Analysis of Payment Methodology for ASC & EOP

Analysis of ASC Payment Methodology

- CMS pays for procedures in an ASC based upon rates paid for the same service in other settings
  - Outpatient Prospective Payment System (OPPS)
    - Hospital outpatient department
  - Physician Fee Schedule (PFS)
    - Physician office based procedures

OPPS or Office-Based Payment?

- Majority of ASC covered services have rates derived from rates for the same services under the Hospital outpatient department
  - Outpatient Prospective Payment System (OPPS)

However

- Some services are considered "office-based procedures" with rates derived from the practice expense portion of rates for the same services under the Physician Fee Schedule (PFS)

Office-Based Procedures in ASC

- Procedures that are done 50 % or more of the time in the physician office
- CMS allows office-based procedures to be performed in an ASC as long as they are on the ASC list, BUT pays at the office rate to prevent "inappropriate" migration of procedures from the office to higher cost sites of service
- ASC payment does not include some "packaged" services such as sedation, selective catheterization, ultrasound, radiologic imaging or add-on codes

Ambulatory Payment Classification (APC)

- Each broad outpatient procedure-type in OPPS falls within an APC group with varying payment levels
- Endovascular APC (2019 proposed rule)
  - 5191 = Geometric mean cost $2,882
  - 5192 = Geometric mean cost $4,843
  - 5193 = Geometric mean cost $9,945
  - 5194 = Geometric mean cost $15,788
- Procedures are of similar cost are grouped into an APC and all paid at similar rate

How the APC Works

- All endovascular procedures – not just dialysis procedures are assigned to 1 of 4 APC groups
- Groups are defined by a range of costs (can be broad)
  - 5191 – lowest
  - 5194 - highest
- A geometric mean is determined for each group which serves as the basis for payment for the entire group

What causes Changes in ASC Payment Rates?

- Changes within the OPPS
  - CMS may change the payment rate for an APC
  - Individual procedure cost may change causing it to shift into a different APC (higher or lower)
- Change from OPPS to PFS
  - A procedure paid under OPPS may be shifted to payment at PFS rate if it is found to be done >50% of time in office site of service
    - "Site Neutral Payment"

Site Distribution of Procedures

2017

Code	ASC	HOPD	Hosp	EOP
36901	2.4%	32.3%	9.3%	55.2%
36902	3.4%	27.7%	4.7%	63.5%
36903	2.3%	30.4%	7.2%	59.6%
36904	0.8%	40.6%	25.5%	30.5%
36905	2.4%	31.1%	11.6%	53.2%
36906	3.4%	27.7%	4.7%	63.5%
36907	2.3%	30.4%	7.2%	59.6%
36908	0.8%	40.6%	25.5%	30.5%
36909	0.8%	26.5%	5.3%	67.1%

Calculating Total Payment for Service

- In determining the payment rates for a procedure, CMS starts by distinguishing two portions of the OPPS rate :
  - The "**device portion**" - the amount of the OPPS rate attributed to devices
  - The "**service portion**," physician service based on OPPS relative weights (RVUs)

Device- Intensive Procedures

- Most rates based on OPPS relative weights using a methodology that results in payment rates that are approximately 56% of the OPPS rates for the same procedures.
  - Procedures are subject to the OPPS-ASC adjustment (100% for 1st, 50% for 2nd, etc)

However

- A small set of procedures, called **device-intensive procedures**, are assigned payment rates that, while they are based on the OPPS rates, are higher than they would be under the otherwise applicable methodology.
  - When a code is determined to be "device intensive" the proportion of the cost attributed to devices is not subjected the OPPS-ASC adjustment.

Device- Intensive Definition

- Device-intensive procedures are procedures with the device share of the OPPS payment rate 40 % or greater
  - CMS has proposed to decrease this to 30% in the 2019 proposed rule

Determining Cost of Devices

- In the past, CMS calculated the device portion from the cost of devices as estimated from hospital claims
- They have started obtaining the "true cost" by examining actual invoices or a GPO list price discount
  - For the 2019 proposed rule CMS engaged a 3rd party to determine device costs

Other Changes in Device- Intensive Classification

- In the past, this determination was made at the APC level (group of procedures)
  - Geometric mean device cost for APC group was determined
  - If the mean device costs for the APC group was greater than 40 % of the APC payment amount, then the all procedures in group were considered device-intensive.
- Currently, CMS determines whether a procedure is device-intensive on a procedure-specific basis
  - Under this approach, only individual procedure codes for which CMS estimates device costs are 40 % or greater of the costs of the APC to which it is assigned will be considered device-intensive

Service Portion of Payment

- The rate for the service portion of the device-intensive procedures in the ASC is calculated using the same methodology as used for other ASC services that are paid based on OPPS relative weights
- This has been approximately 56 % of the level under the OPPS (44% less)

Significance of Device- Intensive Designation

- The overall ASC rate for a device-intensive procedure is the sum of the device portion plus the ASC service portion.
- The resulting ASC payment rate will exceed (perhaps substantially) the payment rate that might apply in the absence of the device-intensive payment provision

Dialysis Access Circuit Codes

2019 ASC Proposed Rule

New Codes

- Payment rates for new codes are "cross-walked" from OPPS and are approximately 56% of the OPPS rates
- For new codes that **require medical devices** but for which CMS does not yet have claims data, CMS calculates the ASC payment rate **assuming that the device costs are 41 %** of the Ambulatory Payment Classification (APC) payment rate calculated under the standard OPPS methodology until it has better information
- Because initially CMS did not have claims data on the dialysis circuit codes, they applied the 41 % device cost to certain of these codes
- **Now CMS has claims data**, and adjustments are being made

Classification of Codes (2017)

36901- Angio	Office-based classification
36902 - Angio, PTA	Device- intensive
36903 - PTA, stent	Device- intensive
36904 - Throm	Device- intensive
36905 - Throm, PTA	Device- intensive
36906 - Throm, PTA, stent	Device- intensive
36907 - Angio, PTA - Central	Add-on code, not eligible
36908 - Angio, PTA, stent - Central	Add-on code, not eligible
36909 - Embolization coil	Add-on code, not eligible

36902-36906 classified as device intensive because of APC (group) classification

Classification of Codes (2018)

36901- Angio	Office-based classification
36902 - Angio, PTA	OPPS (56% rate)
36903 - PTA, stent	OPPS (56% rate)
36904 - Throm	OPPS (56% rate)
36905 - Throm, PTA	OPPS (56% rate)
36906 - Throm, PTA, stent	OPPS (56% rate)
36907 - Angio, PTA - Central	Add-on code, not eligible
36908 - Angio, PTA, stent - Central	Add-on code, not eligible
36909 - Embolization coil	Add-on code, not eligible

CMS did away with all device-intensive classifications

This led to 15-20% reduction for these codes

Proposed Classification of Codes (2019)

36901- Angio	Office-based classification
36902 - Angio, PTA	Office-based classification
36903 - PTA, stent	Device- intensive
36904 - Throm	OPPS (56% rate)
36905 - Throm, PTA	Office-based classification
36906 - Throm, PTA, stent	Device- intensive
36907 - Angio, PTA - Central	Add-on code, not eligible
36908 - Angio, PTA, stent - Central	Add-on code, not eligible
36909 - Embolization coil	Add-on code, not eligible

Stent procedures were re-classified as device intensive again
36904 was unchanged because of inadequate available data

Issues Affecting Payment for Services

- More than 60% of angioplasty and thrombectomy codes originate from office-based procedures
  - CMS rule is that if more than 50%, the procedure is classified as office-based
- Because initially CMS did not have claims data on the dialysis circuit codes, they applied the 41 % device cost to certain of these codes
  - **Now CMS has actual invoice data**, and adjustments are being made

Changes in Proposed Payments

Code	2018	2019	Change
36901	$319	$533	67%
36902	$2052	$1125	-55%
36903	$4480	$6082	36%
36904	$2525	$2719	8%
36905	$4480	$2080	-54%
36906	$6924	$9835	42%

Extension of Physician Office (EOP)

2019 Physician Fee Schedule Proposed Rule

Determining Payment for Service

- Total payment for a service is based upon a consideration of 3 types of RVU:
  - Practice expense RVU
    - Labor costs
    - Equipment costs
    - Supply costs
  - Physician work RVUs
  - Professional liability insurance RVU

New Proposal

- Labor costs – have gone up significantly since last adjustment, presently approximately 50% below value – no change proposed
- Equipment costs – have been based upon list price, now based upon actual invoices – changes proposed
- Supply costs – was based on list price, now based upon actual invoices – changes porposed
- Physician services RVUs – slight adjustments based on surveys
- Malpractice insurance costs – essentially unchanged

EOP Changes

- 4.18% increase in PTA payment
- 4.67% increase in thrombectomy/PTA payment
- Slight decrease in stent payment

- Proposal to increase payment by average of 5% each year for next four years
  - How this will affect individual centers will depend upon their case mix

Payment over time

CPT	2017	2018	2019
36901	$581	$611	$673
36902	$1,235	$1,272	$1,325
36903	$5,663	$5,725	$5,432
36904	$1,801	$1,849	$1,948
36905	$2,304	$2,344	$2,453
36906	$6,867	$6,949	$6,698
36907	$739	$770	$749
36908	$2,722	$2,763	$2,494
36909	$1,985	$2,008	$2,017

2017 - 25% decrease in reimbursement resulting from RUC evaluation which was decreased further by CMS

2018 - Increase in reimbursement due to CMS going back to RUC recommendations

2019 - Changes due to variety of changes in CMS rules

Total Payment for Central Venous Procedure

- Superficially, it appears as though the payment for a central venous procedure is lower than it actually is
- 36907 and 36908 are add-on codes, this means that the cannot be used alone
- The minimum payment for a central venous angioplasty would be 36907 + 36901 or $1,422 in contrast for the peripheral angioplasty payment of $1,325

Payment Site of Service Comparisons

Code	EOP Global	ASC Global	HOPD Global
36901	$673	$710	$1283
36902	$1325	$1378	$5009
36903	$5432	$6417	$10,100
36904	$1948	$3110	$5147
36905	$2453	$2549	$10,234
36906	$6698	$10,377	$16,046
36907	$749	N/A	N/A
36908	$2494	N/A	N/A
36909	$2017	N/A	N/A

Where do we go from here?

The CMS Process

- Propose a “rule” (fee schedule) for public comment in late June
  - ASC (CMS 1695-P)
  - PFS (CMS 1693-P)
- Deadline to submit comments September 10, 2018 (PFS) or September 24, 2018 (ASC)
  - https://www.regulations.gov/
- Publish a “final rule” in November
- New rates become effective January 1

The Usual Response

- Comment to CMS
  - Society's
    - ASDIN
    - RPA
    - AMA, others
  - Coalitions
    - Dialysis vascular access coalition (DVAC)
    - Kidney Care Partners (KCP)
    - Others
- Lobby Congress for support or changes – less common

Today's Response

- Comment to CMS
  - Societies and coalitions are preparing letters now
  - Individuals are welcome but value is uncertain
- Lobby congress for support (This is critical now!) – see DVAC website
  - Grasstop physician leaders
    - DVAC will provide scripts and info for you to call your members of congress and others
    - Email tap@renalcareassoc.com to express your interest
  - Grassroots
    - Everyone (including patients) email your congressperson asking them to sign onto the Costello-Lance-Dingell letter
      - Go to www.dialysisvascularaccess.org/
- Technical focused meetings with HHS, CMS – RPA, DVAC

Message

- The value your center has brought to patients
- The negative impact the changes will have on your patients and practice
- Your opinion of the consequences for the healthcare system