AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation

Legislative Priority – AACVPR – Day on the Hill 2020

Background: Medicare payment methodologies differ dependent on site of service. This is due to the actual payment methodology used by Medicare to determine payment amounts. For example, when Medicare computes payment for services reimbursed in a physician office, three variables are computed: the relative value of the service (RVU), the practice expense associated with the specific service, and the malpractice expense associated with the specific service.

When Medicare computes payment **for the same service** provided in a hospital outpatient setting, the agency uses charge data reported on every claim submitted to Medicare as well as hospital cost report data, also submitted by the hospital. Therefore, it is not unusual for the same service to receive different payment amounts based on the **"site of service."**

Both Congress and CMS recognized that this can create strong incentives to game the payment system. For example, a hospital may choose to purchase an orthopedic practice that owns its own MRI, and simply through that purchase, Medicare would be billed at a significantly higher reimbursement rate for the service through the hospital outpatient department than Medicare was billed by the physician practice for the same service.

To address this problem, Section 603 of the 2015 Budget Act mandated that hospitals would no longer be able to bill under the hospital outpatient methodology, i.e., higher reimbursement rate, under certain conditions:

1. If an existing off campus (beyond 250 yards) service moves to a new location, the hospital is required to bill at the physician fee schedule rate rather than the hospital outpatient rate.

2. If a hospital opens a NEW hospital outpatient service, that new service must be within 250 yards of the main campus in order to receive hospital outpatient reimbursement; otherwise, the physician fee schedule rate applies.

Impact on Pulmonary/Cardiac Rehabilitation (PR/CR): Hospitals that choose to expand or relocate (beyond the 250 yard threshold) services must bill at the physician fee schedule rate, thereby creating a very strong disincentive for hospitals to improve access to PR/CR services. (A very limited number of exceptions to this exist.)

CMS recognizes this reality as an "unintended consequence" of Section 603, but the Agency states it has no authority to address our problem.

Political considerations: Section 603 received strong support on Capitol Hill, on both sides of the political aisle as it addressed an important issue at one end of the Medicare scale. However, PR/CR are at the other end of the scale, definitively evidenced by Medicare data.

> Pulmonary rehabilitation billing under the physician fee schedule **for all medical specialties for G0424** totaled $535K in 2014, a 22% reduction from 2012. The largest single specialty, pulmonary disease, is under $230K **for G0424.**

Cardiac rehabilitation billing under the physician fee schedule **for all medical specialties for CPT 93798** totaled $1.2M in 2014, a 30% reduction from 2012. The largest single specialty, cardiology, is under $1M **for 93798.**

This clearly documents that that the primary premise of Section 603 does not apply to either PR or CR because hospitals are not purchasing pulmonary or cardiac practices to benefit from the higher reimbursement rate for PR/CR services. Simply stated, these services are NOT being performed in physician offices, nor have they been provided in that setting for years.

Solution: Legislation that would exempt certain hospital outpatient services from Section 603 by implementing regulations that create specific financial thresholds. As long as no physician specialty, nationwide, bills for any CPT or HCPCS code under the Medicare Physician Fee Schedule in an aggregate amount greater than $2 million in the previous year for which data are available, that code (or codes) would be exempt from Section 603 requirements.

As noted above, because billing for 93798 and G0424 under the physician fee schedule has no physician specialty billing exceeding $1M, those codes would be exempt from Section 603 requirements.