2018 MEDICARE UPDATE

CHOP

January 2018

Risë Marie Cleland
Oplinc, Inc.

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AGENDA

- The Medicare Access and CHIP Reauthorization Act (**MACRA**)
- Value Modifier Payment (**VM**)
  - Final year payment adjustment
- Quality Payment Program (**QPP**)
  - The Merit-Based Incentive Program (**MIPS**)
  - Alternative Payment Models (**APMs**)
- The Medicare 2018 Final Rules
  - Medicare Physician Fee Schedule (**MPFS**)
  - Outpatient Prospective Payment System (**OPPS**)

VALUE MODIFIER

Physician Feedback

2018 Value Modifier

- Changes to the 2018 Value Modifier to align incentives and smooth transition to the new Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP):
  - Reducing the automatic downward payment adjustment for not meeting the criteria to avoid the PQRS adjustment:
    - From -4% to -2% for groups of 10 or more clinicians;
    - From -2% to -1% for physician and non-physician solo practitioners and groups of 2-9 clinicians.
  - Physician groups & solo practitioners who met the criteria to avoid the PQRS adjustment will not be subject to downward payment adjustments for performance under quality-tiering for the last year of the program; and
  - The maximum upward adjustment amount will be 2xs the adjustment factor for all physician groups and solo practitioners.

2018 VM Quality Tiering for Group Practices of 10 or More

Based on 2016 Reporting

2018 Value-Based Payment Modifier Quality Tiering (based on PY 2016)				
Cost☐ / Quality☐	Low Quality	Average Quality	High Quality	
Low Cost	+0.0%	+1.0x*	+2.0x*	
Average Cost	+0.0%	+0.0%	+1.0x*	
High Cost	+0.0%	+0.0%	+0.0%	

2018 VM Quality Tiering for Solo Physicians and Group Practices of 2-9

Based on 2016 Reporting

2018 Value-Based Payment Modifier Quality Tiering (based on PY 2016)				
Cost☐ / Quality☐	Low Quality	Average Quality	High Quality	
Low Cost	+0.0%	+1.0x*	+2.0x*	
Average Cost	+0.0%	+0.0%	+1.0x*	
High Cost	+0.0%	+0.0%	+0.0%	

"x" refers to the upward payment adjustment factor – the 2018 payment adjustment factor is 6.6%

2016 ANNUAL QUALITY AND RESOURCE USE REPORT
AND THE 2018 VALUE-BASED PAYMENT MODIFIER

Sample Medical Practice A

LAST FOUR DIGITS OF YOUR MEDICARE-ENROLLED TAXPAYER IDENTIFICATION NUMBER (TIN): 0000

PERFORMANCE PERIOD: 01/01/2016 – 12/31/2016

ABOUT THIS REPORT FROM MEDICARE

The 2016 Annual Quality and Resource Use Report (QRUR) shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed in calendar year 2016 on the quality and cost measures used to calculate the Value-Based Payment Modifier (Value Modifier) for 2018.

In 2018, the Value Modifier will apply to all physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists (clinicians subject to the Value Modifier) who bill under the Medicare Physician Fee Schedule.

The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicaid Services (CMS), including, but not limited to, circumstances in which an error is discovered.

Please note that payment adjustments under the 2018 Value Modifier are based on a proposal that was included in the 2018 Medicare Physician Fee Schedule Proposed Rule (82 FR 34124) and is subject to change. Information on the Proposed Rule can be found at **https://federalregister.gov/d/2017-14639**.

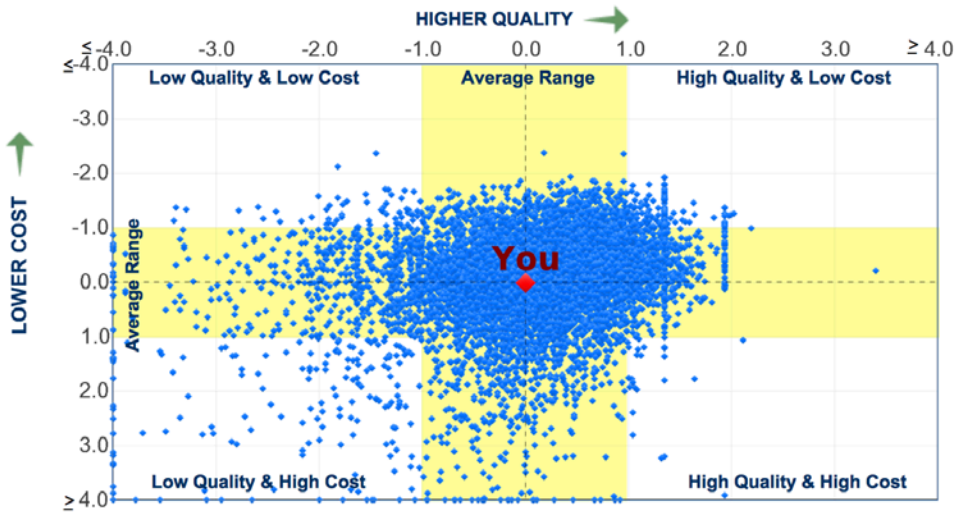
YOUR TIN'S 2018 VALUE MODIFIER

Average Quality, Average Cost = Neutral Adjustment (0.0%)

Your TIN's overall performance was determined to be average on quality measures and average on cost measures.

This means that the Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for clinicians subject to the Value Modifier billing under your TIN in 2018 will result in a neutral adjustment, meaning no adjustment (0.0%).

The scatter plot below shows how your TIN ("You" diamond) compares to a representative sample of other TINs on the Quality and Cost Composite scores used to calculate the 2018 Value Modifier.



Note: The scatter plot shows performance among a representative sample of all TINs with Quality and Cost Composite Scores reflecting standard deviations from the mean for each Composite Score.

2018 Value Modifier Results & Payment Adjustment Status

					2018	2017	2016	2015
Value Modifier Payment Adjustment Status	Total Practices		Total Clinicians		Total Physicians			
	#	%	#	%	%	%	%	
All upward payment adjustments (1.0x, 2.0x, 3.0x in 2018)	3,478	1.70%	20,481	1.80%	1.40%	0.90%	3.20%	
Neutral payment adjustment due to performance	74,024	35.70%	746,556	64.80%	61.30%	65.30%	72.10%	
Neutral payment adjustment due to holding harmless from performance	8,007	3.90%	87,841	7.60%	1.30%	3.80%	N/A	
Downward adjustment due to performance	N/A	N/A	N/A	N/A	3.00%	2.20%	1.10%	
Downward adjustment due to failing quality reporting	121,642	58.70%	296,475	25.80%	33.00%	27.80%	23.60%	
Total Value Modifier Practices & Clinicians	**207,151**	**100.00%**	**1,151,353**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2018-Value-Based-Payment-Modifier-Factsheet.pdf

2018 Medicare Payment Penalties

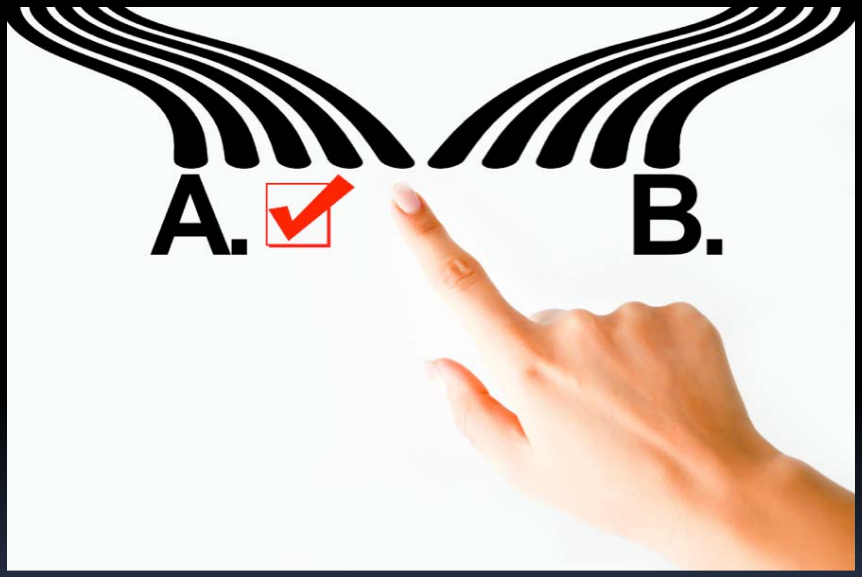
Program	Applicable To	Adjustment Amount	Based on Calendar or Program Year (CY/PY)
PQRS	All EPs (Medicare physicians, practitioners, therapists) who do not meet PQRS reporting requirements	-2.0% of Medicare Physician Fee Schedule (MPFS)	2016 PY
Medicare EHR Incentive Program	Medicare physicians (if not a meaningful user)	-3.0% of MPFS	2016 CY
Value Modifier	**Value Modifier** All physician and non-physician solo practitioners and physicians and non-physicians in group practices of 2 or more EPs who did not meet PQRS reporting requirements	-1.0% for practices with 1-9 EPs -2.0% for groups with 10 or more EPs	2016 CY

Medicare Access and CHIP Reauthorization Act (MACRA)

- In addition to doing away with the SGR formula, MACRA further shifts Medicare payments towards value-based payments.
- MACRA mandates that the base physician payment rate will be increased annually by 0.5% from 2015 through 2019.
- From 2020 through 2025 the base physician rate will be frozen, but eligible providers will have the opportunity to receive additional payment adjustments through the new Quality Payment Program.

MACRA
QUALITY PAYMENT PROGRAM (QPP)

Providers Choose 1 of 2 Paths



Under the Quality Payment Program (QPP), eligible providers must choose between participation in:

1. The Merit-Based Incentive Payment System (MIPS), or
2. A qualified Alternative Payment Model (APM).

Providers will be able to decide annually which program they will participate in.

Merit-Based Incentive Payment System (MIPS)

- Sunsets current Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System (PQRS) penalties at the end of 2018, rolling requirements into a single program.
- Adjusts Medicare payments based on performance on a single budget-neutral payment beginning in 2019.
- Applies to physicians, nurse practitioners, clinical nurse specialists, physician assistants, and certified RN anesthetists.
- Includes improvement incentives for quality and resource use categories.

MIPS

- MIPS measures Medicare Part B providers to develop an annual MIPS score and payment update based on 4 categories:
  1. Quality,
  2. Cost,
  3. Improvement Activities, and
  4. Advancing Care Information
- 2017 was the first performance year for MIPS and 2019 the first payment year.

Who is Included in MIPS?

- For Year 2 (2018) you're included in MIPS if you bill Medicare Part B more than $90,000 a year in allowable charges and provide care for more than 200 Medicare patients a year, and are a:
  - Physician
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist
  - Certified registered nurse anesthetist

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-NPC-Slides.pdf

Who is Excluded From MIPS in 2018?

- Clinicians who are:
  - Enrolled in Medicare for the first time during the performance period (exempt until following performance year), or
  - Below the low-volume threshold of allowed charges of less than or equal to $90,000 a year or see 200 or fewer Medicare Part B patients a year, or
  - Significantly participating in Advanced APMs, receiving 25% of Medicare payments or seeing 20% of Medicare patients through an Advanced APM.

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-NPC-Slides.pdf

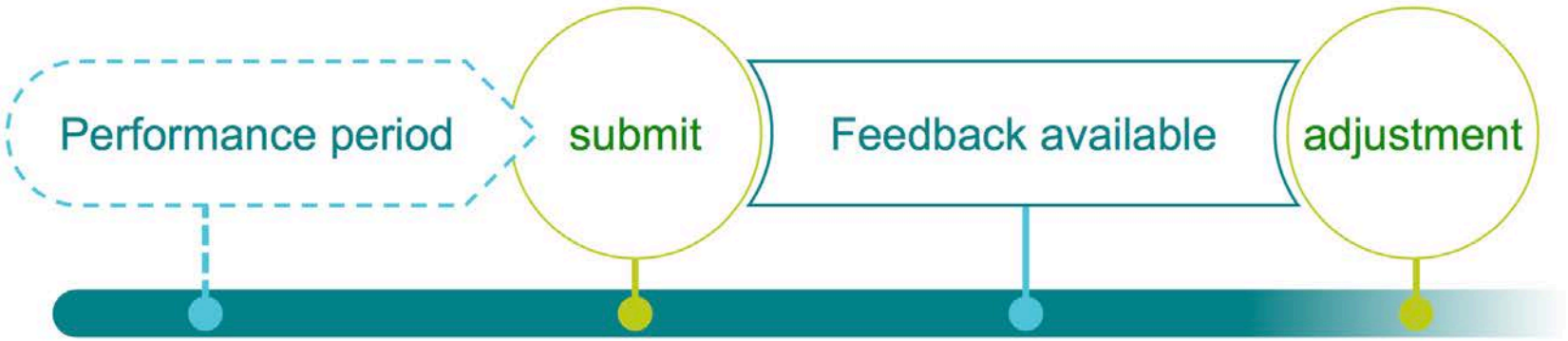
QPP Year 2: MIPS Highlights

- The performance threshold is raised to 15 points in Year 2 (from 3 points in the 2017 transition year).
- Allows the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2, with a bonus for using only 2015 CEHRT.
- Earn up to 5 bonus points on your final score for treatment of complex patients.
- CMS will automatically weight the Quality, Advancing Care Information, and Improvement Activities
- Performance categories will be set at 0% of the final score for clinicians impacted by hurricanes Irma, Harvey and Maria and other natural disasters.
- For small practices of 15 or fewer clinicians:
  - 5 bonus points are to be added to the final scores of small practices
  - Solo practitioners and small practices may choose to form or join a Virtual Group to participate with other practices.
  - Continuing to award small practices 3 points for measures in the Quality performance category that don't meet data completeness requirements.

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf

MIPS Year 2 (2018)

Timeline for Year 2



2018
Performance Year

- Performance period opens January 1, 2018.
- Closes December 31, 2018.
- Clinicians care for patients and record data during the year.

March 31, 2019
Data Submission

- Deadline for submitting data is March 31, 2019.
- Clinicians are encouraged to submit data early.

Feedback

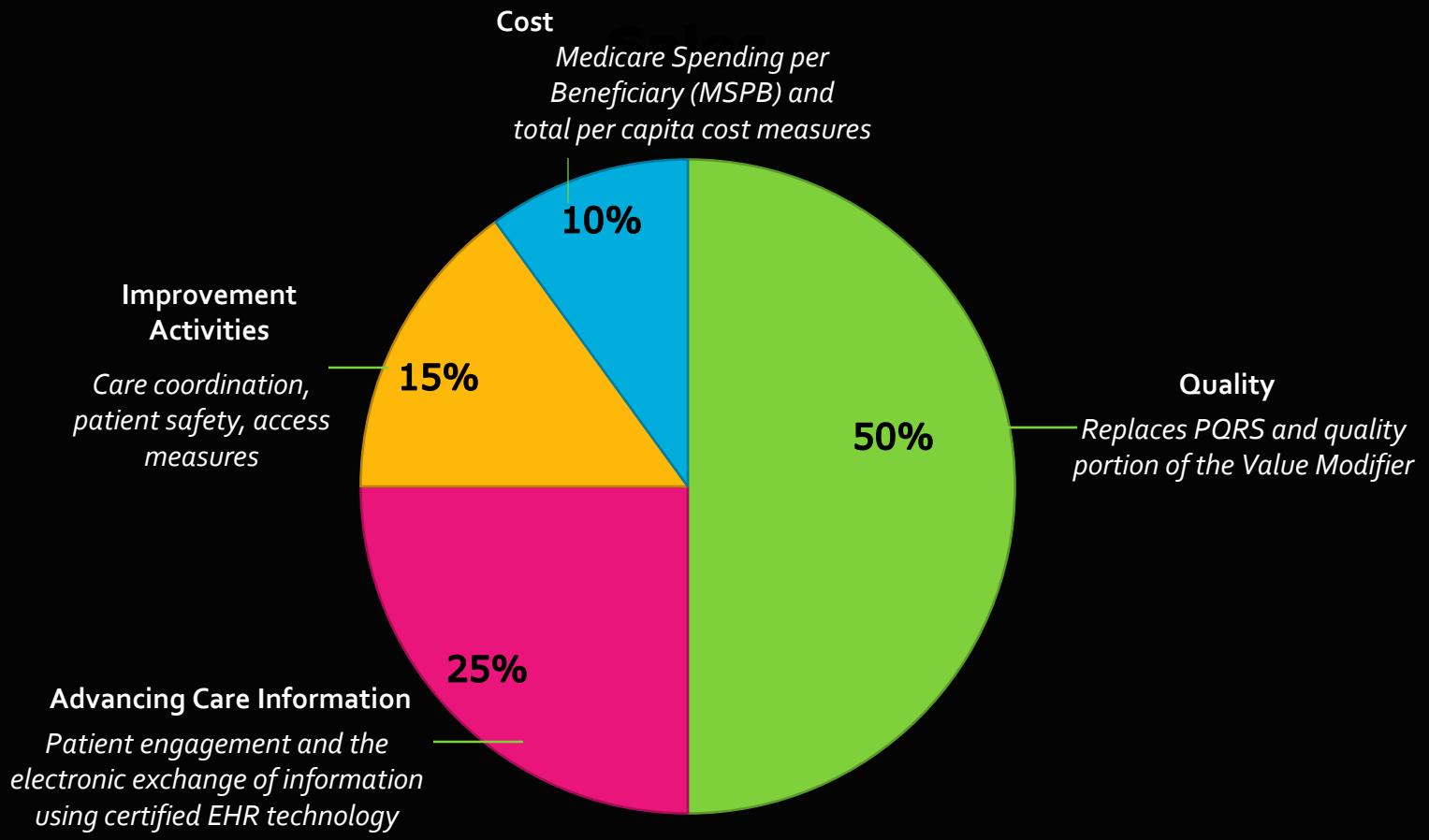
- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2020
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020.

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-NPC-Slides.pdf

MIPS Performance Category Weights Year 2 - 2018



MIPS Year 2 (2018)

Calculating the Final Score

Remember: *All of the performance category points are added together to give you a MIPS Final Score.*

*The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.*

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-NPC-Slides.pdf

MIPS Year 2 (2018) Reporting Options

Three Options for MIPS Reporting in 2018

1 INDIVIDUAL	2 GROUP	3 VIRTUAL GROUP
Individual Under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits	As a Group a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN* b) As an APM entity	As a Virtual Group Solo practitioners & groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-NPC-Slides.pdf

MIPS Year 2 (2018)

Submission Mechanisms

No change: *All of the submission mechanisms remain the same from Year 1 to Year 2*

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups (Including Virtual Groups)
Quality	QCDR Qualified Registry EHR Claims	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
Improvement Activities	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Advancing Care Information	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)

Please note:

- Continue with the use of **1** submission mechanism per performance category in Year 2 (2018). Same policy as Year 1.
- The **use of multiple submission mechanisms** per performance category is deferred to Year 3 (2019).

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-NPC-Slides.pdf

Alternative Payment Models (APMs)

- Alternative Payment Models (APMs) approaches to paying for medical care that incentivizes quality and value.
- MACRA defined APMs include:
  - CMS Innovation Center models
    - The Oncology Care Model (OCM) is a CMS Innovation Center payment and delivery model
  - Medicare Shared Savings Programs (MSSPs)
  - Demonstrations under the Health Care Quality Demonstration Program
  - Demonstrations required by federal law.

https://innovation.cms.gov

Only Advanced APMs Will Exclude you From MIPS

Advanced APMs in 2017*

- Comprehensive ESRD Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program/Tracks 2 and 3
- Next Generation ACO model
- Oncology Care Model (OCM) (Two-Sided Risk Arrangement)
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)

Advanced APMs must:

- Require use of certified EHR technology,
- Tie payment to certain quality measures comparable to those under MIPS, and
- Either:

1. Is a Medical Home Model expanded under CMS Innovation Center authority, or
2. Requires participants to bear a more than nominal amount of financial risk.

*The 2018 Advanced APMs will be listed on the CMS QPP website when released

Thresholds for Advanced APM Participants

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Technical Assistance

Available Resources

CMS has **free** resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISCMail@us.ibm.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-
Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

To learn more, view the Technical Assistance Resource Guide: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf

FINAL PHYSICIAN FEE SCHEDULE 2018

And other 2018 Changes

Calculating the 2018 Conversion Factor

CY 2017 Conversion Factor		**35.8887**
Statutory Update Factor	+0.50% (1.005)	
CY 2018 RVU Budget Neutrality Adjustment	-0.10 % (0.9990)	
CY 2018 Target Recapture Amount	-0.09% (0.9991)	
CY 2018 Conversion Factor		**35.9996**

PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

- CMS finalized their proposal to retroactively decrease the required number of PQRS measures reported in 2016, for the 2018 payment adjustment, from 9 measures to 6 measures with no domain or cross-cutting measures required.
- CMS says the reduction in required measures will limit the negative impact of potential 2018 payment adjustments for quality reporting and better align with the Merit-based Incentive Payment System (MIPS) data submission requirements for the quality performance category.

Biosimilar Drugs HCPCS Codes

- Effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same HCPCS code.
- CMS 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, will require changes to the claims processing systems, this is not expected to be complete by January 1, 2018.
- CMS anticipates the changes will be made by mid-2018 and will issue instructions via change requests/transmittals to contractors and the ASP website

Bone Marrow Aspiration & Biopsy Codes

- Effective for dates of service on and after January 1, 2018 revised/new codes:

  - 38220 Diagnostic bone marrow; aspiration(s)
  - 38221 Diagnostic bone marrow; biopsy(ies)
  - 38222 Diagnostic bone marrow; biopsy(ies) and aspiration(s) NEW

Estimated unadjusted Medicare allowable for 38222 = $174.23

- (Do not report 38221 in conjunction with 38220). (For diagnostic bone marrow biopsy[ies] and aspiration[s] performed at the same session, use 38222)

CPT 96377

- New CPT in 2017: 96377 Application of on-body injector (includes cannula insertion) for timed subcutaneous.
  - But CMS assigned 96377 Status Indicator I = Invalid code.
- In 2018 CPT code 96377 is assigned Status A*
  - Estimated unadjusted Medicare allowable = $20.89

* *Active code. These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts for codes with this status.*

New Patient Relationship Codes

- Beginning on or after Jan. 1, 2018, providers may voluntarily include any of five Patient Relationship HCPCS modifiers:
  - X1 (Continuous/broad services),
  - X2 (Continuous/focused services),
  - X3 (Episodic/broad services,
  - X4 (Episodic/focused services) and
  - X5 (Only as ordered by another physician).
- Medicare claims should also include the NPI of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).
- CMS will not tie the collection of the codes with payment until clinicians have gained ample experience and education in using these modifiers.
- CMS will provide future training resources on these new modifiers in the near future.

New HCPCS Codes Effective Jan. 1, 2018 Include:

- ZC Merck/samsung bioepis
- C9016 Inj. triptorelin extended release, 3.75 mg
- C9024 Inj. liposomal, 1 mg daunorubicin and 2.27 mg cytarabine
- C9028 Inj. inotuzumab ozogamicin, 0.1 mg
- C9492 Inj. durvalumab, 10 mg
- J1555 Inj. immune globulin (cuvitru), 100 mg
- J1627 Inj. granisetron, extended-release, 0.1 mg
- J1729 Inj. hydroxyprogesterone caproate, not otherwise specified, 10 mg
- J7210 Inj. factor viii, (antihemophilic factor, recombinant), (afstyla), 1 i.u.
- J7211 Inj. factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.
- J9022 Inj. atezolizumab, 10 mg
- J9023 Inj. avelumab, 10 mg
- J9203 Inj. gemtuzumab ozogamicin, 0.1 mg
- J9285 Inj. olaratumab, 10 mg

www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

Deleted HCPCs Codes Effective Jan. 1, 2018 Include:

- J1725 Inj. hydroxyprogesterone caproate, 1 mg
- J9300 Inj. gemtuzumab ozogamicin, 5 mg

www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

New Medicare Beneficiary Identifier (MBI)

1. Sign up for CMS' weekly *MLN Connects* newsletter to keep up with announcements.
2. Attend CMS' quarterly calls to get more information. Details about the calls are published in the newsletter.
3. Verify all of your Medicare patients' addresses. If the addresses you have on file are different from the Medicare address you get on electronic eligibility transactions, ask your patients to contact Social Security and update their Medicare records.
4. Help Medicare patients adjust to their new Medicare card. CMS will have posters available this fall you can hang in your office and has published guidelines for talking to patients.
5. Work with your billing vendor to make sure your system will be updated to accept the new MBIs. Test your system changes and work with your billing office staff to be sure your office is ready to use the new MBI format. For more information, visit CMS' provider page on the new Medicare cards.

2018 FINAL RULE

Hospital Outpatient Prospective Payment System (OPPS)

OPPS Payment Rates

- Effective Jan. 1, 2018 CMS is increasing the OPPS payment rates by 1.35% for 2018
- After all other policy changes in the final rule, CMS estimates an overall impact of 1.4% increase for providers paid under the OPPS in 2018.
- Most separately payable physician-administered drugs will continue to be reimbursed at ASP+6% with the exception of packaged drugs and some 340B drugs.

340B Drugs

- CMS finalized their proposal to reduce payment rates for certain 340B drugs to ASP minus 22.5% effective January 1, 2018.
  - Rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals are exempt from the reduced 340B drug payment in 2018.
- Two new modifiers have been implemented to identify if a drug was purchased under the 340B program
  - Modifier "**JG**" *Drug or biological acquired with 340B drug pricing program discount*.
  - Modifier "**TB**" *Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes*.
- The use of modifier JG will trigger the reduction of payment to ASP minus 22.5%

Packaging Threshold

- For CY 2018, CMS finalized their proposal to once again increase the packaging threshold for separate payment for outpatient drugs.
- For CY 2018, CMS will increase the packaging threshold to cost-per-day that exceeds $120; this is up from $110 in 2017.

New 340B Modifiers

- 2018 hospitals that are exempt from the 340B drug payment adjustment will report the informational modifier TB and will continue to be paid at ASP+6%,
- Non-exempted 340 entities are to report modifier JG which will trigger the discounted reimbursement rate,
  - The discounted reimbursement rate is only applicable to OPPS drugs (assigned status indicator “K”) that meet the definition of “covered outpatient drug” and that are acquired through the 340B Program or through the 340B PVP.
  - The discounted reimbursement does not apply to drugs on pass-through payment status (assigned status indicator “G”), modifier TB should be reported with these drugs. Applying modifier JG incorrectly to pass-through drugs will trigger the reduced payment rate.

For more information on the use of these new modifiers read the CMS article:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Billing-340B-Modifiers-under-Hospital-OPPS.pdf

CMS finalized their proposal to expand packaging policies to low-cost drug administration services for CY 2018 stating that conditional packaging of drug administration services will promote equitable payment between the physician office and the hospital outpatient department.

Effective for dates of service on or after January 1, 2018, payment for drug administration codes in Level 1 and Level 2 drug administration APCs (APC 5691 and APC 5692) with the exception of add-on codes will be packaged when reported with other separately payable services.

APC 5692—Level 1 Drug Administration	
HCPCS Code	**Short Descriptor**
96361	Hydrate iv infusion add-on
96366	Ther/proph/diag iv inf addon
96370	Sc ther infusion addl hr
96375	Tx/pro/dx inj new drug addon
96377	Application on-body injector
96379	Ther/prop/diag inj/inf proc
96423	Chemo ia infuse each addl hr
96549	Chemotherapy unspecified

APC 5691--Level 2 Drug Administration	
HCPCS Code	**Short Descriptor**
96367	Tx/proph/dg addl seq iv inf
96371	Sc ther infusion reset pump
96372	Ther/proph/diag inj sc/im
96401	Chemo anti-neopl sq/im
96402	Chemo hormon antineopl sq/im
96405	Chemo intralesional up to 7
96411	Chemo iv push addl drug
96415	Chemo iv infusion addl hr
96417	Chemo iv infus each addl seq

Other OPPS Provisions

- Under (Section 603), effective January 1, 2017, Medicare payments for most items and services furnished at an “off-campus” department of a hospital that was not billing as a hospital service prior to November 2, 2015, will be made under the Medicare Physician Fee Schedule (MPFS) or Ambulatory Surgery Centers (ASCs) fee schedule at a rate of 50% of the OPPS payment rate.
  - "Off-campus" is defined as a physical area located more than 250 yards from the main hospital campus building or a remote location of the hospital.
- In 2018 CMS decreased the payment rate for these services from 50 percent of the OPPS rate to 40 percent of the OPPS rate.
- Finalized their proposal to package payments for low-cost drug administration services
  - CPT codes: 96377, 96379, 96371, 96372, 96401, 96402, 96405

Resources

- CMS QPP Website
  https://qpp.cms.gov

- Quality Payment Program Year 2 – Final Rule Overview

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf

Resources

- 2018 Physician Fee Schedule Final Rule:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html

- 2018 Hospital Outpatient Final Rule: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html

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Risë Marie Cleland
Rise@oplinc.com

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