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Subject: E-Reimbursement News--All 2018 FINAL Medicare Rules Released!!! Learn More At Our Webinars! 11-7-2017
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Issue: #10, Volume 27 November 2017

Dear Jose Luis,

Happy November, everyone! Well, happy for everyone except reimbursement experts as **we have had to pour through about 3500 pages of regulations in the past week. What this means is the Hospital Outpatient, Physician, and Quality Payment Program updates were released by CMS within a 24 hour period!** As many of you know, I am on speaking tour so I must confess I have not finished reading. So, there will be updates to some of these topics over time!! We will also have CPT updates for you as soon as they are released and we review them.

If you belong to a hospital-based cancer

center, be prepared to have a martini after reading this newsletter. Very depressing news indeed.

As we were finishing up, the HCPCS codes came out! See our last article for more information. This table is often revised, so we will update you if it changes, but this gives you some time to update your chargemaster, superbills, and EMRs.

And, speaking of updates, we will again have our ever-popular webinars in December. You can sign up at the end of this newsletter. These webinars are absolutely free and everyone is welcome (even if I don't really like you)!! You will get more details about these regulations and coding changes on the call on these calls.

The bleary-eyed one,

Da' Mistress

Final Physician Fee Schedule Changes for 2018

This rule includes updates to 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 FINAL 2018 rule, click here .

Here are some of the 'highlights':

- **Reduced PFS rates for off-campus departments from 50 percent to 40 percent** . This is actually NOT a change for office-based physicians. **The proposal would change the HOPPS (Hospital outpatient) payment rates for non-excepted (Section 603) items and services from 50 percent of the OPPS payment rate to 40 percent of the OPPS rate.**

payment rate to 40 percent of the OPPS rate.** This is actually an improvement--the discount for these facilities was supposed to be 25% of the HOPPS fee schedule. Again, for off-campus sites that were not in existence by November 2, 2015, CMS pays 40% next year--not as bad as it could have been.

- **Changed the conversion factor per MACRA requirements**. The conversion factor will go from **$35.8877 to $35.9996**. Not a big bump but that is what MACRA requires.
- **Allows biosimilars to have their own J-codes**. In answer to many company prayers, biosimilars will get their own J-codes in 2018. This will allow "for more choice" according to CMS. It will prevent all the terrible coding we have seen in the biosimilar billing this year. But, in reviewing the 2018 HCPCS table, we do not see new codes. Do not expect to right away--"Effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same HCPCS code. We will issue detailed guidance on coding, including instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers. Completion of these changes, which will require changes to the claims processing systems, is planned to occur as soon as feasible, but should not be expected to be complete by January 1, 2018," CMS said.
- **Issued minor rules for Part B drugs**. **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. This means there are no changes in the Physician Space in terms of drug pricing.
- **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. Again

at penalties in 2018 from 2016 reporting? Again, 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. CMS is also aligning the maximum upward adjustment amount to 2 times the adjustment factor for all physician groups and solo practitioners.

- **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.** The archaic Medicare rules have not changed--boo hoo! For CY 2018, CMS adds 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);
    - There will be separate payment for 99091 (Collection and interpretation of physiologic data) in 2018; 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.
- **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. See the Hospital Outpatient Final rule article for some GOOD news on lab tests.
- **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, 2020. This is the third push-back of this program. Question is: will this happen?
- **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 received a lot of feed-back and realizes this will take a boat load of work and so they will research E/M services with**

various groups before implementing any changes.

- **Discussed 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 and will be STRICTLY VOLUNTARY.** The only good news about these codes is that they will more accurately attribute paFor more information, check out the CMS description.

Again, to review the FINAL RULE, go to this site and download it.

Hospital Outpatient 2018 Final Rule: YIKES

This rule was also issued on November 1, 2017. This final 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 FINAL rule, click here.

Here some of 'highlights' of the OPPS Final Rule for cancer clinics in 2018:

- **Decreased in prices for payment for drugs and biologicals ("drugs") purchased with a 340B Program Discount** CMS will reimburse hospitals for **Part B drugs at a rate of average sales price minus 22.5 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. This will be the rate for non-340B facilities. **All 340B drugs will need to be reported with a modifier--which was not named in the rule**.
- **Changed payment for off-campus hospital outpatient departments (HOPDs) to 40 percent rather than 50 percent of the Medicare OPPS rate** for non-grandfathered services provided at off-campus HOPDs. This

services provided at off-campus HOPDs. This was part of the Proposed Physician Rule, but it impacts hospitals. This will definitely be a double whammy for 340B provider-based departments.

- **Bundled 'minor' injections and 'inexpensive' drugs.** As you may know, CMS has tried to bundle more and more stuff into Ambulatory Payment Classifications.They will, however, **bundle injections (96372, 96401, 96402) and 96377 for the on-body injector**.
- **Once again increased the daily bundling of drugs.** Also, CMS for dates of service starting January 1, 2018 increased the **bundled drug threshold to $120 for Calendar Year 2018**. Pharma companies, please check your drugs because we have seen erroneous bundling over the years.
- **Increased the OPPS payment rates by 1.35 percent for 2018.** The change is based on the hospital market basket increase of 2.7 percent minus both a 0.6 percentage point adjustment for multi-factor productivity and a 0.75 percentage point adjustment required by law. After considering all other policy changes under the final rule, including estimated spending for pass-through payments, CMS estimates an overall impact of 1.4 percent payment increase for providers paid under the OPPS in CY 2018.
- **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**. For years, if the patient has a specimen taken during a hospital procedure, a test on the specimen must be billed by the hospital, **if the test is performed within 14 days of when the specimen was removed. The date of service for these tests is the date of acquisition**. The new exception to the laboratory DOS policy

new exception to the laboratory DOS policy generally permits laboratories to bill Medicare directly for ADLTs (Advanced Diagnostic Laboratory Tests, e.g. molecular diagnostics) and molecular pathology tests excluded from OPPS packaging policy **if the specimen was collected from a hospital outpatient during a hospital outpatient encounter and the test was performed following the patient's discharge from the hospital outpatient department**. This is not as generous as the proposed rule, which included INPATIENT procedures.
To further review this FINAL RULE rule, download it here.

QPP Rules for 2018

The Centers for Medicare & Medicaid Services (CMS) released the Quality Payment Program 2018 regulations under the official title, "The Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year". The most important caveat of last week's release in final form is the fact that many physicians will happily be excluded from the program. **The threshold for participation was raised to $90,000 in Medicare Part B total allowed charges - or 200 Medicare patient encounters. If you fall below those benchmarks, you are outta here with QPP for next year. There are more exemptions listed below.**

Other provisions are included in the following sections.

- **The basics of the two-track program are still in effect for CY 2018**-- either be in an advanced alternative payment model (aAPM) or be an active participant in the Merit-based Incentive Payment System (MIPS).
- **Part B drugs WILL be included in the calculation of your reward or penalty starting in 2020 (with reporting in 2018)**. Yes, as crazy

in 2020 (with reporting in 2019). Yes, as crazy as it seems, your payment adjustments will apply to Part B drugs, if the drugs are associated with your TIN/NPI. If you don't believe me, see this.

- **Cost is back with a bullet.** CMS proposed dropping the score related to "cost" for 2018. But, like the Terminator, it is back with a 10% weight. Next year, cost will be based on the Medicare Spending per Beneficiary (MSPB) and total per capita cost measure. The Final Rule also reiterated that there will be a **30% weighting of the cost component for 2019** reporting year and beyond. So, get a handle on your QRUR reports now.
- In 2018, the mix of the scores are: **50% Quality; 25% ACI; and 15% improvement activities, with cost at 10%**.
- **2014 CEHRT-certified EMRs are okay next year.** However, there are bonus points for reporting exclusively on the 2015 edition.
- **15 points are required to avoid the penalty in 2018**, up from three points needed during the 2017 transition year. That being said, read further to see that there are lots of bonus points and small practice perks out there.
- **Providers cannot use multiple reporting mechanisms, despite what the proposed rule said.** Practices can use only one mechanism for reporting the quality measures in 2018, in direct opposition to the proposed rule. Various reporting mechanisms MIGHT be adopted in 2019.
- **The reporting period for the quality and cost measures is 12 months in 2018, but the Advancing Care Information and Improvement Activities are still 90 days**. Several oldie quality measures have "topped out," so it is impossible to score at the highest level even with perfect reporting by your facility. Word to the wise--read each measure each year and use the ones that provide the most value to your point score.
- Points for 'complex patients'--good for us!! Five bonus points are available for the "treatment of complex patients," based upon

"treatment of complex patients," based upon CMS using the dual eligibility ratio and average HCC risk score. HCC coding is important for this and for your cost component. So, do not neglect this when coding your cases.

- **There is a small practice bonus, plus a few other cool perks for the little guys/ gals.** Small practices (15 providers or less) get an automatic bonus 5 points. In addition, they have to worry about data completeness for the quality measures, as they receive an automatic 3 points per measure. Also, there is another exemption where a small practice size exempts one from the ACI category, with an end-of-year due date for the application for this exception.
- **More providers will be exempt.** Providers practicing in off-campus outpatient hospital (place of service 19) clinics are also exempt, as they are now all part of the "hospital-based physician" definition. Another important retroactive exemption falls in the ACI (formerly Meaningful Use) category: physicians who write less than 100 permissible prescriptions are relieved of the e-Prescribing category and those who transfer a patient to another setting or refer a patient fewer than 100 times during the performance period are exempt from the health information exchange/summary of care measures. The last exemptions are retroactive to 2017.
- **There are also exemptions for those struck by the Hurricanes.** For those impacted, in 2018, they will not have to report anything, but the cost category will still be going strong as the only component for the full score in 2018. For 2017, those affected are totally off the hook.
- **Virtual groups can be used for reporting in 2018**. If you are a solo practitioner or small group, your group can join with another to report MIPS this year.
- **All Payer Options will be available in 2019.**

For more information, see the Final Rule on the QPP right here

Q4 right here.

HCPCS 1/1/2018

The HCPCS Table was released today. All changes in the following table are new codes, unless they are in RED--those are deleted codes. This is a preliminary list. We may release more changes in the future--particularly with the biosimilar situation...

HCPC	LONG DESCRIPTION
ZC	Merck/samsung bioepis
C9014	Injection, cerliponase alfa, 1 mg
C9015	Injection, c-1 esterase inhibitor (human), haegarda, 10 units
C9016	Injection, triptorelin extended release, 3.75 mg
C9024	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine
C9028	Injection, inotuzumab ozogamicin, 0.1 mg
C9029	Injection, guselkumab, 1 mg
C9488	Injection, conivaptan hydrochloride, 1 mg
C9492	Injection, durvalumab, 10 mg
C9493	Injection, edaravone, 1 mg
J0565	Injection, bezlotoxumab, 10 mg
J0604	Cinacalcet, oral, 1 mg, (for esrd on dialysis)
J0606	Injection, etelcalcetide, 0.1 mg
J1428	Injection, eteplirsen, 10 mg
J1555	Injection, immune globulin (cuvitru), 100 mg
J1627	Injection, granisetron, extended-release, 0.1 mg
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
J2326	Injection, nusinersen, 0.1 mg
J2350	Injection, ocrelizumab, 1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg

J7210	Injection, factor viii, (antihemophilic factor, recombinant), (afstyla), 1 i.u.
J7211	Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (kyleena), 19.5 mg
J7345	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg
J9022	Injection, atezolizumab, 10 mg
J9023	Injection, avelumab, 10 mg
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg
J9285	Injection, olaratumab, 10 mg
J1725	Injection, hydroxyprogesterone caproate, 1 mg (DELETED)
J9300	Injection, gemtuzumab ozogamicin, 5 mg (DELETED)

Get Ready for 2018 With Da' Mistress!!

Yes, for those of you not receiving intravenous Egg Nog over the Holiday Season, you are invited to our 2018 Reimbursement webinars. Everyone is invited--everyone--but, we implore you to sign up for **only one time slot** and please show up. To sign up, please click the link and select the day that works for you!

Here they are--all times are **Eastern Standard Times**

- Friday, December 8th, 12 Noon (11 CST, 10 MST, 9 PST)
- Friday, December 15th, 12 Noon (11 CST, 10 MST, 9 PST)
- Friday, January 5th, 3 PM (2 PM CST, 3 PM MST, 12 PM PST)

Merry Xmas, everyone!!!