patient, and helps facilitate the scan of the patient. We believe that this may describe activities that are fundamentally disconnected. To illustrate our concern, we offer the example that this is akin to a physician removing a mole from a patient's hand while the clinical staff places a cast on the patient's foot; we see no compelling clinical evidence to indicate that the two tasks are related. In addition, the disparate diagnoses described by the vignettes further calls into question the degree to which the work and PE components are interrelated. While we agree that there should not separate coding for each possible diagnosis for a particular service,

in trying to accurately assess relative value, we believe that the work and PE components should be valued under unified assumptions about the typical service. We are finalizing the RUC-recommended work RVU and PE inputs as proposed; however, we continue to have serious concerns about the validity of this coding.

Linear Accelerator Utilization

CMS will use a 60 percent utilization rate assumption for CY 2016 and a 70 percent utilization rate assumption for CY 2017. CMS continues to seek evidence to verify the usage assumptions.

Global Surgical Period

Since the inception of the MPFS, CMS has valued and paid for certain services, such as surgery, as part of global packages that include the procedure and the services typically provided during the period immediately before and after the procedure. There are 3 primary categories of global packages defined based on the number of post-operative days included in the global period: 0-day, 10-day and 90-day.

In the calendar year 2015 final rule with comment period, CMS finalized the proposal to transition and revalue all 10- and 90-day global surgery services with 0-day global periods, beginning with the 10-day global services in CY 2017 and following with the 90-day global services in CY 2018. However, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was enacted into law on April 16, 2015 and included a paragraph that prohibits CMS from implementing this global surgery policy change. This same Act requires CMS to develop, through rulemaking, a process to gather information needed to value surgical services and requires that this data collection shall begin no later than January 1, 2017.

As part of the 2017 final rule, CMS set forth guidelines for data collection regarding resources used when furnishing global services. The claim-based collection strategy reduces the burden on practitioners by requiring reporting only on high-volume/high-cost procedures, using an existing procedure code (99024, Postoperative follow-up visit, normally included in the surgical package), allowing some provider groups to report voluntarily while mandating larger practices in designated states to comply with reporting. Practitioners are encouraged to begin reporting post-operative visits for procedures furnished on or after January 1, 2017, but the requirement to report will be effective for services related to global procedures furnished on or after July 1, 2017.

In mid-2017 CMS will also survey a large national sample of about 5,000 practitioners. Individuals in this group will be asked to describe 20 postoperative visits furnished to Medicare patients or other patients during the reporting period. Information to be collected includes procedure codes and dates of service for the global procedure, place of service, procedural complications, level of the visit using existing codes, specific activities on the day of the visit, total time, practice expense items and other prior or anticipated care. CMS will also send monitors to a small number of sites for direct observation, as well as survey Accountable Care Organizations (both Pioneer and Next Generation) about their global services.

CMS has statutory authority to withhold up to 5% of the practitioner's Medicare payment for noncompliance with required reporting. The Agency does not plan to use this authority in 2017, but will consider using it in future years if claims-based reporting is not acceptable. At this time, the list of procedures that must be reported is not available; CMS will determine the codes for which reporting is required and display the list on the CMS website. Last, if the aggregated data result in proposals to revalue any global packages, that revaluation will be done through notice and comment rulemaking at a future time.

Moderate Sedation

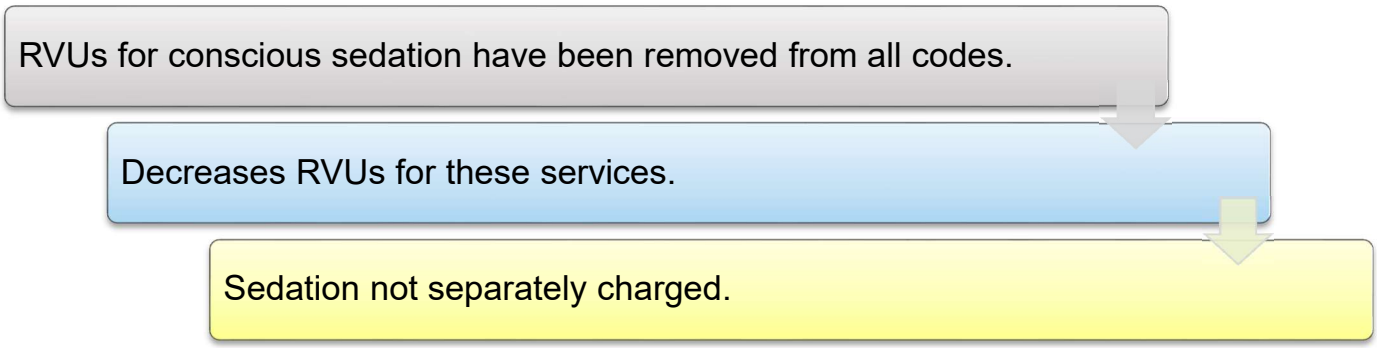
The 2016 codes for moderation sedation were deleted, and replaced with these redefined codes:

Code	Description
99151	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 intraservice time, patient younger than 5 years of age
99152	patient age 5 years or older
+99153	each additional 15 minutes intraservice time (List separately in addition to code for primary service)
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 intraservice time, patient younger than 5 years of age
99156	patient age 5 years or older
+99157	each additional 15 minutes intraservice time (List separately in addition to code for primary service)

In addition, moderate sedation has been deleted by definition for a number of surgical and procedure codes in the *CPT® Manual*. This means that sedation will not be coded and charged separately for an increasing number of services. In addition to the CPT® procedure codes for moderate sedation, there is a new HCPCS code for gastrointestinal endoscopic services:

Code	Description
G0500	Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service (excluding biliary procedures) 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 intraservice time, patient age 5 years or older

As part of this final rule, CMS is finalizing values for the new moderate sedation codes and adopting a uniform methodology for valuation of the procedural codes that currently include moderate sedation as an inherent part of the procedure.



Following is a list of codes related to oncology services that will be impacted by these changes:

Code	Description
19298	Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time or subsequent to) partial mastectomy, includes imaging guidance
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple
32553	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intrathoracic, single or multiple
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (e.g., anesthetic, neurolytic agent) or fiducial marker(s) (including endoscopic ultrasound examination of the esophagus, stomach and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
49411	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple
49418	Insertion of tunneled intraperitoneal catheter (e.g., dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session, multi-source Cobalt 60 based
77600	Hyperthermia, externally generated; superficial (i.e., heating to a depth of 4 cm or less)
77605	Hyperthermia, externally generated; deep (i.e., heating to depths greater than 4 cm)
77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators
77615	Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators
0301T	Destruction of malignant breast tumor with externally applied focused microwave, including interstitial placement of disposable catheter with combined temperature monitoring probe and microwave focusing sensocatheter and ultrasound thermotherapy guidance

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The Protecting Access to Medicare Act of 2014 (PAMA) requires CMS to establish a program to promote utilization of appropriate use criteria (AUC) for advanced diagnostic imaging services. Advanced diagnostic imaging services include diagnostic imaging exams performed using CT, MR, and nuclear medicine (including PET). AUC are criteria that help professionals who order and furnish imaging services to make the most appropriate treatment decision for a specific clinical condition for an individual patient. CMS can only approve AUC that are developed or endorsed by provider-led entities (PLEs) such as national professional medical specialty societies. In most cases the AUC will be evidence-based and CMS can approve more than one set of AUC for a given imaging service.

The 2017 MPFS final rule lists the first eight priority clinical areas for the AUC:

- Coronary artery disease (suspected or diagnosed)
- Suspected pulmonary embolism
- Headache (traumatic and non-traumatic)
- Hip pain
- Low back pain
- Shoulder pain (to include suspected rotator cuff injury
- Cancer of the lung (primary or metastatic, suspected or diagnosed)
- Cervical or neck pain

Ordering professionals will be required to consult AUC for all advanced imaging services, not just those in priority clinical areas, as long as the service is furnished in an applicable setting such as office or outpatient hospital and paid under an applicable payment system like the MPFS or OPPS. However, the priority clinical areas will be used to identify outlier ordering professionals in the future.

Medicare will initially pay for the imaging study regardless of whether it was recommended by the AUC. Eventually, however, CMS will identify those ordering professionals who are consistently failing to follow AUC recommendations, and these "outliers" will be required to obtain prior authorization for advanced imaging studies they wish to order. CMS will address outlier calculations, which may be used to determine whether clinicians will be subject to prior authorization.

The final rule also addressed the clinical decision support mechanism (CDSM) requirements, stating that CDSMs are "electronic tools through which a clinician consults AUC to determine the level of clinical appropriateness for an advanced diagnostic imaging service for that particular patient's clinical scenario." CMS finalized the CDSM application to allow for preliminary qualification or full qualification based on whether the applicant can demonstrate that all requirements are met at the time of application. The application deadline for the first round of preliminary and full qualifying CDSMs is March 1, 2017.

The first list of qualified CDSMs will be posted no later than June 30, 2017 and CMS expects furnishing professionals to be required to begin reporting on January 1, 2018. In addition, CMS is considering the mechanisms for appending the AUC consultation information to the Medicare claim and will issue that information as part of the 2018 rulemaking. Among the mechanisms CMS is considering are the use of HCPCS G codes and HCPCS modifiers. Current exceptions to the use of AUC include:

- Patients with emergency medical conditions (including situations where such a condition is suspected but not yet confirmed)
- Inpatients (the Inpatient Prospective Payment System is not an applicable payment system)
- The ordering professional has a hardship exception, such as practicing in a rural area without sufficient Internet access

CMS recognizes that the number of clinicians impacted by the scope of this program is massive as it will apply to every physician or other practitioner who orders or furnishes applicable imaging services. This crosses almost every medical specialty and could have a particular impact on primary care physicians since their scope of practice can be quite broad.

Qualified Medicare Beneficiaries

Federal law prohibits providers from collecting Medicare Part A and B deductibles, coinsurance or copayments from beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB) Program. The QMB program is a Medicaid program that helps low-income individuals with Medicare cost-sharing liability. Under QMB, state Medicaid programs are supposed to pay these patients' Medicare cost-sharing, but Federal law allows the states to limit their payment to the difference between the Medicare payment and the Medicaid rate. Since Medicaid generally reimburses at a lower rate than Medicare, this usually means the provider does not receive any additional payment beyond the Medicare allowance.

Providers are required to accept the Medicare reimbursement (and Medicaid allowance, if any) as payment in full and may not bill the patients for any balance. The same rules apply to dual eligible beneficiaries who are enrolled in both Medicaid and Medicare Advantage plans. In July 2015 CMS released a study finding that confusion and inappropriate balance billing persisted, even in the presence of laws that prohibit these collections.

Some commenters noted that it can be difficult for providers to identify these beneficiaries, and CMS stated it is actively exploring additional mechanisms for Medicare providers to readily identify the QMB status of these patients. Regardless, CMS states that Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. CMS further recommends that providers take steps to educate themselves and their staff about QMBs to ensure that cost-share is not inappropriately collected prior to treatment or billed to the patient after services are rendered.

OIG Work Plan: Medicare Payments for Incarcerated Beneficiaries

In general, Medicare does not pay for services rendered to incarcerated beneficiaries because they do not have a legal obligation to pay (SSA, § 1862). However, the regulation does permit Medicare payment where an incarcerated beneficiary has an obligation for the cost of care. (42 CFR § 411.4.) Section 502 of MACRA requires the HHS Secretary to establish and maintain procedures to ensure that Medicare does not pay for services rendered to incarcerated beneficiaries. A prior OIG review identified $33.6 million in improper payments made to providers for services rendered to incarcerated beneficiaries for CYs 2009 through 2011. OIG is required to submit to Congress a report on such activities established by CMS no later than 18 months after the date of the enactment (MACRA § 502(b).) We will review the procedures established by CMS to prevent and recoup Medicare payments for items and services furnished to incarcerated beneficiaries.

https://oig.hhs.gov/reports-and-publications/archives/workplan/index.asp

Services furnished for incarcerated beneficiaries are covered, when **both** of these criteria are met (if met, modifier QJ, Services provided to a prisoner or patient in state or local custody, requirements met):

- State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody.
- The State or local government entity enforces the requirement to pay by billing and seeking collection from all such individuals or groups of individuals in custody with the same legal status (for example, not guilty by reason of insanity), whether insured or uninsured. It must also pursue collection of the amounts owed in the same manner and with the same vigor that it pursues the collection of other debts. This includes the collection of any Medicare deductible and coinsurance amounts and the costs of items and services that are not covered by Medicare.

The Hospital Outpatient Prospective Payment System (HOPPS or OPPS) is not intended to be a fee schedule, in which separate payment is made for each coded line item. Instead, the OPPS is currently a prospective payment system that packages some items and services, but not others. The CMS overarching goal is to make payments for all services covered under OPPS more consistent with those of a prospective payment system and less like those of a per-service fee schedule.

In calendar year (CY) 2017, outpatient hospital payment rates will increase by 1.7 percent and CMS will continue the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting requirements. The calendar year 2016 conversion factor of $73.725 increases to $75.001 for CY 2017, but for hospitals that fail to meet the OQR (Outpatient Quality Reporting) requirements, the conversion factor will drop to $73.411. CMS will once again continue the policy of providing additional payments to the eleven designated cancer hospitals so that the hospital's payment-to-cost ratio, with the adjustment, is equal to the weighted average for the other OPPS hospitals. In addition, outlier payments will be triggered when the hospital's cost for furnishing a service exceeds two thresholds:

- Multiplier threshold: The cost must be at least 1.75 times the Ambulatory Payment Classification (APC) payment amount (no change from CY 2016); and
- Fixed-dollar threshold: The cost must also exceed the APC payment amount by at least $3,825; up from $3,250 last year.

Off-Campus Provider-Based Departments

CMS finalized policies to implement Section 603 of the Bipartisan Budget Act of 2015, which requires that certain items and services furnished by specific off-campus hospital outpatient departments will no longer be paid under the OPPS reimbursement mechanism beginning January 1, 2017. Currently, Medicare pays for the same services at a higher rate if those services are provided in a hospital outpatient department rather than a physician's office. This payment differential has provided an incentive for hospitals to acquire physician offices in order to receive the higher rates. This acquisition trend and difference in payment has been highlighted as a long-standing issue of concern by Congress, the Medicare Payment Advisory Commission and the Department of Health and Human Services Office of Inspector General. This difference in payment also increases costs for the Medicare program and raises the cost-sharing liability for beneficiaries.

Therefore, CMS is issuing an interim final rule with comment period (IFC) in conjunction with the OPPS final rule to establish new payment rates under the Medicare Physician Fee Schedule (MPFS) for items and services provided by certain off-campus provider-based departments (PBDs) in CY 2017. These new interim final rates adopted in the IFC will permit hospitals to be paid for furnishing items and services that may no longer be paid under the OPPS, and CMS believes this will reduce incentives for hospitals to acquire independent physician practices and convert them into more highly paid outpatient facilities. Physicians furnishing professional services in this setting will continue to be paid on the CMS1500 claim form and will be paid at the facility rate under the MPFS, in the same manner as all physicians practicing in an outpatient facility setting.

Hospitals will be paid under the MPFS at these newly established MPFS rates for nonexcepted items and services, which will be billed on the UB04 claim (institutional claim) with a new claim line modifier:

Modifier	Description
PN	Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital

CMS states that non-excepted off-campus PBDs must report modifier PN on each UB04 claim line to indicate a non-excepted item or service. All non-excepted items and services billed by a hospital on an institutional claim with modifier "PN" will be paid under the MPFS at the rate established in this final rule. For CY 2017, the payment rate for these services will generally be 50 percent of the OPPS rate (with limited exceptions, such as separately payable drugs). Other OPPS policies, such as packaging of integral services, will continue to apply. CMS continues to seek comments on these new payment mechanisms and payment rates, and will make adjustments as necessary through future rulemaking.

CMS also finalized several policies regarding which off-campus PBDs and which items and services are "excepted" from the payment charges, and will therefore continue to be paid under OPPS reimbursement. Excepted items and services furnished after January 1, 2017 include:

- Services rendered by a dedicated emergency department;
- Items and services performed in an off-campus PBD that was billing for covered outpatient department services furnished prior to November 2, 2015, and has not impermissibly relocated or changed ownership; or
- Services performed in a PBD that is "on the campus" (within 250 yards) of the hospital or a remote location of the hospital.

With respect to the relocation of an excepted off-campus PBD, CMS finalized the proposal that items and services must continue to be furnished and billed at the same physical address of the off-campus PBD to be considered excepted from Section 603 requirements. The final relocation policy includes a notable change from the proposed rule to allow these off-campus PBDs to relocate temporarily or permanently without loss of excepted status due to extraordinary circumstances outside the hospital's control, such as natural disasters. However, these exceptions for extraordinary circumstances will be reviewed by the CMS Regional Office and are expected to be rare and unusual.

In the CY 2017 OPPS proposed rule, CMS noted that they had received questions from some hospital regarding whether an excepted off-campus PBD could expand the number or type of services the department furnished and still maintain excepted status. In response to public comments regarding the expansion of services performed in an excepted off-campus PBD, CMS is not finalizing their original proposal. Instead, CMS will monitor the expansion of clinical service lines by off-campus PBDs and continue to consider whether a potential limitation of service line expansion should be adopted in the future.

It is important to remember that the site-neutral rates only apply to facilities that began billing Medicare after November 2, 2015. For those off-campus provider-based departments that were billing Medicare prior to this date, CMS will continue to require the following modifier on all excepted services:

Modifier	Description
PO	Excepted service provided at an off-campus, outpatient, provider-based department of a hospital

As a result, hospitals will append either the PN or PO modifier to every code for all outpatient hospital services furnished in an off-campus PBD of the hospital. These modifiers should not be used on services performed at remote locations of the hospital, satellite facilities of the hospital, or emergency departments. A remote location is defined as "a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider." CMS states that questions about whether a particular location requires the reporting modifier PO should be referred to the CMS regional offices.

Comprehensive-APCs

A comprehensive APC, by definition, will provide a single payment that includes the primary service and all adjunct services performed to support the delivery of the primary service. For services that trigger a comprehensive APC payment, the comprehensive APC will treat all individually reported codes on the claim as representing components of the comprehensive service, resulting in a single prospective payment for the comprehensive service. This means that hospitals will continue to report procedure codes for all services performed, on one claim submission regardless of service date, and will receive a single payment for the total service and collect a single beneficiary copayment for the procedure and related services and supplies.

Effective January 1, 2015 CMS implemented C-APCs for single fraction stereotactic radiosurgery (SRS, procedure codes 77371 and 77372) and intraoperative radiation therapy (IORT), although CMS has reassigned intraoperative radiation therapy codes 77424 and 77425 from a breast surgery C-APC to the Level 7 Radiation Therapy C-APC. Effective January 1, 2017, some brachytherapy catheter or needle insertion codes and other related procedures are now designated as Comprehensive-APCs:

2017 C-APC	Codes Assigned to APC
5091	19499: Unlisted breast procedure
5092	19298: Breast brachytherapy button & tube catheter placement
5093	19296: Breast brachytherapy balloon catheter placement
5113	20555: Placement of needles/catheters into muscle and/or soft tissue for subsequent interstitial radioelement application
5153	31643: Diagnostic bronchoscope, catheter placement
5165	41019: Placement of needles/catheters into head and/or neck region for radioelement application
5302	43241: Upper GI endoscopy, catheter placement
5341	55920: Placement of needles/catheters into pelvic organs and/or genitalia (except prostate) for radioelement application
5414	57155: Insertion of uterine tandem and/or vaginal ovoids 58346: Insertion of Heyman capsules for clinical brachytherapy

Hospitals have 2 choices:

1. All services related to the C-APC procedure are billed on one claim submission, regardless of date of service. This includes all preparatory and planning services that occur in the 30-day period leading up to treatment – from the initial patient visit through the delivery of treatment.
2. The hospital can report preparatory and planning services on separate claims as they occur, appending modifier CP to each procedure that constitutes a service related to the primary procedure. Every service that occurs up to 30 days prior to treatment (+ 30 days post-treatment for SRS) related to the primary procedure billed on a separate claim must have this modifier.

CP	Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification (C-APC) procedure, but reported on a different claim

CMS finalized a proposal to create 25 additional C-APCs, bringing the total to 62; most of these represent major surgical procedures, but one new C-APC involves allogeneic hematopoietic stem cell transplantation. Allogeneic hematopoietic stem cell transplantation (HSCT) involves the intravenous infusion of hematopoietic stem cells derived from the bone marrow, umbilical cord blood, or peripheral blood of a donor to a recipient. As provided in the Medicare Claims Processing Manual, donor acquisition charges for allogeneic HSCT include charges for the costs of several services. These services include, but are not necessarily limited to, National Marrow Donor Program fees, tissue typing of donor and recipient, donor evaluation, physician pre-procedure donor evaluation services, costs associated with the collection procedure (for example, general routine and special care services, procedure/operating room and other ancillary services, apheresis services, among others), post-operative/post-procedure evaluation of donor, and the preparation and processing of stem cells.

When the allogeneic stem cell transplant occurs in the hospital outpatient setting, providers are instructed to report stem cell donor acquisition charges for allogeneic HSCT separately in Field 42 on Form CMS-1450 (or UB-04) by using revenue code 0819 (Organ Acquisition: Other Donor). Revenue code 0819 charges should include all services required to acquire hematopoietic stem cells from a donor, as defined earlier, and should be reported on the same date of service as the transplant procedure in order to be appropriately packaged for payment purposes.

Based on current analysis of several longstanding issues and stakeholder input, CMS proposed to create a new C-APC 5244 (Level 4 Blood Product Exchange and Related Services) and to assign procedures described by CPT© code 38240 (Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor) to this C-APC. The creation of a new C-APC for allogeneic HSCT would allow for the costs for all covered outpatient services, including donor acquisition services, listed on the claim to be packaged into the C-APC payment rate. CMS will analyze these costs using their comprehensive cost accounting methodology to establish future C-APC payment rates.

After consideration of the public comments received, CMS established C-APC 5244 (Level 4 Blood Product Exchange and Related Services), with the modification to exclude claims that do not include donor acquisition costs reported with revenue code 0819 from ratesetting. CMS also established a final payment rate for new C-APC 5244 of $27,752 for CY 2017.

Radiation Oncology APC Changes

Section 1833(t)(2)(A) of the Social Security Act requires CMS to develop a classification system for covered outpatient department services. In accordance with these provisions, CMS developed a grouping classification system, referred to an Ambulatory Payment Classifications (APCs).

The APCs are organized so that each group is homogenous, both clinically and in terms of resource use. As part of its continuing review of the structure of APC families, CMS finalized the proposal to reduce the number of clinical APCs for Therapeutic Radiation Treatment Preparation from 4 levels to 3 levels.

APC 5611	Level 1 Therapeutic Radiation Treatment Preparation
APC 5612	Level 2 Therapeutic Radiation Treatment Preparation
APC 5613	Level 3 Therapeutic Radiation Treatment Preparation

Essentially, CMS consolidated prior Level 1 & Level 2 procedure codes into Clinical APC 5611 (Level 1), with the exception of code 77306 (teletherapy isodose plan; simple), which remains in APC 5612. All codes previously listed in Level 3 have been assigned to Level 2, and all codes previously listed in Level 4 are now included in Level 3. With regard to reimbursement, the following procedures that will now be reimbursed at the Level I payment are expected to decrease approximately 29.5 percent:

77280	Therapeutic radiology simulation-aided field setting; simple
77333	Treatment devices, design and construction; intermediate
77370	Special medical radiation physics consultation

Once again, CMS will continue paying for Low Dose Rate Prostate Brachytherapy using composite APC 8001. In order for the hospital to receive the higher composite APC reimbursement, both code 77778 (Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed) and 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) must be billed on the same claim.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 requires CMS to continue to separate payment for brachytherapy sources in CY 2017 and subsequent years. These sources are reimbursed on a prospective basis, with 2017 payment rates set using the 2015 geometric mean unit codes for each source. CMS assigned new status indicator E2 (Items and services for which pricing information and claims data are not available) to HCPCS code C2644 (Brachytherapy source, cesium-131 chloride solution, per millicurie) because this code was not reported on CY 2015 claims.

Packaged Services

The OPPS currently packages many categories of items and services that are typically provided as part of the primary hospital outpatient service. According to CMS, packaging encourages hospital efficiency, flexibility and long-term cost containment, as well as promoting the stability of payment for services over time. For calendar year 2017, CMS will continue to refine packaging policies under the OPPS. Updates to packaging include:

- CMS finalized their proposal to align the packaging logic for all of the conditionally packaged services so that packaging occurs at the claim level, rather than date of service. According to CMS, this promotes consistency and ensures that items and services provided during a hospital stay are packaged even when the care spans more than a single service date.
- CMS previously adopted a policy to exclude molecular pathology tests from the laboratory packaging policy because these tests may have a different pattern of clinical use than more common and routine laboratory tests. As part of this final rule, CMS finalized the proposal to expand this laboratory test packaging exclusion to advanced diagnostic laboratory tests (ADLTs) that meet the same criteria.

- In CY 2014, CMS implemented modifier L1 to allow for separate payment of laboratory tests when these tests were the only services on the claim or when the laboratory tests were unrelated to the other services on the claim. For CY 2017, CMS will discontinue separate payment for unrelated laboratory tests, and as a result the following modifier will be discontinued:

Modifier	Description
L1	Provider attestation that the hospital laboratory test(s) is not packaged under the hospital OPPS

Patient Access and Medicare Protection Act, 2015
CMS is directed to submit a report to Congress on the development of an Alternative Payment Model or episode-of-care payment methodology for radiation therapy services delivered in the nonfacility setting.

MLN Matters MM9708 – November 18, 2016
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9708.pdf

Contractors shall assume the provider, physician, supplier should have known about a policy or rule, if:

- The policy or rule is in the provider, physician, or supplier manual or in Federal regulations;
- The Centers for Medicare & Medicaid Services (CMS) or a CMS contractor provided general notice to the medical community concerning the policy or rule;
- CMS, a CMS contractor, or the Office of Inspector General (OIG) gave written notice of the policy or rule to the particular provider/physician/supplier;
- The provider, physician, or supplier was previously investigated or audited as a result of not following the policy or rule;
- The provider, physician, or supplier previously agreed to a Corporate Integrity Agreement as a result of not following the policy or rule;
- The provider, physician, or supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements which are related to the policy or rule; or
- The provider, physician, or supplier previously received documented training/outreach from CMS or one of its contractors related to the same policy or rule.

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