On November 1, 2016, the Centers for Medicare & Medicaid Services (CMS) released the 2017 Hospital Outpatient Prospective Payment System (HOPPS) final rule, resisting ASTRO-recommended changes to the agency’s methodology for Comprehensive Ambulatory Payment Classifications (C-APCs).

In the Medicare hospital outpatient environment, hospital reimbursement is based on Ambulatory Payment Classifications or APCs. CMS assigns CPT codes to an APC based on clinical and resource use similarity. All services in an APC are reimbursed at the same rate. Cost data collected from OPPS claims are used to calculate rates. Certain services are considered ancillary and their costs are packaged into the primary service. Packaged services do not receive separate payment. For example, in the hospital outpatient environment imaging is not paid separately when reported with treatment delivery services. Below is a summary of key issues impacting radiation oncology.

**Update**
CMS is increasing the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 1.65 percent. This increase factor is based on the hospital inpatient market basket percentage increase of 2.7 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus the multifactor productivity (MFP) adjustment of 0.3 percentage point, and minus a 0.75 percentage point adjustment required by the Affordable Care Act. Based on this update, the agency estimates that total payments to OPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY 2017 will be approximately $63 billion, an increase of approximately $5.0 billion compared to estimated CY 2016 OPPS payments.

**Comprehensive-Ambulatory Payment Classification (C-APC) Methodology**
CMS is not making extensive changes to the already established methodology used for C-APCs. The Agency is creating 25 new C-APCs, which will bring the total number to 62 C-APCs as of January 1, 2017.

**C-APC 5627 - Level 7 Radiation Therapy (SRS & IORT)**
CMS will continue the policy for the payment of SRS treatment as described in the 2016 HOPPS final rule. This policy removes claims reporting for planning and preparation services for SRS treatment from the geometric mean cost calculation for the 2017 payment rate for C-APC 5627 and pays separately for the planning and preparation services. In 2015 the C-APC reimbursement rate was $9,769. This policy change resulted in a 25 percent decline between 2015 and 2016 rates. The continuation of the policy results in a continued decline of 31 percent from the 2015 rate.

For 2018, CMS will examine the claims for cranial single session SRS patients and evaluate the services reported with modifier “CT” (Adjunctive service related to a procedure assigned to a
comprehensive ambulatory payment classification [C-APC] procedure). They will consider in future rulemaking whether repackaging all adjunctive services (planning, preparation, and imaging, among others) back into cranial single session SRS is appropriate in order to preserve the integrity of the C-APC policy and the HOPPS as a prospective payment system.

ASTRO remains concerned that this policy decision does not address the fundamental issues associated with different practice patterns involving multisource Cobalt-60-based SRS (77371) and linear accelerator-based (77372) SRS, which is evident in HOPPS claims data. Additionally, the SRS claims are also contaminated with charges for CPT Code 77373 Fractionated Stereotactic Body Radiation Therapy (SBRT). Patients being treated for brain metastases (with SRS) may concurrently or consecutively be treated for a primary lung cancer (with SBRT). The CMS/HOPPS C-APC methodology is not designed to differentiate which charges are linked to which major procedure, as such, the methodology does not appropriately capture charges for these services.

CMS proposed assigning CPT Codes 77424 and 77425, intraoperative radiation treatment (IORT) delivery, to C-APC 5093 Level 3 Breast/Lymphatic Surgery and Related Procedures. This would have resulted in an 11 percent reduction in reimbursement. ASTRO urged CMS not to finalize this proposal, as IORT is not clinically similar to the breast procedures included in C-APC 5093. CMS agreed with ASTRO’s concerns stating that the Agency’s intention was to temporarily assign the codes to C-APC 5093 until more claims data became available. By making this change, the IORT codes will only experience a 1 percent reduction in reimbursement compared to 2016.

In the final rule, CMS is assigning the IORT codes to APC 5627 Level 7 Radiation Therapy, based on the fact that the codes are radiation oncology codes and their geometric mean costs are similar to the SRS codes. CMS notes that if planning and preparation and imaging services are repacked into the SRS codes, this could cause the geometric mean cost for the SRS codes to increase such that it may no longer be appropriate to group the IORT codes with SRS in the same C-APC.

C-APCs 5113, 5165, 5165, 5302, 5341 and 5414 - Brachytherapy Insertion

In the proposed rule, ASTRO expressed concern that claims for several of the brachytherapy device/insertion codes (CPT codes 57155, 20555, 31643, 41019, 43241, 55920, and 58346) often did not contain a brachytherapy treatment delivery code. As a result, brachytherapy delivery charges are underrepresented in rate setting under the C-APC methodology. A correctly coded claim should always include an insertion and treatment delivery code combination. It was suggested that CMS adopt a composite APC methodology for CPT code 57155 similar to the composite methodology for LDR prostate brachytherapy services.

In the final HOPPS, CMS will not modify the methodology for these brachytherapy insertion codes. The Agency stated that it is the hospitals’ responsibility to code correctly. CMS said they will continue examine the claims for these brachytherapy insertion codes and determine if any future adjustment to the methodology (or possibly code edits) would be appropriate.
Similar to the scenario described above for gynecologic brachytherapy (using CPT Code 57155), other insertion codes used to prepare for radiation treatment delivery (CPT codes 20555, 31643, 41019, 43241, 55920, 58346, etc) yield similar problems. The C-APCs don’t appropriately capture the charges for these radiation oncology services.

C-APCs 5092 Level 2 Breast/Lymphatic Surgery and Related Procedures
CMS finalized its proposal to reassign CPT Code 19298 Placement of radiotherapy afterloading brachytherapy catheters into the breast for interstitial radioelement application following partial mastectomy, includes image guidance to newly converted C-APC 5092 for 2017. CMS rejected comments requesting that CPT Code 19298 stay in the APC 5093 Level 3 APC because the geometric mean cost for code decreased from approximately $6,269 in 2016 to approximately $5,128 for 2017. CMS does not believe that the CY 2017 geometric mean cost supports continued assignment to APC 5093. The decision results in a 42 percent lower payment for 19298.

Ambulatory Payment Classifications (APCs)

APC 5625 Level 5 Radiation Therapy - Proton Therapy
In the final rule, CMS decreased the reimbursement rate for APC 5625 by 13.6 percent. This was an unanticipated reduction in reimbursement as the proposed rule indicated that the Agency was considering a 3 percent reduction. Upon further analysis, it has been determined that charges for CPT code 77522 Proton Treatment, simple with compensation have declined resulting in a lower geometric mean cost for the APC. As a result, the APC will be reimbursed at reimbursed at $994 in 2017, compared to $1,151 in 2016.

Therapeutic Radiation Treatment Preparation APCs 5611, 5612 and 5613
CMS finalized its proposal to move CPT code 77370 Radiation physics consult, along with CPT codes 77280 Set radiation therapy field and 77333 Radiation treatment aid(s), from APC 5612 Level 2 Therapeutic Radiation Treatment Delivery to APC 5611 Level 1 Therapeutic Radiation Treatment Preparation, thus combining Level 1 and Level 2 services. According to the agency, the geometric mean costs between Levels 1 and 2 are not significant and combining the two levels promotes resource homogeneity. As a result, payment will decrease from $167 in 2016 to $117 in 2017, a 30 percent decrease in reimbursement.

CMS finalized reassignment of CPT codes 77295 Three-Dimensional Radiotherapy Plan and 77301 Intensity Modulated Radiotherapy Plan to APC 5613 Level 3 Therapeutic Radiation Treatment Preparation. In proposed rule comments, ASTRO expressed concern that the significant costs associated with the simulation services bundled into CPT Code 77301 are not appropriately reflected in the 2015 and 2016 data. CMS was urged to create a new Level 4 Therapeutic Radiation Treatment Preparation APC and assign CPT Code 77301 to the new APC.

In the final rule, CMS acknowledged ASTRO’s concerns about CPT Code 77301 but declined to move the code to a new APC to account for costs associated with simulation. The Agency said that it will wait to analyze claims data before making any changes to the APC assignment. ASTRO believes this omission is costing physicians $500 for every IMRT plan in the hospital
Composite APC 8001 - Low Dose Rate (LDR) Prostate Brachytherapy

In 2017, CMS will continue to use the payment rate for composite APC 8001 to pay for LDR prostate brachytherapy services and to set the payment rate for this APC using the existing methodology. Using the 2015 claims data, CMS identified 224 claims that contained both CPT codes 55875 and 77778 to calculate the geometric mean cost of approximately $3,598 for these procedures upon which the final 2017 payment rate for composite APC 8001 is based. This is a 6 percent increase over the 2016 payment rate of $3,385.

New CPT and Level II HCPCS Codes

The final rule includes the CPT and Level II HCPCS codes that were implemented on July 1, 2016, along with the final status indicators and APC assignments for CY 2017.

HCPCS code C9743 (Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies) was deleted June 30, 2016 and replaced with CPT code 0438T effective July 1, 2016. 0438T Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance

Brachytherapy Sources

CMS finalized their proposal to set the payment rates for brachytherapy sources using the existing prospective payment methodology, which is based on geometric mean costs. Additionally, the Agency is finalizing the proposal to assign new status indicator “E2” to HCPCS code C2644 Brachytherapy cesium-131 chloride because there are no CY 2015 claims reporting use of this code. CMS did not determine a 2017 payment rate for C2644.

Site Neutral Payments

CMS is implementing section 603 of the Bipartisan Budget Act of 2015. This provision requires that certain items and services furnished in certain off-campus provider based departments (PBDs) shall not be considered covered hospital outpatient department (OPD) services for purposes of HOPPS payment and those nonexcepted items and services will instead be paid “under the applicable payment system” beginning January 1, 2017. CMS is finalizing, with modification, the policies they proposed relating to which off-campus PBDs and which items and services furnished by such off-campus PBDs may be excepted from application of payment changes under this provision. ASTRO will be providing more information regarding how these policies impact radiation oncologists at a future date.

Hospital Outpatient Quality Reporting (HOQR) Program

Penalty Adjustments

CMS finalized penalty adjustments for hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Reporting (OQR) Program. Hospitals will continue to be subject to a further reduction of 2.0 percentage points to the Outpatient Department (OPD) fee schedule increase factor. However, CMS will use a reduced OPD fee schedule update factor of -0.45
percent (that is, the proposed OPD fee schedule increase factor of 1.55 percent further reduced by 2.0 percentage points). This would result in a proposed reduced conversion factor for CY 2017 of $73.411 for hospitals that fail to meet the Hospital OQR requirements (a difference of -1.498 in the conversion factor relative to hospitals that met the requirements).

**Electronic Health Records Incentive Program (Meaningful Use)**

**Reduced Reporting Period**

CMS finalized its proposal to reduce the 2016 reporting period from a full calendar year to a 90-day reporting period for new and returning Meaningful Use participants. The decision responds to concerns from ASTRO regarding the challenges of preparing for Stage 3 and the implementation of 2015 Edition Certified RHT Technology (CHERT), as well as the transition to the Merit-Based Incentive Payment System.

CMS also finalized its proposal to establish a 90-day reporting for Clinical Quality Measures (CQMs), consistent with ASTRO’s recommendations. CQMs can either be reported electronically or by attestation. CQM reporting can be for a different 90-day period than for the Meaningful Use objectives and measures.

**CY 2017 New Participants and Hardship Exception Application**

CMS finalized its proposal to require that providers, who have not successfully demonstrated Meaningful Use in the past, attest to the Modified Stage 2 objectives and measures for 2017. These providers are exempt from reporting and attesting to Stage 3 of the Meaningful Use program, and will have to attest to the Modified Stage 2 by October 1, 2017.

Furthermore, providers who have not successfully demonstrated Meaningful Use in previous years, who intend to attest to Meaningful Use in 2017 and transition to the MIPS Advancing Care Information objectives and measures, may apply for a new hardship exception. Consistent with ASTRO’s recommendation in proposed comments, these providers will be required to submit their hardship application by October 1, 2017, explaining why participating in both Meaningful Use and reporting the Advancing Care Information category in 2017 will result in a significant hardship. This hardship exception will allow providers to avoid the 2018 Meaningful Use payment adjustment.

Additional information about the 2017 HOPPS final rule can be found at the following links:

A display copy of the final rule can be found at: [https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-26515.pdf](https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-26515.pdf)

The Addenda relating to the OPPS are available at: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-FC.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-FC.html)

A fact sheet on this proposed rule is available at: