Ultrasound payments to drop under CMS' proposed rates

By Jill Rathbun

On July 6, the Centers for Medicare & Medicaid Services (CMS) proposed updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for CY 2017. Comments are due by 5 p.m. ET on Sept. 6, 2016, and can be submitted at www.regulations.gov.

CMS estimates that total OPPS payments would be about $63 billion in CY 2017, an increase of about $5.1 billion from CY 2016. On average, payment rates would increase by 1.6 percent, with the exception of Ambulatory Payment Classifications (APCs), like what is being proposed for ultrasound services, where CMS is proposing a policy change and reorganization. Hospitals that fail to meet the outpatient quality reporting program would continue to be subject to a two percent reduction.

In addition to the proposed reorganization of payments for imaging services performed in hospital outpatient departments, CMS is also proposing a change in its policy for when it will package ancillary services and thus not pay for them separately. Services, many of which are imaging, that have assigned a status indicator in the payment files that is either a "Q1" or "Q2" are considered to be "conditionally" packaged.

What does this mean? The answer is that when services with a status indicator of "Q1" or "Q2" are billed with the same date as a surgical service or other procedural type of service, the code with conditional packaging status will not receive a separate payment. Instead, it will come out of the overall payment for the procedural type of services provided on that same date of service.

For CY 2017, CMS is proposing a policy refinement with respect to packaging for all conditional packaging status indicators. This proposed policy could have a negative impact on hospitals. Imaging services that were ordered on the day before a surgical procedure that is an outpatient surgical procedure are paid separately today, but starting Jan. 1, 2017, they would not be. While analysis is still being performed, it is a concern that the proposed 1.6 percent increase in payment rates for the services that imaging is being packaged into will not cover the previous separately collected review.

The other proposed policy change in this rule that will potentially have a major impact on imaging services is that CMS is reorganizing payments for imaging services. CMS proposes to take the number of APCs for imaging services (excluding PET) down to seven. In the proposal, these payment categories would no longer be modality-specific, or have any clinical sameness regarding anatomy or body system. Clinical homogeneity is one of the two foundations of the outpatient payment classification system. It is confusing that CMS believes that imaging modalities are interchangeable and that there is no difference between the clinical functionality of an X-ray versus ultrasound versus CT versus MRI.

In an initial analysis of CMS' proposed reorganization of payments for imaging services, there do appear to be some dramatic changes in payments for certain imaging services. Also, with some exceptions, ultrasound services would see sizable reductions. This should be a concern for emergency departments. Emergency physicians and their hospitals may wish to further analyze and provide comments to CMS by the Sept. 6, 2016, deadline.

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