CY 2019 Proposed Rule Highlights Radiology Hospital Outpatient Prospective Payment System (HOPPS)
August 1, 2018

Introductory Summary
On July 25, 2018, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the Hospital Outpatient Prospective Payment System (HOPPS) for CY 2019.

HOPPS Proposed Rule
The CY 2019 proposed rule may be located in its entirety by following the link below:
https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-15958.pdf

This document in PDF form is 761 pages in length. The format of the information is intended to serve as a highlight to the proposed changes and readers are encouraged to view the document in its entirety for further details.

Payment Rates
CMS is proposing an increase of payment rates under the Outpatient Department (OPD) fee schedule with a 1.25% increase to the conversion factor of CY 2018. The CY 2019 conversion factor is proposed to be $79.546; however, for hospitals that fail to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements, CMS is proposing a conversion factor of $77.955. To determine this payment rate, CMS utilized data released in the inpatient prospective payment system (IPPS) proposed ruling for FY 2019 which reflected a proposed 2.8% increase for inpatient services.

Taking the IPPS proposed increase into account, CMS then applies a few other factors as mandated when calculating payment rates for hospitals. CMS is proposing a decrease of 0.8% for the multifactor productivity (MFP) adjustment. The MFP takes into consideration economy-wide productivity typically on a 10-year moving average. CMS is also proposing a decrease of 0.75% due to the requirement in the Affordable Care Act for years 2010 through 2019. Based on the proposed updates to the payment rates, CMS is projecting CY 2019 HOPPS expenditures will be approximately $74.6 billion, an increase of approximately $4.9 billion compared to CY 2018 HOPPS payments.

CMS is proposing a rural adjustment factor of 7.1% to the OPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs) for CY 2019 and subsequent years. This payment adjustment will continue to exclude separately payable drugs, biologicals and devices paid under the pass-through payment policy. Ambulatory Surgical Center (ASC) payments are proposed to increase by 1.3% that meet quality reporting under the ASCQR program.

Wage Index

CMS is proposing to continue applying a wage index of 1.000 for frontier state hospitals the policy has been since CY 2011. CMS is also proposing not to extend the imputed floor for CY 2019 and subsequent years. The imputed floor is an adjustment where the wage index for hospitals in metropolitan areas cannot be less than hospitals in rural areas of the state. There are three states which currently are considered all-urban, meaning states without hospitals in rural areas: Delaware, New Jersey and Rhode Island.

The imputed floor is calculated determining the average of the highest and lowest wage indexes in each all-urban state. The average can never be greater than 1.000, and if the core-based statistical area (CBSA) has a wage index already set and it is higher than the imputed floor, there is no gained advantage. If the wage index for a particular urban hospital was lower than the calculated imputed floor, there would be a gain as the hospital could use the higher value. CMS is not proposing to extend this adjustment and is proposing to allow it to expire as planned after December 31, 2018.

The Office of Management and Budget (OMB) released a bulletin in which it announced that one Micropolitan Statistical Area now qualified as a Metropolitan Statistical Area, the new urban CBSA is Twin Falls, Idaho (CBSA 46300). This CBSA is comprised of the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho. The significance of this relates to reimbursement. Under HOPPS, the payment rates for a particular hospital are listed by county and each county is assigned to a particular payment CBSA locale or name. If the assignment is left blank, then the county where the hospital resides is paid per the rural designation and not one of the urban specified locations. In CY 2018, Twin Falls, ID is considered rural, but will be changing for CY 2019 to urban.

Reimbursement

Using the proposed payment information, the following is a small selection of services and payment amounts based upon the published Medicare allowable for the CPT®/HCPCS codes in an on-campus hospital outpatient department.

HCPCS Code	Short Descriptor	2018 National Average Payment Rate	2019 National Average Payment Rate	Variance	% of Change
70220	X-ray exam of sinuses	$62.12	$62.86	$ 0.74	1%
70460	Ct head/brain w/dye	$252.74	$203.21	$ (49.53)	-20%
70470	Ct head/brain w/o & w/dye	$252.74	$203.21	$ (49.53)	-20%
70551	Mri brain stem w/o dye	$232.31	$231.79	$ (0.52)	0%
70552	Mri brain stem w/dye	$252.74	$388.70	$ 135.96	54%
70553	Mri brain stem w/o & w/dye	$456.37	$388.70	$ (67.67)	-15%
71046	X-ray exam chest 2 views	$62.12	$62.86	$ 0.74	1%
71047	X-ray exam chest 3 views	$62.12	$62.86	$ 0.74	1%

71270	Ct thorax w/o & w/dye	$252.74	$203.21	$	(49.53)	-20%
71275	Ct angiography chest	$252.74	$203.21	$	(49.53)	-20%
72040	X-ray exam neck spine 2-3 vw	$62.12	$62.86	$	0.74	1%
72050	X-ray exam neck spine 4/5vws	$114.46	$113.80	$	(0.66)	-1%
72125	Ct neck spine w/o dye	$114.46	$113.80	$	(0.66)	-1%
72126	Ct neck spine w/dye	$456.37	$388.70	$	(67.67)	-15%
72170	X-ray exam of pelvis	$114.46	$113.80	$	(0.66)	-1%
72191	Ct angiograph pelv w/o&w/dye	$252.74	$203.21	$	(49.53)	-20%
73100	X-ray exam of wrist	$62.12	$62.86	$	0.74	1%
73501	X-ray exam hip uni 1 view	$62.12	$62.86	$	0.74	1%
73502	X-ray exam hip uni 2-3 views	$62.12	$62.86	$	0.74	1%
76536	Us exam of head and neck	$114.46	$113.80	$	(0.66)	-1%
76604	Us exam chest	$114.46	$113.80	$	(0.66)	-1%
76641	Ultrasound breast complete	$114.46	$113.80	$	(0.66)	-1%
76642	Ultrasound breast limited	$62.12	$62.86	$	0.74	1%

Outlier Payments

Outlier payments were established by CMS to help mitigate the financial risk associated with some high cost procedures and services. For services which meet specific criteria set up by CMS, an additional payment is made to the hospital to assist in off-setting the cost and potential loss of revenue due to the ambulatory payment classification (APC) established rate.

In CY 2019, CMS is proposing if the cost of the procedure utilizing the individual hospital's assigned cost-to-charge ratio (CCR) exceeds 1.75 times the APC payment and exceeds the APC payment by more than $4,600; CMS will provide an outlier payment. The outlier payment is calculated to be 50% of the amount by which the cost of the service exceeds the 1.75 times the APC payment.

Standardizing APC Payment Weights

Ambulatory payment classifications (APCs) group services which are considered clinically comparable to each other with respect to the resources utilized and the associated cost. Ancillary services or items which are necessary components of the primary service are packaged into the APC rates and not separately reimbursed. CMS instructs providers to apply current procedure-to-procedure edits and then report all remaining services on the claim form. CMS will only pay for those services which are considered not packaged into another service.

CMS is proposing to continue using HCPCS code G0463, hospital outpatient clinic visit for assessment and management of a patient, in APC 5012 (Level 2 Examinations and Related Services) as the standardized code for the relative payment weights. A relative payment weight of 1.00 is proposed to be assigned to APC 5012 (code G0463). CMS is proposing use of the proposed factor of 1.00 and then dividing the geometric mean cost of each APC by the geometric mean cost of APC 5012 to derive the unscaled relative payment weight for each APC.

CMS does address the high volume of reporting for the outpatient clinic visit billed with code G0463, which will also be discussed later in this summary). CMS is proposing different reimbursement values for code G0463 to counter what CMS stated was *"unnecessary increases in the volume of outpatient service."* CMS assures that the reimbursement changes proposed would not have an impact on the APC payment weights due to budget neutrality and CMS' requirement to operate within $20 million above or below the expected budget. When the calculations project spending outside the budget, factors and/or adjustments are applied to maintain budget values.

Multiple Imaging Composite APC

For those cancer centers that perform diagnostic imaging, CMS is proposing to continue to pay for all multiple imaging procedures within an imaging family performed on same date of service using multiple imaging composite APC payment methodology. Standard APC assignments will continue to apply for single imaging procedures and multiple imaging procedures performed across families. A single imaging session performed "with contrast" is part of a composite APC when at least one or more imaging procedures from the same family are also performed with contrast on same date of service. For example, if a hospital performs one MRI without contrast during same session as one with, the payment rate will be for the "with contrast" composite APC.

The five multiple imaging composite APCs established in CY 2009 with CY 2019 proposed reimbursement rates are:

- APC 8004 (Ultrasound Composite), proposed payment rate $302.05
- APC 8005 (CT and CTA without Contrast Composite), proposed payment rate $268.50
- APC 8006 (CT and CTA with Contrast Composite), proposed payment rate $489.03
- APC 8007 (MRI and MRA without Contrast Composite), proposed payment rate $546.23
- APC 8008 (MRI and MRA with Contrast Composite), proposed payment rate $860.89

For CY 2019 and subsequent years, CMS is proposing to pay for all multiple imaging procedures within an imaging family on the same date of service using the multiple imaging composite APC payment methodology. Table 4 within the CY 2019 HOPPS proposed rule contains the complete listing of imaging families and multiple imaging procedures for the composite APCs.

Proposed APC 2 Times Rule Exceptions for CY 2019

CMS identified 16 APCs in which the 2 times rule violation was found. The 2 times rule does not allow the codes to be assigned to an APC where the highest costing code is more than 2 times that of the lowest costing code. When a 2 times rule violation is identified, CMS and the HOP Panel will reassign codes or create a new APC. CMS only considers HCPCS codes that are significant based on the number of claims when determining if there is a 2 times rule violation.

For CY 2019, CMS is proposing to make exceptions to all of the 2 times rule violation APCs, this meaning no adjustments or movement of codes to other APCs to balance the highest and lowest costing codes. There are four imaging APCs, which are proposed to be excluded from any change; APC 5521 Level 1 Imaging without Contrast, APC 5522 Level 2 Imaging without Contrast, APC 5523 Level 3 Imaging without Contrast and APC 5571 Level 1 Imaging with Contrast.

Table 12 lists the APCs identified as in violation of the 2 times rule, but will not be adjusted.

TABLE 12.—PROPOSED APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2019

Proposed CY 2019 APC	Proposed CY 2019 APC Title
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5113	Level 3 Musculoskeletal Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5612	Level 2 Therapeutic Radiation Treatment Preparation
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5724	Level 4 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5732	Level 2 Minor Procedures
5735	5735 Level 5 Minor Procedures
5822	5822 Level 2 Health and Behavior Services
5823	5823 Level 3 Health and Behavior Services

Cost allocation for CT and MRIs

In CY 2014, CMS finalized the policy to create new costs centers in relation to calculation of the cost-to-charge (CCR) ratio value assigned to each particular hospital specifically for implantable devices, magnetic resonance imaging (MRI), computed tomography (CT) and cardiac catheterizations. The CCR is a value used by CMS to convert charges to estimated costs as a means of determining the reimbursement for any particular APC.

Comments received by CMS indicated that some hospitals continue to use an imprecise "square feet" allocation methodology for large moveable equipment like CT and MRI machines. In response, CMS removed the data for those hospitals that used "square feet" as a means or calculating cost allocation. This was intended to end after CY 2018 and CMS would begin using cost data to estimate the relative APC payment weights using cost data from all providers, and not excluding any using "square feet."

The data in Table 1 reflects the impact of CMS removing the cost data from the hospitals that use "square feet". The result is nearly all of the imaging APCs would have payment increases.

This is due primarily to the fact that the CCR values are generally lower for providers that use cost allocation of “square feet”.

TABLE 1.—PERCENTAGE CHANGE IN ESTIMATE COST FOR CT AND MRI APCs WHEN EXCLUDING CLAIMS FROM PROVIDER USING “SQUARE FEET” AS THE COST ALLOCATION METHOD		
APC	**APC Descriptor**	**Percent Change**
5521	Level 1 Imaging without Contrast	-3.6%
5522	Level 2 Imaging without Contrast	5.5%
5523	Level 3 Imaging without Contrast	4.3%
5524	Level 4 Imaging without Contrast	4.7%
5571	Level 1 Imaging with Contrast	7.7%
5572	Level 2 Imaging with Contrast	8.4%
5573	Level 3 Imaging with Contrast	2.8%
8005	CT and CTA without Contrast Composite	13.9%
8006	CT and CTA with Contrast Composite	11.4%
8007	MRI and MRA without Contrast Composite	6.6%
8008	MRI and MRA with Contrast Composite	7.4%

The data is Table 2 reflects the CCR values of the different methods for calculating and reporting of cost allocations.

TABLE 2.—CCR STATISTICAL VALUES BASED ON USE OF DIFFERENT COST ALLOCATION METHODS				
Cost Allocation Method	**CT**		**MRI**	
	Median CCR	**Mean CCR**	**Median CCR**	**Mean CCR**
All Providers	0.0377	0.0527	0.0780	0.1046
Square Feet Only	0.0309	0.0475	0.0701	0.0954
Direct Assign	0.0553	0.0645	0.1058	0.1227
Dollar Value	0.0446	0.0592	0.0866	0.1166
Direct Assign and Dollar Value	0.0447	0.0592	0.0867	0.1163

Based on feedback in response to the CY 2018 HOPPS final rule, CMS is proposing to extend the practice of removing the cost data from the hospitals using “square feet” for CY 2019. CMS does not believe that beyond CY 2020 it will be necessary to exclude any data. For CY 2020, CMS plans to use all cost data, regardless of how it is calculated.

New HCPCS Code Effective July 1, 2018

CMS introduced a new HCPCS code effective July 1, 2018, code 0505T (Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated

radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion).

Code 0505T is proposed to be assigned to APC 5193 (Level 3 Endovascular Procedures) with a status indicator (SI) of J1. The assignment of J1 would mean code 0505T is considered part of a comprehensive APC (C-APC) and is the primary service. All ancillary services are still reported on the claim form, after applying edits, but only the primary code assigned J1 is paid. The other services are considered packaged into the primary service. The proposed national average C-APC reimbursement for APC 5193 is $9,765.28.

Imaging Procedures and Services (APCs 5521-5524 and 5571-5573)

Section 1833(t)(2)(G) of the Social Security Act requires the Secretary to create additional groups for those covered outpatient department services that utilize contrast agents separately from those that do not. In CY 2016, CMS conducted a comprehensive review and restructuring of APCs that contained imaging services. The purpose was to better allocate the resource cost and clinical characteristics of the imaging services within each APC. In CY 2017, there were additional adjustments made, in which 17 APCs were reduced to 7. Four of the APCs include imaging services without contrast and three include imaging services with contrast.

For CY 2019, CMS is proposing to maintain the seven APCs as finalized in CY 2017. CMS is not proposing to add another APC, as was proposed but not finalized for CY 2018, to account for high cost imaging procedures. Table 17 reflects the seven APCs with a comparison of the CY 2018 APC geometric mean cost vs. the proposed CY 2019 APC geometric mean cost. CMS is seeking comments on maintaining the seven APCs, any input on the codes assigned to each APC and any comments to make changes.

TABLE 17.—PROPOSED CY 2019 IMAGING APCs

APC	CY 2019 APC Title	CY 2018 APC Geometric Mean Cost	Proposed CY 2019 APC Geometric Mean Cost
5521	Level 1 Imaging without Contrast	$62.08	$64.02
5522	Level 2 Imaging without Contrast	$114.39	$115.89
5523	Level 3 Imaging without Contrast	$232.17	$236.05
5524	Level 4 Imaging without Contrast	$486.38	$502.75
5571	Level 1 Imaging with Contrast	$252.58	$206.94
5572	Level 2 Imaging with Contrast	$456.08	$395.84
5573	Level 3 Imaging with Contrast	$681.45	$699.02

Proposed Site-Neutral Payments for Hospital Outpatient Clinic Visits

The concern or practice of CMS neutralizing payments for services based on utilization is not new. In CY 2008, CMS had concerns about expenditures for some hospital outpatient services which showed significant growth. At that time, CMS also established a set of packaging policies that were intended to encourage efficiency and potentially control future growth in the number of HOPPS services. Effective CY 2008, CMS packaged seven categories of services and items

specific to primary diagnostic or therapeutic modalities that were believed to be ancillary or supportive.

In CY 2014, and made effective in CY 2015, CMS also introduced another method of controlling spending with the introduction of comprehensive APCs (C-APCs). CMS expanded the packaging of services to include items involved in many same day or surgical procedures. The idea was to make HOPPS more like a prospective payment system and less like a per service fee schedule.

HOPPS is the fastest growth sector of Medicare payments out of all of the payment systems under Part A and B. The rate of growth, approximately 8% a year, is concerning to CMS. Total spending for HOPPS is projected to increase by more than $5 billion from approximately $70 billion in CY 2018 through CY 2019 to nearly $75 billion. This is approximately twice the estimated spending of a decade ago in CY 2008.

For CY 2019, CMS is proposing a site-neutral method for controlling *"unnecessary increases in the volume of covered outpatient department services."* For CY 2019, CMS has proposed to utilize a Medicare Physician Fee Schedule (MPFS) payment rate for code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) when billed in excepted off-campus provider-based departments

Excepted off-campus provider-based departments (PBDs) are the settings which were established and billing for services prior to November 2, 2015 and within the previously set distance of 35 miles. Excepted off-campus PBDs are paid at the HOPPS full established rate for each service in CY 2018, and includes outpatient clinic visits.

For CY 2019, CMS is proposing to reimburse outpatient clinic visits billed by excepted off-campus PBDs at the same rate that nonexcepted off-campus PBDs are paid, which is 40% of the HOPPS established rate. CMS believes this will neutralize payments for the most widely reported code under the HOPPS fee schedule. Only on-campus hospital outpatient departments would be reimbursed at the full HOPPS value for code G0463 in CY 2019. Excepted off-campus PBDs would continue to report G0463 with modifier PO, only the reimbursement would change from what is currently paid in CY 2018.

CMS is also seeking comments on the following items:

- How might Medicare define the terms "unnecessary" and "increase" for services (other than the clinic visit) that can be performed in multiple settings of care?
- Should the method to control for unnecessary increases in the volume of covered OPD services include consideration of factors such as enrollment, severity of illness, and patient demographics?
- For what reasons might it ever be appropriate to pay a higher OPPS rate for services that can be performed in lower cost settings?
- Several private health plans use utilization management as a cost-containment strategy. How might Medicare use the authority at section 1833(t)(2)(F) of the Act to implement an

evidence-based, clinical support process to assist physicians in evaluating the use of medical services based on medical necessity, appropriateness, and efficiency?

- Could utilization management help reduce the overuse of inappropriate or unnecessary services?
- How should providers be accounted for that serve Medicare beneficiaries in provider shortage areas, which may include certain rural areas? With respect to rural providers, should there be exceptions from this policy, such as for providers who are at risk of hospital closure or that are sole community hospitals?
- What impact on beneficiaries and the health care market would such a method to control for unnecessary increases in the volume of covered OPD services have?
- What exceptions, if any, should be made if additional proposals to control for unnecessary increases in the volume of outpatient services are made?
- How to maintain access to new innovations and technology while controlling unnecessary increases in reported services for covered HOPPS services.

Expansion of Clinical Families Services in Excepted Off-Campus Departments

In response to the Bipartisan Budget Act of 2015, CMS established new guidelines to address the difference in reimbursement payments for the exact same procedure between varying places of service, primarily hospital vs. ambulatory surgical center (ASC) vs. physician office. The Act established a hard and fast deadline (November 2, 2015) for establishment of any new provider-based departments and the distance (250 yards) the new department could be from the main building of the hospital and still receive payment rates established under HOPPS. Due to what was considered an alarming rate of hospitals acquiring physician practices and the tendency for provider-based departments of a hospital to be paid more than a traditional office setting, changes were made. CMS addresses the proposed rates for CY 2019 and beyond for nonexcepted off-campus PBDs in the CY 2019 MPFS proposed rule; refer to the summary for details.

In the CY 2019 HOPPS proposed rule, CMS is addressing concerns with services provided in excepted off-campus PBDs. As explained previously, excepted off-campus provider-based departments (PBDs) are settings which were established and billing for services prior to November 2, 2015 and within the previously set distance of 35 miles. Excepted off-campus PBDs are paid at the HOPPS full established rate for each service and considered grandfathered into the payments under HOPPS even if the new distance threshold is not met.

In response to the CY 2017 HOPPS proposed rule, CMS received questions regarding whether or not excepted off-campus PBDs could expand the number or type of services offered and still maintain the excepted status, meaning still be paid as an HOPPS outpatient department of the hospital. This raised concerns for CMS as there was no limit to hospitals continuing to acquire physician practices, adding new services to already established and excepted departments, and receiving potentially higher reimbursement due to the combined technical and professional amounts. CMS believes the services furnished at the time of the Act are those services which are covered or fall under the grandfathered pricing and any new services would be considered nonexcepted.

In the CY 2017 proposed rule, CMS outlined a clinical family of services. In the original proposal, if an excepted off-campus PBD provided or billed for services in one of the clinical families for the first time on or after November 2, 2015, those services were not considered expected and would not be paid under HOPPS. The services instead would be paid under MPFS in alignment with nonexcepted off-campus PBDs. The proposal was not finalized as there were considerable comments and concerns on whether or not CMS had the authority to make the changes based on interpretations of the law, the complexity of reporting and no account for the negative impact for emerging technologies, among other things. In CY 2018, CMS did not address the clinical families other than state claims data would continue to be monitored.

CY 2019 provides the first year in which the claims data from CY 2017 can be analyzed and review reporting of the PN and PO modifiers. The PN modifier is billed on all services in a nonexcepted off-campus PBD and "PO" is reported for all services in an excepted off-campus PBD. CMS continues to maintain concerns that the previous rulings may have incentivized hospitals to continue to acquire physician practices and add those practices to nonexcepted off-campus PBDs or transition services from nonexcepted off-campus PBDs; thereby driving up expenses and decreasing competition to hospitals that own the provider-based departments.

For CY 2019 and subsequent years, CMS is proposing changes for excepted off-campus PBDs. If any items or services from any of the clinical families listed below in Table 32 were not furnished during the baseline of November 1, 2014 through November 1, 2015, the services are not considered covered under the excepted status and would instead be nonexcepted and paid under MPFS. However, if an excepted off-campus PBD furnishes new services or items from a clinical family for which other services were already provided as part of that family, these services would be considered excepted and paid under HOPPS, as it would not be considered a "service expansion."

CMS is also proposing a 1-year baseline period for excepted off-campus PBDs that did not begin billing for services until after November 1, 2014, but before November 2, 2015, to use the first date the services were provided and determine the 1-year baseline from there. Similarly, those sites that were in mid-construction when the law was passed and granted exception, the 1-year baseline would begin on the first date a service was billed under HOPPS. CMS is concerned that a year is a long period of time for the baseline and are seeking comments on using 3 or 6 months instead.

The list of 19 clinical families encompasses those services which CMS believes a PBD might bill under HOPPS and covers the possibilities. At the same time, CMS believes this also allows for addition of new services within a clinical family to be considered "excepted items and services" and still allow for innovation and advancement of care. CMS is not proposing to limit the care and services to the exact same ones provided during the baseline period as this would be too restrictive. Instead CMS is proposing to use the "families" of services and not limit to only the individual CPT® or HCPCS codes reported as this would allow for the expansion of services within the same family service line without the adjustment to reimbursement.

CMS is seeking comments on the proposed families and whether or not any specific groups of hospitals should be excluded, such as certain rural hospitals (for example, rural sole community hospitals), in light of recent reports of hospital closures in rural areas. CMS is also seeking comments on any alternative methods to limit expansion of excepted services in excepted off-campus PBDs for CY 2019.

TABLE 32.—PROPOSED CLINICAL FAMILIES OF SERVICES FOR PURPOSES OF SECTION 603 IMPLEMENTATION	
Clinical Families	**APCs**
Airway Endoscopy	5151–5155
Blood Product Exchange	5241–5244
Cardiac/Pulmonary Rehabilitation	5771; 5791
Diagnostic/Screening Test and Related Procedures	5721–5724; 5731–5735; 5741–5743
Drug Administration and Clinical Oncology	5691–5694
Ear, Nose, Throat (ENT)	5161–5166
General Surgery and Related Procedures	5051–5055; 5061; 5071–5073; 5091–5094; 5361–5362
Gastrointestinal (GI)	5301–5303; 5311–5313; 5331; 5341
Gynecology	5411–5416
Major Imaging	5523–5525; 5571–5573; 5593–5594
Minor Imaging	5521–5522; 5591–5592
Musculoskeletal Surgery	5111–5116; 5101–5102
Nervous System Procedures	5431–5432; 5441–5443; 5461–5464; 5471
Ophthalmology	5481, 5491–5495; 5501–5504
Pathology	5671–5674
Radiation Oncology	5611–5613; 5621–5627; 5661
Urology	5371–5377
Vascular/Endovascular/Cardiovascular	5181–5184; 5191–5194; 5200; 5211–5213; 5221–5224; 5231–5232
Visits and Related Services	5012; 5021–5025; 5031–5035; 5041; 5045; 5821–5823

Proposed Payment Adjustment Policy for Radioisotopes Derived From Non-Highly Enriched Uranium Source

Radioisotopes are commonly used in imaging and some of the Technetium-99 (Tc-99m), used in majority of diagnostic imaging, is produced in legacy reactors outside the United States using highly enriched uranium (HEU). The United States has made it a goal to eliminate domestic reliance on these reactors by promoting the conversion of all medical radioisotope production to non-HEU sources.

CMS indicated the options for doing this are technologically and economically viable. CMS expects this conversion, which is under way, will create new costs into the payment system that are not currently accounted for in historical claims data. In CY 2013, CMS finalized a policy to provide an additional payment of $10 for the marginal cost of radioisotopes produced by non-HEU sources. Hospitals report code Q9969 (Tc-99m from non-highly enriched uranium source, full cost recovery add-on per study dose) once per dose along with the diagnostic scan using

the Tc-99m, with the caveat the hospital must be able to certify at least 95 percent of the Tc-99m dose is derived from non-HEU sources. A 2016 report from the National Academies of Sciences, Engineering and Medicine indicated the conversion of Tc-99m production from non-HEU sources would not be complete until the end of CY 2019.

For CY 2019, CMS is proposing to continue to provide an additional $10 payment for radioisotopes produced by non-HEU sources. Once the conversion to non-HEU sources is closer to completion or has completed, CMS will reassess the payment policy.

Requirements for the Hospital Outpatient Quality Reporting (OQR) Program

For CY 2019, CMS is proposing to remove a total of ten Hospital Outpatient Quality Reporting Program (OQR) measures for CY 2020 and CY 2021 payment determinations. There are two criteria for determining when a measure has "topped out" under the Hospital OQR Program:

- When there is statistically indistinguishable performance at the 75th and 90th percentiles of national facility performance
- When the measure's truncated coefficient of variation (TCOV) is less than or equal to 0.10

CMS is clarifying the process for calculating the TCOV for measures PO-11 Thorax Computed Tomography (CT) – Use of Contrast Material (NQF #0513) and PO-14 Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT (no NQF number). These two particular measures actually assess the rate of rare, undesired events for which a lower rate is preferred. CMS used the following example, OP-11 assesses the use of both contrast and non-contrast CT Thorax study at the same time, which is not recommended and there are no clinical guidelines or peer-reviewed literature to support a combined study.

CMS is also proposing to remove OP-9: Mammography Follow-up Rates. The claims-based measure assesses the percentage of patients with mammography screening studies followed by a diagnostic mammography, ultrasound or MRI of the breast in an outpatient or office setting within 45 days. The removal of the measure is based on the fact it no longer aligns with current clinical guidelines or practice. Current clinical practice guidelines from the American College of Radiology (ACR) include the use of digital breast tomosynthesis (DBT). DBT has increased the rate of cancer detection and the use of the technology is expected to continue to increase.

Submitting Comments

Comments to CMS regarding the HOPPS proposed rule must refer to file code **CMS-1695-P** and be received no later than 5 pm EST September 24, 2018. Electronic submission is encouraged by CMS, http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.