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2018 Medicare Reimbursement Rates Make Deciding Whether to Convert a VAC or OBL Into an ASC Even More Challenging

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November 10, 2017
(Updated November 13, 2017)
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Earlier this month the Centers for Medicare and Medicaid Services (CMS) issued the 2018 Medicare Physician Fee Schedule (MPFS) and Ambulatory Surgical Center Fee Schedule (ASCS), which included updates to payment policies, payment rates and quality provisions for services furnished during the 2018 calendar year. The 2018 reimbursement rates continue to place significant financial pressure on physicians who provide dialysis vascular access services in a Place of Service-11 (POS-11) vascular access center (VAC) or office-based laboratory (OBL) setting, while at the same time significantly decreasing any site-specific financial benefit of providing such services in a Medicare-certified ambulatory surgery center (ASC).

Significant changes in reimbursement for dialysis vascular access care were first implemented in 2017 by CMS as a result of a new payment policy requiring services billed together more than 75 percent of the time to be bundled. The following interventional CPT code bundles were developed, which resulted in significant Medicare reimbursement reductions for a variety of commonly performed interventional services:

Procedure	2016 CPT Codes	2016 FFS Reimbursement	2017 Bundled CPT Code	2017 MPFS (POS-11) Reimbursement	% Change (2016-2017)
Angiogram of access	36147	$855	36901	$581	-32%
Angiogram with angioplasty	36147 35476 75978	$2,052	36902	$1,235	-40%
Angiogram with stent	36147 37238	$4,712	36903	$5,663	17%
Thrombectomy	36147 36148 36870	$2,567	36904	$1,801	-30%
Thrombectomy with angioplasty	36147 36148 36870 35476 75978	$3,222	36905	$2,304	-20%
Thrombectomy with stent	36147 36148 36870 37238	$5,701	36906	$6,868	17%

These dramatic reimbursement cuts made it financially difficult for many physicians to continue providing dialysis vascular access care in a POS-11 setting and, as a result, a significant number of VACs and OBLs closed in 2017 and additional centers are slated to close in 2018. It is

widely believed that a significant number of VACs and OBLs that exclusively provided dialysis vascular access care (and which do not perform peripheral arterial disease (PAD) services) experienced a net financial loss of between — 10 percent and 0 percent in 2017 in providing these services, depending upon a center's patient volume, case mix and payor mix.

A number of trade groups and organizations, including the Renal Physicians Association (RPA), the Dialysis Vascular Access Coalition (DVAC) and the American Society of Diagnostic and Interventional Nephrology (ASDIN), actively engaged with CMS to advise the agency of the consequences of its reimbursement changes, including decreased availability of quality office-based care for this at-risk patient population, and increased cost to the Medicare program resulting from patients receiving dialysis access-related services in more expensive hospital outpatient departments. In an attempt to address the medical needs of this critically vulnerable patient population, some providers have considered the financial, operational and legal viability of converting their VAC or OBL into a Medicare-certified ASC and/or expanding their service offering to include PAD and other interventional procedures consistent with a physician's relevant training and experience. The table below highlights the difference in 2017 Medicare reimbursement for certain dialysis vascular access services performed in an office-based VAC or OBL, as compared to the same services performed in an ASC setting:

Procedure	Bundled CPT Code	2017 MPFS Final Rate	2017 ASC Final Rate	$ Differential
Angiogram of access	36901	$581	$520	$61
Angiogram with angioplasty	36902	$1,235	$3344	$2109
Angiogram with stent	36903	$5,663	$6,334	$671
Thrombectomy	36904	$1,801	$3,474	$1673
Thrombectomy with angioplasty	36905	$2,304	$6471	$4167
Thrombectomy with stent	36906	$6,868	$9,861	$2993

Based upon the 2018 MPFS rates it appears that these organizations' concerns have been addressed in a limited manner. CMS has made modest increases in Medicare reimbursement for services performed in an ASC or OBL in 2018 as demonstrated in the following table:

Procedure	Bundled CPT Code	2018 MPFS Final Rate	2016 MPFS Final Rate	2017 MPFS Final Rate	$ Change (2016-2018)	$ Change (2017-2018)
Angiogram of access	36901	$611	$855	$581	-$244	$30
Angiogram with angioplasty	36902	$1,272	$2,052	$1,235	-$780	$37

Angiogram with stent	36903	$5,725	$4,712	$5,663	$1,013	$62
Thrombectomy	36904	$1,849	$2,567	$1,801	-$718	$48
Thrombectomy with angioplasty	36905	$2,344	$3,222	$2,304	-$878	$40
Thrombectomy with stent	36906	$6,949	$5,701	$6,868	$1,248	$81

The financial impact of the 2018 MPFS rates presents a "mixed bag" of news. When compared against the 2017 MPFS reimbursement rates, CMS made minor positive reimbursement changes to the entire crosswalk of dialysis vascular access codes, including to the industry's most commonly billed CPT code (36902), which will experience a 3 percent reimbursement increase versus the 0.8 percent decrease that was originally proposed in the 2018 Proposed Rule. However, when the 2018 MPFS reimbursement rates are compared against the 2016 MPFS reimbursement rates one can see that 2018 Medicare reimbursement for a significant number of the most commonly used dialysis vascular access codes still falls far below 2016 reimbursement rates.

CMS also unexpectedly made significant reimbursement cuts to codes for dialysis vascular access services performed in an ASC setting in 2018 when it released the 2018 Final ASCS, which changes had not been previously discussed in the 2018 Proposed ASCS earlier this year. Industry groups continue reaching out to CMS to voice their concern about these reimbursement cuts, which may continue to enhance the problem of patients seeking out dialysis vascular access care in a more expensive hospital outpatient department setting. According to Jan Dees, President of American Vascular Access, a national provider of VAC and OBL services, "it is estimated there are 30 million patients in the United States in need of procedures impacted by these and other similar CPT codes. It is therefore critically important for patients to have easy access to VAC and OBL sites of service that can continue to provide conveniently located, high quality, timely and lower cost services."

Yet, despite this decrease in Medicare reimbursement for dialysis vascular access care provided in an ASC setting, there continues to be a significant reimbursement differential between dialysis vascular access care provided in an OBL or VAC as compared against care provided in an ASC:

Procedure	**Bundled CPT Code**	**2018 MPFS Final Rate**	**2018 ASC Final Rate**	**$ Differential**
Angiogram of access	36901	$611	$495	$116
Angiogram with angioplasty	36902	$1,272	$2,776	$1504
Angiogram with stent	36903	$5,725	$4,414	$861
Thrombectomy	36904	$1,849	$2,913	$1064
Thrombectomy with angioplasty	36905	$2,344	$4,947	$2603

Thrombectomy with stent	36906	$6,949	$7464	$515

These Medicare reimbursement changes come at a time when many providers are considering converting their VACs and OBLs into Medicare-certified ambulatory centers as we discussed in a recent Whitepaper entitled Practical Considerations for Medical Practices Considering Converting Their Vascular Access Centers Into Medicare-Certified Ambulatory Surgery Centers. These reimbursement changes and the possible eventual elimination of site-of-service payment reimbursement differentials by CMS across outpatient care settings as CMS moves to site-neutral payments, will only make conversion decisions more challenging.

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