CY2015 Proposed Rule Summary
Medical Oncology

Hospital Outpatient Prospective Payment System (HOPPS)

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Prepared On:

July 8, 2014

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Introductory Summary

On July 3, 2014, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the Hospital Outpatient Prospective Payment System (HOPPS) for CY2015.

HOPPS Proposed Rule

The CY2015 may be located in its entirety by following the link below:
http://www.ofr.gov/OFRUpload/OFRData/2014-15939_PI.pdf

This document in PDF form is 687 pages in length. The format of the information on the following pages is intended to serve as highlights, and readers are encouraged to view the document in its entirety for further details. Within the summation, which follows, Revenue Cycle Inc. has provided examples of potential reimbursement based on the interpretation of the published ruling.

CY2015 HOPPS Proposed Rule Highlights

The highlights of the Proposed Rule are provided below in a succinct manner.

- Payment rates – overall 2.2% increase in OPPS payments to providers
  - Increase of 2.1% for urban hospitals and rural 2.4% increase
  - 2.0% point reduction for hospitals failing to meet the hospital outpatient quality reporting requirements
- Conversion Factor – proposed for CY 2015 $74.176
- Wage Index – Frontier States to continue with 1.000, if when calculating the wage index the value were to be below 1.000
  - Proposing to adopt the proposed wage indexes from the FY2015 IPPS/LTCH PPS proposed rule for hospitals paid under IPPS and OPPS as a source for the adjustment factor. Hospitals not paid under IPPS will be assigned a wage index relative to if they were paid under IPPS.
- Cancer hospital payment adjustments – will continue and payment to-cost ratio (PCR) of 0.89 will be used to determine the proposed CY 2015 cancer hospital payment adjustment
- OPPs Payment Changes of Drugs, Biologicals, and Radiopharmaceuticals –
  - Pass-through status of 9 drugs and biologicals proposed to expire on December 31, 2014
  - Continue pass-through status for 22 drugs and biologicals for CY 2015
  - Drugs and biologicals which do not have pass-through status will be set at statutory default of average sales price (ASP) plus 6 percent
  - Drug packaging threshold proposed to be set at $90
- Proposed exception to the 2 times rule for APC 0634 (Hospital Clinical Visits)
- Off Campus Provider-Based - a HCPCS modifier is proposed to be reported with every code for physicians' services and outpatient hospital services furnished in an off-campus provider-

based department of a hospital. The modifier would be reported on both the CMS-1500 claim form for physicians' services and the UB-04 form (CMS Form 1450) for hospital outpatient services.

- Critical Access Hospital proposing the same payment-to-cost ratio target in CY2015 as CY2014.
- New HCPCS codes effective July 1, 2014

Payment rates

Payment rates are proposed to be increased under OPPS for outpatient departments (OPD) by 2.1%. Medicare is also proposing to continue the 2% point reduction in payments for hospitals failing to meet the outpatient quality reporting requirements. For rural hospitals a 7.1% increase is proposed, this is for all services paid under OPPS excluding payable drugs and biologicals and devices paid under the pass-through payment policy.

Cancer hospitals are proposed to continue receiving additional payments so the payment to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for other hospitals using the most recently submitted cost report data. A target PCR of 0.89 will be used to determine the proposed CY2015 cancer hospital payment adjustment.

Payments for those drugs and biologicals which do not have pass-through status are proposed to be set at the statutory default average sales price (ASP) plus 6%. Additionally Medicare is proposing to package certain ancillary services when they are integral, supportive, dependent or adjunctive to a primary service. The initial set of services to be packaged under this proposed payment policy is any services assigned to an APC having a geometric mean cost of $\leq$ $100.

Payment rates for Ambulatory Surgical Centers (ASC) are proposed to increase by 1.2%, with the projected payments expected to be $4.086 billion, an increase of $243 million compared to estimated CY2014 payments. For Critical Access Hospitals Medicare is proposing the same payment-to-cost ratio target in CY2015 as CY2014.

The conversion factor proposed for CY2015 for OPPS payment is $74.176 which is a 2.1% increase from the CY2014 conversion factor. In addition to changes for the conversion factor, Medicare is proposing to changes to the wage index used to determine the wage adjustments. Medicare has proposed to continue for Frontier States a wage index of 1.000 if the otherwise applicable wage index (including reclassification, rural and imputed floor, and rural floor budget neutrality) is less than 1.00.

Medicare is also proposing to use the proposed Inpatient Prospective Payment System (IPPS) wage index for urban and rural areas as the wage index for OPPS hospitals to determine the wage adjustments for the payment rate and copayment standardized amount for CY2015.

As proposed, for those hospitals paid under the IPPS and OPPS, the final FY2015 IPPS wage index would be applied for CY2015. Any adjustments related to the new OMB delineations that are finalized would be reflected in the OPPS wage index. For more information on the IPPS proposed wage index can be found on CMS website and specifically *FY 2015 IPPS/LTCH PPS proposed rule (79 FR 28054)* and the proposed FY 2015 hospital wage index files.

Medicare feels given the logical and inseparable subordinate status of the Hospital Outpatient Department (HOPD) within the hospital overall, the use of the IPPS FY2015 wage index as a source of an adjustment factor to be a reasonable and appropriate change. Medicare is not proposing to charge the current regulations, which require the FY2015 IPPS wage indexes for calculating the OPPS payments in CY2015. Hospitals paid under OPPS, but not IPPS, do not have an IPPS wage index. These hospitals would be assigned a wage index applicable if they hospital were in fact paid under IPPS and based upon the geographic location and wage index adjustments.

Provided below is a list of HCPCS codes commonly used in hospital outpatient infusion departments, the proposed payment rate changes for 2015 are referenced and the variance from the current 2014 rates.

HCPCS Code	Short Descriptor	National Payment Rate		Variance
		2014 Final	2015 Proposed	
36415	Routine venipuncture	$0.00	$0.00	$0.00
36430	Blood transfusion service	$285.17	$296.98	$11.81
36591	Draw blood from venous device	$80.98	$79.86	($1.12)
36593	Declot vascular device	$183.76	$199.83	$16.07
38220	Bone marrow aspiration	$640.91	$821.63	$180.72
38221	Bone marrow biopsy	$640.91	$821.63	$180.72
96360	Hydration iv infusion init	$105.90	$106.21	$0.31
96361	Hydration iv infusion add-on	$29.50	$33.01	$3.51
96365	Ther/proph/diag iv inf init	$172.18	$173.12	$0.94
96366	Ther/proph/diag iv inf addon	$29.50	$33.01	$3.51
96367	Tx/proph/dg addl seq iv inf	$43.78	$52.39	$8.61
96368	Ther/diag concurrent inf	$0.00	$0.00	$0.00
96372	Ther/proph/diag inj sc/im	$43.78	$52.39	$8.61
96374	Ther/proph/diag inj iv push	$105.90	$106.21	$0.31
96375	Tx/pro/dx inj new drug addon	$43.78	$33.01	($10.77)
96376	Tx/pro/dx inj same drug adon	$0.00	$0.00	$0.00
96401	Chemo anti-neopl sq/im	$105.90	$106.21	$0.31
96402	Chemo hormon antineopl sq/im	$43.78	$52.39	$8.61

96409	Chemo iv push sngl drug	$172.18	$173.12	$0.94
96411	Chemo iv push addl drug	$43.78	$52.39	$8.61
96413	Chemo iv infusion 1 hr	$299.53	$282.61	($16.92)
96415	Chemo iv infusion addl hr	$43.78	$52.39	$8.61
96416	Chemo prolong infuse w/pump	$299.53	$282.61	($16.92)
96417	Chemo iv infus each addl seq	$43.78	$52.39	$8.61
96450	Chemotherapy into cns	$299.53	$282.61	($16.92)
96521	Refill/maint portable pump	$172.18	$173.12	$0.94
96523	Irrig drug delivery device	$80.98	$79.86	($1.12)
99195	Phlebotomy	$80.98	$79.86	($1.12)
G0364	Bone marrow aspirate &biopsy	$318.79	$0.00	($318.79)
G0463	Hospital outpt clinic visit	$92.53	$98.06	$5.53

Cancer Hospital Adjustment

Medicare proposes to continue to provide additional payments to designated cancer hospitals. CMS has proposed a payment to-cost ratio (PCR) of 0.89 will be used to determine the proposed CY 2015 cancer hospital payment adjustment. The actual amount of the payment adjustment for each cancer hospital will be dependent on each hospital's CY 2015 payments and costs.

OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

Medicare has proposed to expire pass-through status of nine (9) drugs and biologicals on December 31, 2014. Included are drugs and biologicals that have received OPPS pass-through payment for at least two (2) years and no longer than three (3) years by this expiration date. A section of Table 33 is provided below detailing the drugs and biologicals proposed to be removed from the pass-through list for CY 2015 utilized within oncology.

Table 33 – Proposed Drugs and Biologicals for Which Pass-Through Status Will Expire December 31, 2014

Proposed CY 2015 HCPCS Code	Proposed CY 2015 Long Descriptor	Proposed CY 2015 SI	Proposed CY 2015 APC
J9019	Injection, asparaginase (erwinaze), 1,000 iu	K	9289
J9306	Injection, pertuzumab, 1 mg	K	1471

Medicare has also proposed to continue pass-through status in CY 2015 for 22 drugs and biologicals, which were approved for pass-through status between January 1, 2013 and July 1, 2014. For CY 2015, CMS has proposed to pay for pass-through drugs and biologicals at the Average Sales Price (ASP) plus 6 percent and continue to update pass-through payment rates on a quarterly basis through the CMS website.

A section of Table 34 is provided below detailing the drugs and biologicals utilized within oncology proposed to be maintained on the pass-through list for CY 2015.

Table 34 – Proposed Drugs and Biologicals With Pass-Through Status In CY 2015

Proposed CY 2015 HCPCS Code	CY 2015 Long Descriptor	Proposed CY 2015 SI	Proposed CY 2015 APC
J1446	Injection, tbo-filgrastim, 5 micrograms	G	1447
J1556	Injection, immune globulin (Bivigam), 500 mg	G	9130
J9047	Injection, carfilzomib, 1 mg	G	9295
J9354	Injection, ado-trastuzumab emtansine, 1 mg	G	9131
J9400	Injection, Ziv-Aflibercept, 1 mg	G	9296

CMS proposed to continue packaging items estimated at a per day administration cost less than or equal to $90, which is unchanged from the current CY 2014 rate. CMS proposes to pay separately for items with an estimated per day cost greater than $90 with the exception of 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. Packaging costs in this manner into a single aggregate payment for a service procedure or episode of care is a fundamental principle that distinguishes the prospective payment system from a fee for service system.

APC Re-assignments and Changes

Medicare considered and proposed an exception to the 2 times rule for APC 0634 (Hospital Clinical Visits) which includes the new code for CY2014, G0463 (Hospital outpatient clinic visit for assessment and management of a patient).

Provider Based Status

The increased trend of hospital acquiring physicians and physician practices has posed concern with regard to effectively and accurately establishing payment rates for the facility based pricing. The total payment for services received by a patient in a hospital based system is typically higher than those received in an office-based or free-standing center.

The ability to accurately establish and set pricing information for both individual items and indirect PEs is critical in establishing accurate PE RVUs for PFS services. Medicare indicated there are serious concerns in some of the information used to establish the PE RVUs. This includes concerns with the direct PE time allocations or assumptions and prices of services and equipment. In addition, for indirect PE the information used was collected several years ago and likely needs to be updated.

In was indicated a comparison of payment amounts for OPPS vs. PFS is not an accurate or appropriate means of ensuring the PFS payment rates are based on accurate cost assumptions. PAMA gives authority to collect information on resources used to furnish services from eligible professionals and other sources. Medicare is reviewing ways of collecting better data from physician practices including provider based and other non-facility entities that are paid through PFS.

For CY2015 Medicare is proposing to create a HCPCS modifier to be reported with every code for physician and hospital services furnished in an off-campus provider-based department of a hospital. The modifier would be reported on both claim forms, CMS-1500 for physician services and the UB-04 for hospital outpatient claims. A hospital campus is defined as "*the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office.*"

Collection of the data provided will begin the process of accurately assessing the PE data, including both the service-level direct PE inputs and specialty-level indirect PE information currently used to value PFS services. In addition, this data will provide better understanding of the growing trend towards hospital acquisition of physician offices and the impact of payments for these scenarios under PFS and beneficiary cost-sharing. Understanding which PE costs are actually incurred by the physician and which are incurred by the hospital is expected to provide a more accurate representation of the PE values.

New HCPCS Codes

Medicare released five new HCPCS codes effective July 1, 2014, which included drugs and biologicals utilized within oncology. Provided is Table 16 referencing the HCPCS code, proposed status indicator and reimbursement for CY 2015.

Table 16 – New Level II HCPCS Codes Implemented in July 2014

CY 2014 HCPCS Code	CY 2014 Long Descriptor	Proposed CY 2015 SI	Proposed CY 2015 APC	Proposed CY 2015 Payment Rate
C2644	Brachytherapy source, cesium-131 chloride solution, per millicure	U	2644	$18.97
C9022	Injection, elosulfase alfa, 1 mg	G	1480	$226.42
C9134	Factor XIII (antihemophilic factor, recombinant), Tretten, per 10 i.u.	G	1481	$14.10
Q9970	Injection, ferric carboxymaltose, 1mg	G	9441	$1.06
Q9974	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg	N	N/A	N/A

Submitting Comments

Comments are encouraged and must be delivered no later than 5 pm, EST, September 2, 2014. When commenting please refer or list the file code **CMS-1613-P** for HOPPS. No comments by fax can be accepted.

You may submit comments in one of four ways (no duplicates); however, it is recommended to submit them electronically at http://www.regulations.gov**.** Follow the instructions under the "submit a comment" tab.

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