Understanding Medicare Payment Adjustments to Avoid Overinflated ROIs

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Success in health care, particularly oncology, is often measured in patient outcomes. To achieve those outcomes, oncology programs and practices must be able to invest in the latest technology and drug therapies, so it is important to understand the true return on investment (ROI) on these purchases. Developing an accurate ROI is complicated. Administrators must understand the Medicare payment systems, the Medicare Physician Fee Schedule (MPFS)[1] and the Hospital Outpatient Prospective Payment System (OPPS),[2] and the various applicable Medicare payment adjustments that can dramatically change the final payment rate.

Regardless of whether your cancer program is office- or outpatient hospital-based, there may be several reasons you may not be paid for all services provided to patients and/or paid at the "finalized" Medicare rate. Some of the more common payment adjustments may be due to annual or quarterly procedure code valuation updates, sequestration, packaging and bundling, multiple procedure reductions, and/or comprehensive ambulatory payment classifications (C-APCs).

Annual Procedure Code Updates

Valuations for procedure codes paid under MPFS and OPPS are updated quarterly when new Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are released. Other adjustments could be due to legislative action, or most often final rule policy updates.

Services provided by physicians and physician practices in a facility (hospital or ambulatory surgical center) and nonfacility (office-based/freestanding) setting are paid under MPFS. Rates are calculated using a complex equation based on assigned values known as relative value units for physician work, practice expense, and malpractice. These values, adjustments based on cost of living within geographic locations, and, finally, a conversion factor are all used to calculate a recognized dollar amount that results in a final assigned payment.

Services provided by the hospital in the facility setting are paid for under OPPS. Services reimbursed under OPPS are assigned an Ambulatory Payment Classification (APC) with multiple CPT or HCPCS codes receiving the same APC designation. Services considered similar from both a clinical and resource aspect may be placed in a single APC. All procedure codes within a single APC are paid the exact same amount by Medicare. These Medicare finalized rates for the start of each year are released at the time of final rule, typically on or by November 1 of each calendar year. Over the past several years, due to various Congressional interventions, the finalized rates have been subsequently adjusted from the rates finalized by CMS. It is vital that administrators update their fee schedules, chargemasters, and ROI models with the most recent and accurate Medicare rates to ensure they are establishing an accurate baseline.

Sequestration

Outside of a temporary hold placed during the COVID-19 public health emergency (PHE), a 2% reduction "sequestration" has applied to all Medicare Fee-for-Service (FFS) payments since April 1, 2013, as required by The Budget Control Act of 2011.[3] The sequestration is only applied to the Medicare portion of payment, 80% of the assigned rate, at the individual code level. The other 20%, which is the responsibility of the patient or their secondary insurance, is not adjusted.

During the PHE, sequestration was suspended due to various mandates. The Coronavirus Aid, Relief, and Economic Security (CARES) Act[4] suspended sequestration reductions to all FFS claims from May 1 to December 31, 2020. The Consolidated Appropriations Act, 2021,[5] extended the suspension of sequestration until March 31, 2021. The Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes,[6] extended the suspension until December 31, 2021. Finally, The Protecting Medicare and American Farmers From Sequester Cuts Act[7] suspended sequestration through March 31, 2022, implemented a sequestration of 1 percent from April 1 to June 30, 2022, and resumed the 2% sequestration effective July 1, 2022. Sequestration is scheduled to continue through fiscal year 2031.[8]

Packaged Services

The terms "packaged" and "bundled" are often used interchangeably by health care providers, but there are very important differences. Understanding these differences can help providers avoid incorrect coding practices and even potential revenue loss for the health care organization.

Packaging is a reimbursement term that relates only to outpatient hospital services. It refers to the practice of making a single payment that includes payment for a significant procedure, as well as the "minor, ancillary services" generally associated with the procedure. Even though CMS may not provide separate payment, the codes for packaged

services should still be reported on the claim unless contraindicated by authoritative coding guidance or National Correct Coding Initiative (NCCI) edits.

CMS addresses drug administration codes specifically within Chapter 4 of its *Medicare Claims Processing Manual*[9]: "Hospitals should report all HCPCS codes that describe the drug administration services provided, regardless of whether or not those services are separately paid, or their payment is packaged." It is especially important hospitals continue to charge for packaged services so CMS can collect accurate cost data for individual procedures. Also, not all payers follow Medicare payment policies, and some may provide payment in situations where CMS does not.

There are a few different scenarios when packaging of services impacts oncology. For example, radiation oncology hospital outpatient departments have not been paid for image-guided radiotherapy (IGRT) since 2008. Hospitals have continued to report IGRT, and other imaging during the course of treatment, even though CMS has not made separate payments as they consider the services to be part of other, more primary services. Similarly, the use of contrast with setup simulations is not separately reimbursed.

One note, CMS establishes a drug packaging threshold each year. Drugs and biologicals estimated at a per day administration cost less than or equal to the finalized amount, for 2023, drugs with payments of $135 and less are not paid separately. Any diagnostic radiopharmaceuticals, contrast agents, anesthesia drugs, drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure, and drugs and biologicals that function as supplies or devices when used in a surgical procedure are also not paid separately when their estimated per day cost is greater than the set threshold. Although there may be instances when conditionally packaged services are paid when they are the only service for an encounter, when combined with other services, these services are not paid separately.

C-APCs and Bundled Services

Under OPPS, CMS also created C-APCs, which have created a hierarchy of services common to single day surgical procedures. The primary code of the single-day surgical procedure is assigned a status indicator "J1," which means it is the highest valued code. When any other services are performed, which are considered ancillary to the primary service and assigned a status indicator of anything except "F," "G," "H," "L," and "U," the services are not paid separately, but considered packaged into the primary service.

If 2 services both designated as J1 are performed as part of the same encounter, they may qualify for a complexity adjustment, where the lesser valued code is included in the higher J1 code and not paid separately. For example, when **CPT 38220** for bone marrow aspiration and **38221** for bone marrow biopsy are reported on the same claim, a complexity adjustment is made, and they are paid the same as the combination code **38222** for bone marrow biopsy and aspiration.

For radiation oncology, in gynecological brachytherapy when needles and HDR tandem and ovoid applicator are placed in the OR, needle placement (reported with **CPT 55920**) and tandem and ovoid applicator placement (reported with **CPT 57155**) have a complexity adjustment into the next APC. However, when hydrogel is placed and billed with **CPT 55874**, and fiducial markers are placed and reported with **CPT 55876**, the marker placement code is not separately reimbursed. It is considered ancillary to the hydrogel placement and part of the primary designated procedure.

Bundling refers to the application of coding rules to ensure the procedure codes submitted on the claim accurately reflect the services provided. CMS utilizes the Medicare National Correct Coding Initiative, which provides an overall set of guidelines that define how multiple procedure codes will be reimbursed if submitted for the same patient on the same date of service. Other payers may employ the same NCCI edits or develop separate payer-specific bundling guidelines. Providers who have a signed participation agreement or contract with an insurer have generally agreed to accept their payer-specific bundling edits, which may be different from those applied by Medicare.

Bundling edits apply across all practice settings. CMS has repeatedly stated that bundled services should not be billed to Medicare; the physician, practice, or facility should apply all bundling edits prior to issuing a claim. According to Coding Clinic for HCPCS,[10] "procedures should be reported with the most comprehensive CPT code that describes the services performed." For example, within radiation oncology, all simulations with IMRT planning are commonly bundled. Regardless of the medical necessity and documentation, the work by the physician, physician office, and hospital for the simulation process is not reported on the claim with IMRT. In medical oncology, infusions and injections include items that are considered integral and bundled into the administration, such as:

- IV start or access to indwelling catheter, IV, or port
- Local anesthesia
- Standard supplies (tubing, syringes, etc)
- Flush at initiation and/or conclusion of infusion
- Monitoring for adverse reactions

Although Medicare's nonpayment for services due to packaging and bundling cannot be avoided, there may be scenarios where "hurry up and treat" is not in the best interest of the patient or practice. However, CMS has repeatedly said that unbundling of services (to split them out over different days and maximize reimbursement) is not appropriate, as well as use of modifiers for the sole purpose of increasing payment rates.

Multiple Procedure Reduction

Under the MPFS, when multiple procedures are provided during the same single encounter, CMS will typically not reimburse at 100% of the assigned rate for all the services provided because the agency believes there is duplicity in the utilization of the overhead (eg, supplies, equipment, and staffing). Instead, CMS will apply a multiple procedure reduction. The reduction may apply to designated surgical and diagnostic imaging. The procedure with the

highest assigned value is paid at 100%, each subsequent service is paid at a reduced rate, such as 50% or 25% of the assigned rate.

To determine if a procedure or imaging service is subject to a multiple procedure reduction under MPFS, within the quarterly RVU file, CMS will identify under the column titled "Mult Proc" the assigned designation. Procedure codes assigned 1, 2, or 4 would most likely apply to oncology and are subject to reductions. For example, bone marrow biopsy and aspiration codes, intralesional chemotherapy therapy codes, placement of brachytherapy applicators, and hydrogel are all assigned a designation of 2. When performed with other designated multiple procedures, the highest code in the group is paid 100% of the assigned rate and the others are paid at 50%.

Even if your program or practice treats very few Medicare beneficiaries, an understanding of Medicare payment systems is important because many private payers use Medicare rates as a baseline for their contracts.

Remember: An accurate ROI is only as good as the data put in. Overvaluing or forgetting some of the factors impacting Medicare's assigned payment can skew the ROI. In the end, if the calculated return on investment and reimbursement outlook seems too good to be true, it probably is. OI

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