Payment Alert
November 1, 2017

CY 2018 Outpatient Hospital PPS and ASC Final Rule with Comment Released

November 1, 2017— Today, the Centers for Medicare & Medicaid Services (CMS) released a final rule updating payment rates and other policies under the Medicare Outpatient Prospective Payment System (OPPS)/ Ambulatory Surgical Center (ASC) Payment System for CY 2018.

The Medicare Program: Hospital OPPS) and ASC Payment Systems and Quality Reporting Programs final rule includes updates to payment rates for Medicare services under the hospital OPPS and ASC payment system, and to refine requirements for the Hospital Outpatient Quality and ASC Quality Reporting Programs for CY 2018.

AdvaMed will provide a detailed summary of the final rule in the near future. Highlights and links to the final rule and related materials are below.

For OPPS, the final CY 2018 update is based on the hospital market basket percentage increase of 2.7 percent, minus the proposed multifactor productivity (MFP) adjustment of 0.6 percentage point, and minus a 0.75 percentage point adjustment required by the Affordable Care Act. CMS estimates that total payments to OPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY 2018 would be approximately $70 billion, an increase of approximately $5.8 billion compared to estimated CY 2017 OPPS payments. (p. 40)

For ASC, the final CY 2018 CPI-U update is 1.7 percent. The MFP adjustment is 0.5 percent, resulting in a CY 2018 MFP-adjusted CPI-U update factor of 1.2 percent. CMS estimates that total payments to ASC providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY 2018 would be approximately $4.62 billion, an increase of approximately $130 million compared to estimated CY 2017 ASC payments. (p. 45)

CMS is soliciting comments on a limited number of issues through December 31, 2017.

CMS responded to several issues included in AdvaMed’s comments on the proposed rule:

- **Complexity Adjustments**—Despite AdvaMed recommendations CMS will not be modifying its complexity adjustment policy in any way for CY 2018 (p. 99-107)

- **Brachytherapy Insertion (High Dose Rate)**—CMS is not finalizing the proposal to establish a code edit that requires a brachytherapy treatment code when a brachytherapy insertion code is billed. CMS will however, continue to pay brachytherapy insertion procedures as a part of a C-APC. (p. 117-123)

- **Calculation and Use of Cost-to-Charge Ratios**—CMS finalized its policy to delay by one more year, until 2019, a transition to imaging CCR reporting that eliminates square footage reporting. (p. 65-71)
- **APC Specific Policies**
  - **Imaging APCs** – In response to stakeholder comment, including from AdvaMed, CMS will not be finalizing the proposals to add a fifth level to the Imaging without Contrast APC series. CMS will instead maintain the four level structure and will make minor reassignments to the HCPCS codes within the series to resolve or mitigate violations of the two times rule. (p. 365-369)
  - **Pass-through** – CMS did not approve any of the five applications that it evaluated for device pass-through and ended device-pass through on the three devices that currently have that status and were proposed for termination. (p. 405-459)
  - **Drug Coated Balloon Angioplasty** – CMS agreed to track use of CPT code 37224 with HCPCS code C2623 per the HOPs panel recommendation. CMS will not however establish a C or G code to distinguish drug-coated versus non-drug-coated balloon angioplasty procedures. Additionally, CMS will not take steps to modify the C-APC levels for the endovascular C-APC family. Instead, CMS will consult with the appropriate HOPs Panel subcommittee to determine if additional granularity is necessary. (p. 316-318; 407-412)
  - **MRgFUS** – In response to comments CMS is modifying its proposal to assign 0398T to New Technology APC 1537 and will instead finalize assignment of the procedure to New Technology APC 1576 (Level 39: $15,001-$20,000) for CY 2018. (p. 262-265)
  - **Endovenous Chemical Ablation for Lower Extremity Chronic Venous Disease** – CMS will finalize placement of CPT codes 364X5 and 364X6 into APC 5054 instead of the proposed placement in APC 5053 to accommodate additional supply expense. (p. 375-381)
  - **Proton Therapy**—It appears that CMS may have failed to address our comments on this issue in the final rule. AdvaMed staff has reached out to CMS for additional information.
  - **C-APC 5155 Combine Endoscopic Sinus and Multiple Endoscopic Sinus Surgery Procedures** – CMS is finalizing its proposal without modification to place the new nasal sinus endoscopy procedures into APC 5155 and will not make any other modifications to this APC. (p. 336-341)
  - **High Cost/Low Cost Threshold for Packaged Skin Substitutes**—CMS finalized its proposal to leave skin substitutes that no longer exceed the CY 2018 MUC or PDC thresholds in the high cost group if they were in that group in CY 2017. (p. 381-383)

- **Inpatient Only List (IPO)**
  - **Removing total knee arthroplasty from the Inpatient Only List** – CMS finalized the policy to remove TKA from the IPO and to assign it to C-APC 5115 with status indicator J1 and will rely on hospitals to accurately bill for the procedures. (p. 661-673)
  - **CMS also removed six procedures from the IPO list and added one additional procedure to the list as indicated in TABLE 78 of the rule.** (p. 675-678)
  - **Possible Removal of Partial Hip Arthroplasty and Total Hip Arthroplasty Procedures from the Inpatient Only List** – CMS discussed feedback received from stakeholders regarding this possible change and indicated that the Agency will consider the comments that were received in future policy making. (p. 679-685)

- **Changes to the HOPs Meeting Schedule**—CMS will not make any modifications to the comment submission deadlines or meeting frequency of the HOP panel despite comments. (p. 57-61)

- **Revisions to the Laboratory Date of Service Policy (14-day policy)**—CMS added an exception to its current laboratory date of service (DOS) regulations so that the DOS for molecular pathology tests and tests designated
by CMS as advanced diagnostic laboratory tests (ADLTs) is the date the test was performed only if: (1) the test was performed following a hospital outpatient’s discharge from the hospital outpatient department; (2) the specimen was collected from a hospital outpatient during an encounter (as defined in CMS regulation); (3) it was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter; (4) the results of the test do not guide treatment provided during the hospital outpatient encounter; and (5) the test was reasonable and medically necessary for the treatment of an illness. This new exception to the laboratory DOS policy will enable laboratories performing these tests, which are excluded from the OPPS packaging policy, to bill Medicare directly for those tests, instead of requiring them to seek payment from the hospital outpatient department. (p.704 – 737)

- **Ambulatory Surgery Center Policies**—Despite feedback on ASC Payment Reform CMS will continue to use the CPI-U as the update factor for ASC rates. (p. 818- 824)

- **ASC Quality Reporting Program**—In the CY 2018 OPPS/ASC final rule, CMS is finalizing the addition of two measures of hospital events following specified surgical procedures to the ASCQR program measure set for the CY 2022 payment determinations and subsequent years. The measures finalized for addition are:
  - ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Proceeedures, which assesses all-cause, unplanned hospital visits within seven days of an orthopedic procedure performed at an ASC (beginning with the CY 2022 payment determination). For the purposes of this measure, “hospital visits” include emergency department visits, observation stays, and unplanned inpatient admissions.
  - ASC-18: Hospital Visits after Urology Ambulatory Surgical Center Procedures, which assesses all-cause, unplanned hospital visits occurring within seven days of the urology procedure performed at an ASC (beginning with the CY 2022 payment determination). For the purpose of this measure, “hospital visits” include emergency department visits, observation stays, and unplanned inpatient admissions.
  - ASC-16: Toxol Anterior Segment Syndrome (TASS), will not be adopted as a measure and is not being finalized.

CMS is finalizing proposals to remove three measures for the CY 2019 payment determination and subsequent years. Removal of these measures will alleviate maintenance costs and administrative burdens to the ASCs, resulting in a burden reduction of 1,314 hours and $48,066 with respect to requirements for the CY 2019 payment determination. The three measures being removed are:

  - ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing, which assesses whether intravenous antibiotics given for prevention of surgical site infection were administered on time.
  - ASC-6: Safe Surgery Checklist Use, which is a structural measure of facility process that assesses whether an ASC employed a safe surgery checklist that covered each of the three critical perioperative periods (prior to administering anesthesia, prior to skin incision, and prior to patient leaving the operating room) for the entire data collection period.
  - ASC-7: ASC Facility Volume Data on Selected Procedures, which is a structural measure of facility capacity that collects surgical procedure volume data on six categories of procedures frequently performed in the ASC setting.

(p. 922-946)

- **Future Measure Topics for Outpatient hospital quality measures reporting**—CMS is developing a comprehensive set of quality measures to be available for widespread use for informed decision-making and quality improvement in the hospital outpatient setting. Current measures include process, structure, outcome, and efficiency measures. Through future rulemaking, CMS will propose new measures to further its goal of achieving better health care and improved health for Medicare beneficiaries who receive health care in hospital outpatient settings, while aligning quality measures across the Medicare program. Additionally, CMS wants to move away from process measures and toward more use of outcome measures across its quality reporting and value-based purchasing programs. CMS is soliciting comments on possible measure topics for future consideration in the Hospital OQR Program, and specifically on any outcomes measures that would be useful to add, as well as any clinical process measures that should be eliminated from the Hospital OQR Program. (p 878-
- CMS is finalizing its proposal regarding 340(B) drug cuts with exceptions for rural sole community hospitals, PPS-exempt cancer hospitals and children’s hospitals for the next two years. CMS anticipates redistributing money resulting from these changes to non-drug items and services across the OPPS. (p. 540-618)

The display version of the final OPPS/ASC rule can be downloaded from the Federal Register website at: https://www.federalregister.gov/public-inspection/current

The CMS Press Release for the OPPS final rule can be accessed at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-11-01-2.html

The OPPS Final Rule Fact Sheet can be accessed at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-01.html

For additional information or questions, please contact DeChane Dorsey.

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