Dear Jose Luis,

Well, with all the arguing and gnashing of teeth regarding Obamacare and whether or not it should be repealed, replaced, re-hashed, re-upped, and rejected, some of you out there may have forgotten that the beginning of July is Proposed Rules Season for the following calendar year. True to form, CMS (Can More Suck?) released the Proposed Physician Fee Schedule and the Hospital Outpatient Prospective Payment for 2018 on July 13, 2017. These proposed rules are a glimpse into Medicare rules for next year.

To cut to the chase, the hospital proposed rule is the one with the biggest changes. This proposal will change the way the Medicare drugs are paid by significantly lowering Medicare payment for 340B drugs, i.e. drugs purchased under the 340B program. Another cut to hospitals will include further lowering of fee
schedule ("APC") payments to non-grandfathered provider-based facilities.

Just remember all or some of what we outline herein is subject to change.

Have a quintuple latte and check out the proposed rules!!!

Da' Mistress

Proposed Physician Fee Schedule Changes for 2018

This draft rule includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2018. To read the CMS fact sheet, click here. To read the proposed rule, click here.

Here are some of the 'highlights':

• **Reduced PFS rates for off-campus departments from 50 percent to 25 percent**. This is actually NOT a change for office-based physicians. The proposal would change the PFS payment rates for non-excepted (Section 603) items and services from 50 percent of the OPPS payment rate to 25 percent of the OPPS rate. For off-campus sites that were not in existence by November 2, 2015, CMS pays half of hospital rates, and CMS proposes to pay only 25 percent of hospitals rates next year.

• **Changed the conversion factor per MACRA requirements**. The conversion factor will go from $35.8877 to $35.9903. That's about 10-cents--don't spend it all in one place.

• **Issued minor rules and solicit comments for Part B drugs**. The two sections devoted to Part B drugs are actually currently in effect. So. these will not change things for you a
Drug provided in Durable Medical Equipment (like pumps) were paid for 12 years at a rate of 95% of Average Wholesale Price. As of January 1, 2017, the rate changed to ASP plus 6%. This was codified in the proposed regulations. Also, CMS wants comments on the idea that biosimilars will share a single Q-code and how that will influence reimbursement and patient care.

- **Made retroactive changes to PQRS reporting.** To create parity with the MIPs quality programs, CMS will lower the bar when looking at penalties in 2018 from 2016 reporting. Please be aware: **CMS is not asking people to re-report.** To align with MIPS requirements, clinicians and groups **who successfully reported six quality measures for Physician Quality Reporting with no cross-cutting measures.** The original ask was for 9 measures with 3 measures from the National Quality Domain. So, this reporting reduction for 2016 will avoid the -2.0 percent penalty that was to be applied in 2018.

- **Changed requirements for the Value Modifier.** Practices that successfully report PQRS based on the reduced requirements will be held harmless. That is, CMS will hold all groups and solo practitioners who are in Category 1 (those who meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50 percent of the group’s EPs meet the criteria as individuals) harmless from downward payment adjustments under quality tiering for the last year of the program. Additionally, the maximum penalties for the Value-based Payment Modifier would be reduced from -4.0 percent to -2.0 percent for groups of 10 or more and -2.0 percent to -1.0 percent for groups of 10 or fewer.

- **Added services to the list Medicare telehealth services.** For CY 2018, CMS is proposing to add several codes to the list of...
telehealth services, including:
  ◦ HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility);
  ◦ CPT code 90785 (Interactive Complexity);
  ◦ CPT codes 96160 and 96161 (Health Risk Assessment);
  ◦ HCPCS code G0506 (Care Planning for Chronic Care Management); and
  ◦ CPT codes 90839 and 90840 (Psychotherapy for Crisis).
  ◦ Additionally, CMS is proposing to eliminate the required reporting of the telehealth modifier (-GT) for professional claims.
  
- **Updated certain codes for care management services.** CMS is proposing to adopt Current Procedural Terminology (CPT) codes for CY 2018 for reporting several care management services currently reported using Medicare G-codes, such as Behavioral Health Integration. Also CMS is seeking public comment on ways they might further reduce burden on reporting practitioners for chronic care management and similar services, which are still underutilized.

- **Established some new codes for 2018.** Below are some of the changes you will see if what is proposed go through.
  ◦ There will be relative values for the OnPro® injections (96377) under the MD fee schedule in 2018.
  ◦ There will be a new G-code code for Superficial Radiation Treatment & Management ("SRT").
  ◦ Coding for INR Management will be overhauled in 2018.
  ◦ And, there will be new Level II codes for Prolonged Preventive Services.

- **Established new Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs).** CMS proposes for RHCs and
FQHCs to receive payment for regular and complex chronic care management services, general behavioral health integration services, and psychiatric collaborative care model services using two new billing codes created exclusively for RHC and FQHC payment. This payment would be in addition to the payment for an RHC or FQHC visit.

- **Changed the Clinical Laboratory Payment Schedule for many lab tests.** Starting January 1, the Clinical Lab Fee Schedule will be based on the median private payer fees collected from the PAMA effort his Spring. This data collection will occur every three years.
- **Delayed (again) Appropriate Use Criteria for Advanced Imaging.** Providers who do Advanced Imaging were supposed to consult outside portals to obtain criteria for the patient diagnosis and testing. This program was supposed to start January 1, 2017. We are now looking at January 1, 2019. Cancer of the lung will be a priority area.
- **Asked for feed-back regarding Evaluation & Management Services.** Evaluation & Management Services codes and documentation guidelines are used by all physicians. This coding has long been a problem due to complex and cumbersome guidelines. CMS wants to know, if requiring histories and physicians as being a driving force of coding, is outdated and should be simplified. They also want to know if other items, like time and the nature of the presenting problem should be more prominent in the code selection.
- **Issued Patient Relationship Modifiers:** These five Level II modifiers, which are required by MACRA, will denote whether or not the billing provider has an ongoing or periodic relationship with the patient. These modifiers will not impact payment in 2018. For more information, check out the CMS description.
- **Modified the Medicare Shared Savings
**Program rules.** CMS is proposing several modifications to the rules for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program. The proposals include the following:

- Revisions to the assignment methodology to reflect the requirement under the 21st Century Cures Act that beginning on or after January 1, 2019, HHS will determine an appropriate method to assign Medicare FFS beneficiaries to an ACO based on their utilization of services furnished by rural health clinics (RHCs) or federally qualified health centers (FQHCs);
- The addition of three new chronic care management codes (CCM) and behavioral health integration (BHI) codes to the definition of primary care services used in the ACO assignment methodology; and
- Reduction of burden for stakeholders submitting an initial Shared Savings Program application and the application for use of the skilled nursing facility (SNF) 3-Day Rule Waiver.

Again, to review the Proposed Rule, go to this site and download it.

**Hospital Outpatient 2018 Proposed Rule: Buckle Up!!**

This rule was also issued on July 13, 2017. The proposed rule includes updates to the 2018 rates and quality provisions, and proposes other policy changes. To read the CMS fact sheet, click here. To read the proposed rule, click here.

Here some of 'highlights' of the OPSS Proposed Rule for cancer clinics in 2018:

- **Decreased in prices for payment for drugs and biologicals ("drugs") purchased with a 340B Program Discount** CMS is proposing to reimburse hospitals for Part B drugs at a rate of average sales price minus 22.5 percent for drugs purchased through the 340B
percent for drugs purchased through the 340B program which is what MedPAC estimates to be the minimum 340B discount received by hospitals. The current reimbursement rate for Part B drugs to 340B hospitals is average sales price plus 6 percent. The proposal does not apply to vaccines and CMS is soliciting comment on whether certain types of drugs such as blood-clotting factors should also be excluded.

- **Changed payment for off-campus hospital outpatient departments (HOPDs) to 25 percent rather than 50 percent of the Medicare OPPS rate** for non-grandfathered services provided at off-campus HOPDs. This was part of the Proposed Physician Rule, but it impacts hospitals.

- **Bundled 'minor' injections and 'inexpensive' drugs.** As you may know, CMS has tried to bundle more and more stuff into Ambulatory Payment Classifications. Next year, CMS will NOT bundle 'add-on' drug administration codes, which they have threatened to do. They propose, however, to **bundle injections (96372, 96401, 96402) and 96377 for the on-body injector.** Also, CMS once again increased the **bundled drug threshold to $120 for Calendar Year 2018.**

- **Established a net 1.75 percent payment increase after the 2.9 percent market basket increase is adjusted for a 0.4 percentage point adjustment for multi-factor productivity and a 0.75 percentage point adjustment mandated by the Affordable Care Act, excluding budget-neutrality adjustment**

- **Reinstated a moratorium on direct supervision of some hospital outpatient therapeutic services for some facilities.** CMS is proposing to reinstate the non-enforcement of direct supervision enforcement instructions for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds for CYs 2018 and 2019.

- **Changed the controversial 14-Day Rule.** The proposal will revise the Laboratory Date of
The proposal will revise the Laboratory Date of Service policy to allow laboratories to bill Medicare directly. Right now, if a specimen is needed within 14 days of collection, the hospital must bill for it and pay the lab for it. **CMS proposes potential modifications to the Date of Service ("DOS") policy that would allow laboratories to bill Medicare directly for molecular pathology tests and diagnostic laboratory tests which are excluded from the OPPS packaging policy and ordered less than 14 days following the date of the patient's discharge from the hospital.** This would be a great improvement for personalized medicine! **To further review this proposed rule, download it here.**

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onPoint Oncology Inc,
3006 Pine Trails Circle, Hudson, OH 44236

[SafeUnsubscribe™ execdir@anco-online.org](mailto:execdir@anco-online.org)

[bbuell@onpointoncology.com](mailto:bbuell@onpointoncology.com) | [Update Profile](mailto:Update Profile) | [About our service provider](mailto:About our service provider)

Sent by [bobbibuell1@yahoo.com](mailto:bobbibuell1@yahoo.com) in collaboration with

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