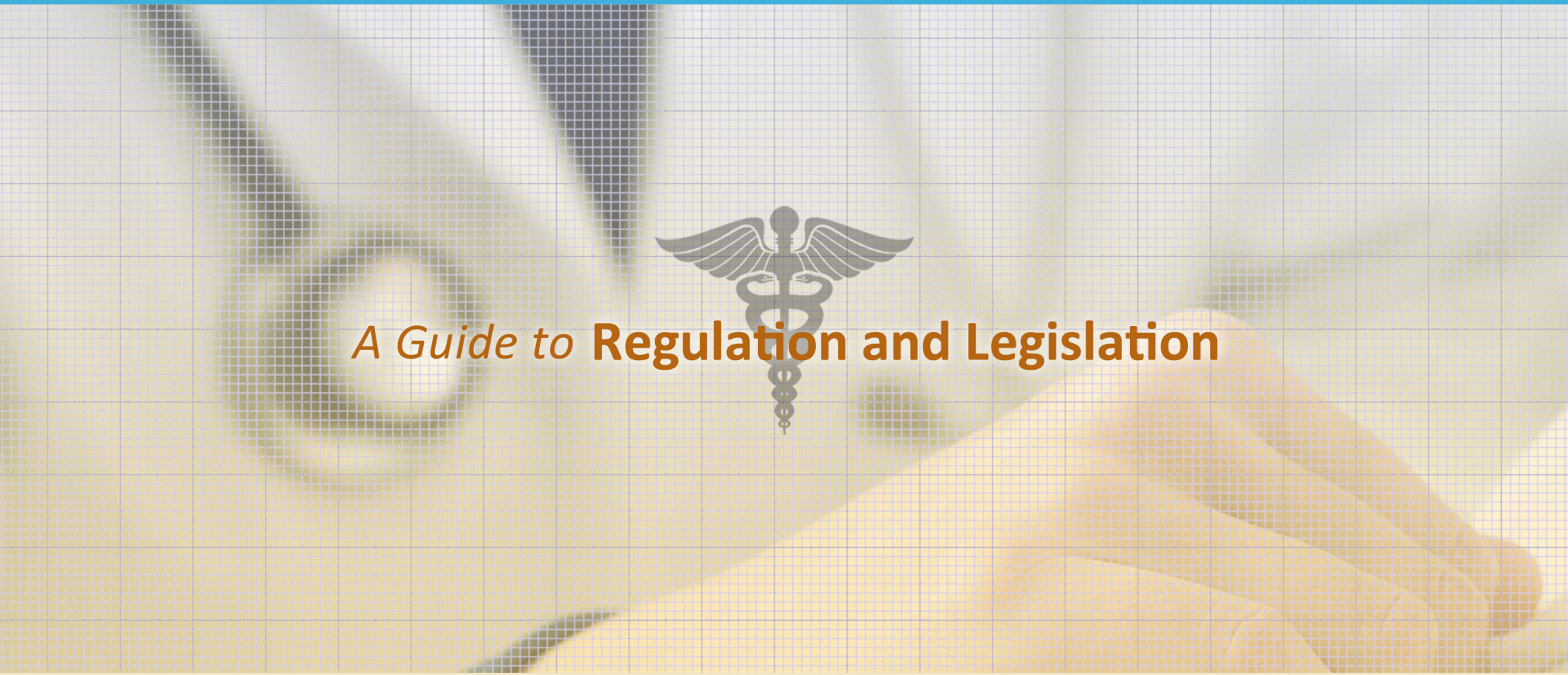
CliftonLarsonAllen

Regulatory Advisor Volume Five

2017 Proposed Rule for Outpatient PPS and Ambulatory Surgery Centers



A Guide to **Regulation and Legislation**

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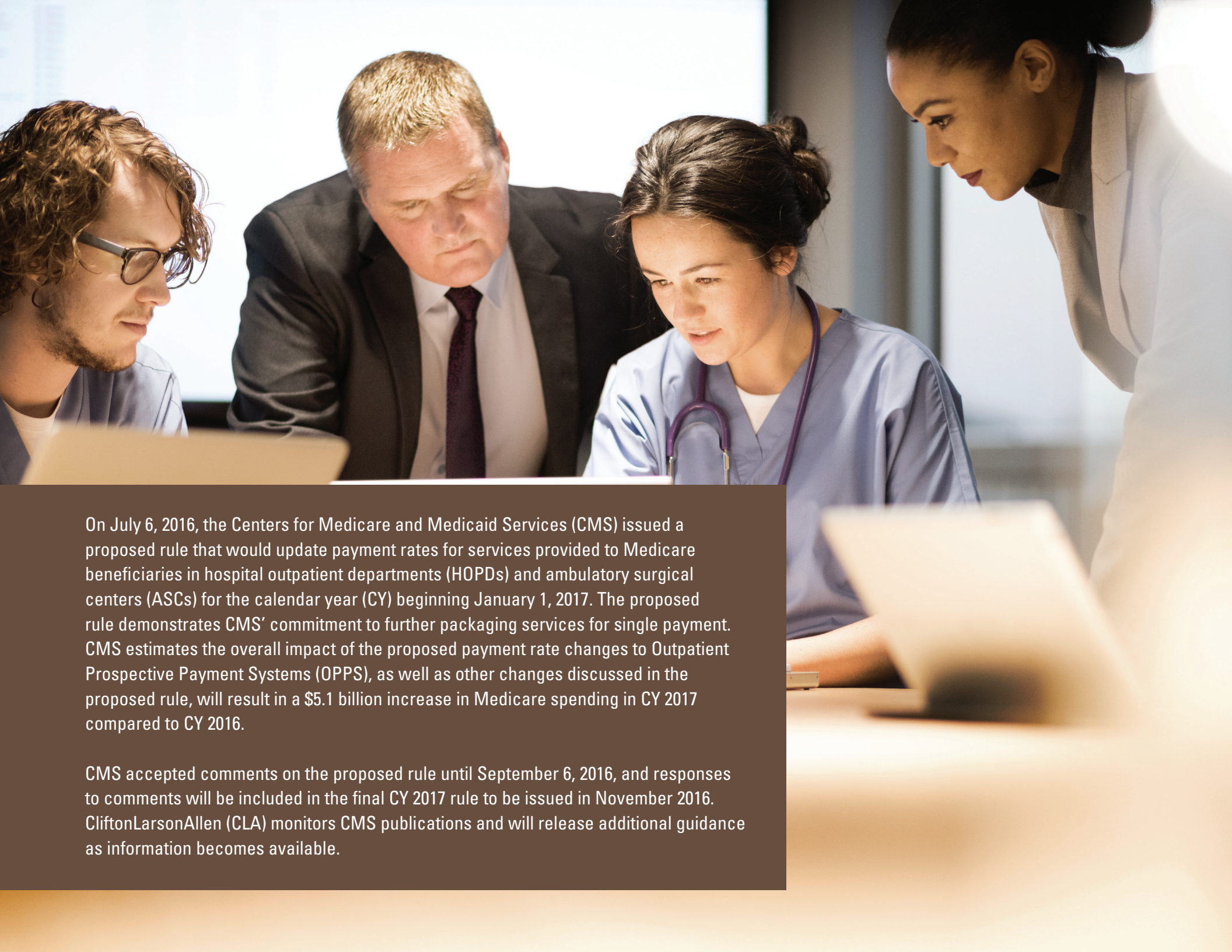

On July 6, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would update payment rates for services provided to Medicare beneficiaries in hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) for the calendar year (CY) beginning January 1, 2017. The proposed rule demonstrates CMS' commitment to further packaging services for single payment. CMS estimates the overall impact of the proposed payment rate changes to Outpatient Prospective Payment Systems (OPPS), as well as other changes discussed in the proposed rule, will result in a $5.1 billion increase in Medicare spending in CY 2017 compared to CY 2016.

CMS accepted comments on the proposed rule until September 6, 2016, and responses to comments will be included in the final CY 2017 rule to be issued in November 2016. CliftonLarsonAllen (CLA) monitors CMS publications and will release additional guidance as information becomes available.

Proposed payment rate changes to OPPS

The rule proposes to increase reimbursement payment rates for outpatient services by 1.55 percent. The increase is the net result after CMS applies the changes for market basket conditions and various provisions of the Affordable Care Act (ACA).

- Hospital inpatient market basket increase 2.8%
- ACA mandated reduction to market basket increase -.75%
- ACA mandated multi-factor productivity adjustment -.50%

Hospitals that fail to meet the hospital outpatient quality reporting requirements will continue to receive a 2 percent reduction in payments as required by statute.

In terms of recalibration of ambulatory payment classification (APC) relative payment weights, CMS used final action claims for HOPD services furnished on or after January 1, 2015, and before January 1, 2016. In order to recalibrate the weights, CMS arrived at overall cost-to-charge ratios (CCRs) by taking the CY 2015 claims data and applying these claims to the most recently available hospital cost reports, which is generally the CY 2014 reports.

Health Care Common Procedure Coding System (HCPCS) P-Codes

The CY 2016 OPPS/ASC final rule included a solicitation for comment on whether the HCPCS P-Codes for blood products should be revised. CMS noted that these codes have been in effect for many years, and would like feedback to know if these codes are accurate, necessary in terms of their granularity, and line up with today's technology for blood products that hospitals currently provide to hospital outpatients.

Comprehensive Ambulatory Payment Classifications (C-APCs)

Comprehensive APCs were implemented in CY 2014 final rule with an effective date of January 1, 2015. These created packaged payments for adjunctive and secondary items, services, and procedures into the most costly primary procedure under the OPPS at an individual claim level. Initially, there were 25 C-APCs in CY 2015. Ten were added in CY 2016. In this proposed rule, CMS suggests adding 25 more C-APCs. Table Two is reproduced from the proposed OPPS rule and identifies these C-APCs along with their clinical family.

Proposed CY 2017 C-APCs Proposed CY 2017 C-APC's

C-APC	CY 2017 APC title	Clinical family	Proposed new C-APC
5072	Level 2 Excision/Biopsy/Incision and Drainage	EBIDX	(*)
5073	Level 3 Excision/Biopsy/Incision and Drainage	EBIDX	(*)
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	BREAS	(*)
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	BREAS	(*)
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	BREAS	
5094	Level 4 Breast/Lymphatic Surgery and Related Procedures	BREAS	
5112	Level 2 Musculoskeletal Procedures	ORTHO	(*)
5113	Level 3 Musculoskeletal Procedures	ORTHO	(*)
5114	Level 4 Musculoskeletal Procedures	ORTHO	
5115	Level 5 Musculoskeletal Procedures	ORTHO	
5116	Level 6 Musculoskeletal Procedures	ORTHO	
5153	Level 3 Airway Endoscopy	AENDO	(*)
5154	Level 4 Airway Endoscopy	AENDO	(*)
5155	Level 5 Airway Endoscopy	AENDO	(*)
5164	Level 4 ENT Procedures	ENTXX	(*)
5165	Level 5 ENT Procedures	ENTXX	
5166	Cochlear Implant Procedure	COCHL	
5191	Level 1 Endovascular Procedures	VASCX	(*)
5192	Level 2 Endovascular Procedures	VASCX	
5193	Level 3 Endovascular Procedures	VASCX	
5194	Level 4 Endovascular Procedures	VASCX	
5200	Implantation Wireless PA Pressure Monitor	WPMXX	(*)
5211	Level 1 Electrophysiologic Procedures	EPHYS	
5212	Level 2 Electrophysiologic Procedures	EPHYS	
5213	Level 3 Electrophysiologic Procedures	EPHYS	

Source: Federal Register / Vol. 81, No. 135; p. 45621

C-APC	CY 2017 APC title	Clinical family	Proposed new C-APC
5222	Level 2 Pacemaker and Similar Procedures	AICDP	
5223	Level 3 Pacemaker and Similar Procedures	AICDP	
5224	Level 4 Pacemaker and Similar Procedures	AICDP	
5231	Level 1 ICD and Similar Procedures	AICDP	
5232	Level 2 ICD and Similar Procedures	AICDP	
5244	Level 4 Blood Product Exchange and Related Services	SCTXX	(*)
5302	Level 2 Upper GI Procedures	GIXXX	(*)
5303	Level 3 Upper GI Procedures	GIXXX	(*)
5313	Level 3 Lower GI Procedures	GIXXX	(*)
5331	Complex GI Procedures	GIXXX	
5341	Abdominal/Peritoneal/Biliary and Related Procedures	GIXXX	(*)
5361	Level 1 Laparoscopy and Related Services	LAPXX	
5362	Level 2 Laparoscopy and Related Services	LAPXX	
5373	Level 3 Urology and Related Services	UROXX	(*)
5374	Level 4 Urology and Related Services	UROXX	(*)
5375	Level 5 Urology and Related Services	UROXX	
5376	Level 6 Urology and Related Services	UROXX	
5377	Level 7 Urology and Related Services	UROXX	
5414	Level 4 Gynecologic Procedures	GYNXX	(*)
5415	Level 5 Gynecologic Procedures	GYNXX	
5416	Level 6 Gynecologic Procedures	GYNXX	
5431	Level 1 Nerve Procedures	NERVE	(*)
5432	Level 2 Nerve Procedures	NERVE	(*)
5462	Level 2 Neurostimulator and Related Procedures	NSTIM	
5463	Level 3 Neurostimulator and Related Procedures	NSTIM	
5464	Level 4 Neurostimulator and Related Procedures	NSTIM	
5471	Implantation of Drug Infusion Device	PUMPS	
5491	Level 1 Intraocular Procedures	INEYE	(*)
5492	Level 2 Intraocular Procedures	INEYE	
5493	Level 3 Intraocular Procedures	INEYE	
5494	Level 4 Intraocular Procedures	INEYE	
5495	Level 5 Intraocular Procedures	INEYE	
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	EXEYE	(*)
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	EXEYE	(*)
5627	Level 7 Radiation Therapy	RADTX	
5881	Ancillary Outpatient Services When Patient Dies	N/A	
8011	Comprehensive Observation Services	N/A	

Source: Federal Register / Vol. 81, No. 135; p. 45621

Packaging policies

The OPPS packages payments to promote efficiency and cost effective resource utilization. In using larger payment bundles in the OPPS, CMS' goal is to maximize hospitals' incentives to provide efficient patient care. It also promotes effective negotiations with manufacturers and suppliers to reduce cost of items and services, and highlights the need to find more cost-effective options. The ultimate goal of these policies is to bring the OPPS in line with other prospective payment systems and less oriented toward payment per service.

CMS is proposing to modify the CY 2014 final rule packaging policies with the following changes:

- Eliminate the L1 modifier for unrelated lab tests. All lab tests would be packaged if they appear on a claim with other hospital outpatient services.
- Expand the lab packaging exception that is currently in effect for molecular pathology test to apply to all advance diagnostic lab tests (ADLTs).
- To promote consistency, change the logic for conditional packaging status indicators Q1 and Q2 so the packaging would occur at the claim level rather than date of service.

Payment modifier for x-ray films

Amendments made as a result of the Consolidated Appropriations Act, 2016, provides that for services furnished during 2017 or any subsequent year, the payment for x-ray imaging services utilizing film under the OPPS will be subject to a 20 percent reduction factor. To facilitate this, CMS is proposing to create a new modifier to be used to identify these services starting in CY 2017.

Inpatient only procedures

In the November 15, 2004, final rule, CMS established criteria to arrive at what we know today as the list of procedures that are inpatient only (IPO). For Medicare beneficiaries, CMS has concluded that these procedures require an inpatient stay. Therefore, they will not be paid under the OPPS. While the criteria remain the same, CMS is proposing to remove six codes from the IPO list related to procedures on the spine and larynx. They are:

- CPT code 22840
- CPT code 22842
- CPT code 22845
- CPT code 22858
- CPT code 31584
- CPT code 31587

CMS is also looking for input on the possible removal of the Total Knee Anthroplasty (TKA) Procedure from the IPO list. CMS would like comments on how to modify the Comprehensive Care for Joint Replacement (CJR) and Bundled Payments for Care Improvements (BPCI) models if the TKA procedure were to be removed from the list.

Section 603 implementation: off-campus departments of a provider

Section 603 of the Bipartisan Budget Act of 2015 changed the definition of when off-campus departments of a hospital can be paid under the OPPS, rather than the Medicare Physician Fee Schedule (MPFS) or another payment system.

An off-campus outpatient department of a hospital in Section 603, refers to an "off-campus outpatient provider-based department" or an "off-campus PBD." As of November 2, 2015, an off-campus PBD is one "that is not located on the campus of such provider, or within the distance from a remote location of a hospital facility."

Those departments that were billing under subsection (t) prior to the enactment date of Section 603 receive "excepted" status for certain off-campus PBDs. Certain items and services furnished by such OPDs would continue to be paid under OPPS. In addition, excepted services would include those things furnished in a dedicated emergency department, as well as those services located on the campus of the hospital or that meet the distance criteria from the hospital. All of these services would continue to be paid under the OPPS.

CLA's three ideas for Section 603 implementation

CLA's many years of work in reimbursement allows us to provide insightful responses to changes in the industry. The following focus areas offer understandable starting points from which to consider Section 603 implementation.

Determine if the items or services provided in an off-campus PBD are considered excepted and paid under OPPS.

In the CY 2015 OPPS/ASC final rule, CMS adopted a voluntary claim modifier "PO" to identify services furnished in off-campus PBDs. The use of this modifier became mandatory beginning in CY 2016. CMS is seeking comments on what type of information would be needed to identify non-excepted off-campus PBD items or services that are not payable under the OPPS. Though CMS is seeking input on this, they are not proposing to collect such information in CY 2017.

Determine which requirements needed for an excepted off-campus PBD to maintain its excepted status.

CMS has proposed that certain items and services be exempted from the PBD regulations and paid under the OPPS as long as certain requirements are met.

1. Dedicated emergency departments: Whether it is located on or off the main hospital campus, as long as it meets one of the requirements (i.e., state licensure, held out to the public with no need for an appointment, or meets the outpatient visit test), CMS is proposing that all services provided in such a department would qualify for exemption and be paid under OPPS.
2. On-campus locations: Services would be exempted if they are provided as a department of the provider and include both the site of service, personnel, and equipment for the type of payment to be claimed under the Medicare or Medicaid program.

3. Within the distance from remote locations: CMS is proposing that off-campus PBDs must be located at or within the distance of 250 yards from a remote location of a hospital facility. It is suggested by CMS that hospitals use surveyors to ensure their off-campus PBDs are within the 250 yards (straight-line) from any point of a remote location. If the off-campus PBD meets the requirements, as well as the other PBD requirements in effect before the enactment of Section 603, this department would be exempted. However, CMS has considered some situations which would cause the status to change to non-excepted:

    a. Relocation of excepted off-campus PBDs: CMS is proposing that if relocation from the physical address noted on the hospital enrollment form as of November 1, 2015, occurs, status will be changed to non-excepted. This is the case even if the move is within the physical address to a different "unit" in a multi-unit building. CMS is looking to define further criteria for when such relocations are the result of a situation which falls under the disaster/extraordinary circumstances exception process or other situations that may be outside of the control of the hospital, which would not trigger a change in status.

    b. Expansion of clinical families of services at excepted off-campus PBDs: CMS is proposing that only those items and services defined in Table 21 that were being provided and billed for as of November 1, 2015, at the site can be excepted and paid under OPPS. Any new items or services that were not provided at or before this time period would not be paid under the OPPS. CMS considered, but is not yet proposing, to go a step further and require a time period that the services would have had to be provided to meet the requirement.

Proposed Clinical Families of Services for Purposes of Section 603 Implementation

Clinical families	APCs
Advanced Imaging	5523-25, 5571-73, 5593-4.
Airway Endoscopy	5151-55.
Blood Product Exchange	5241-44.
Cardiac/Pulmonary Rehabilitation	5771, 5791.
Clinical Oncology	5691-94.
Diagnostic tests	5721-24, 5731-35, 5741-43.
Ear, Nose, Throat (ENT)	5161-66.
General Surgery	5051-55, 5061, 5071-73, 5091-94, 5361-62.
Gastrointestinal (GI)	5301-03, 5311-13, 5331, 5341.
Gynecology	5411-16.
Minor Imaging	5521-22, 5591-2.
Musculoskeletal Surgery	5111-16, 5101-02.
Nervous System Procedures	5431-32, 5441-43, 5461-64, 5471.
Ophthalmology	5481, 5491-95, 5501-04.
Pathology	5671-74.
Radiation Oncology	5611-13, 5621-27, 5661.
Urology	5371-77.
Vascular/Endovascular/Cardiovascular	5181-83, 5191-94, 5211-13, 5221-24, 5231-32.
Visits and Related Services	5012, 5021-25, 5031-35, 5041, 5045, 5821-22, 5841.

Source: Federal Register / Vol. 81, No. 135; p. 45685.

Other related concerns noted in the proposed rule address the impact of excepted status due to change of ownership and data collection, including reporting on the CMS 855 provider enrollment form. There is a proposal to require separate identification of all excepted off-campus PBD locations to determine the date each location began billing, and the clinical families of services that were provided prior to November 2, 2015.

Establish policies for payment for applicable items and services furnished by an off-campus PBD that is non-excepted (i.e., not paid under OPPS).
Under the current payment structure, Medicare pays for those items and services provided at excepted PBD for the facility, as well as the physician's professional services. The facility portion of the payment falls under the OPPS. Physician payment is paid under the MPFS. Medicare beneficiaries are required to cost-share and are responsible for paying approximately 20 percent on both the OPPS and MPFS allowed amounts.

The issue is that no other payment or billing structure exists to accommodate this new set of items or services, which fall under the non-excepted definition because they are not physician services, nor do they qualify for the OPPS facility payments. There also is no mechanism to bill for such services. CMS acknowledges this in the proposed rule and states "…there is no straightforward way to do that before January 1, 2017."

So for CY 2017, CMS has proposed the MPFS would be the "applicable payment system" for the majority of non-excepted items and services furnished in these off-campus PBDs. They propose that physicians bill for physician services on the CMS 1500 and be paid under the MPFS at the non-facility rate. No separate payment would be made for this one year time period for the facility component.

For CY 2018, CMS has acknowledged the need to define "applicable payment system" and proposes that the MPFS be considered as such a system. In addition, a new provider/supplier type would need to be established for the non-excepted items and services. CMS has also proposed that an off-campus PBD can choose to enroll for CY 2018 as a free-standing facility/supplier. CMS acknowledges that numerous complex systems would need to be modified in the CMS/MACs and provider community for these changes to occur.

Finally, CMS is interested in comments on the impact on cost reporting, as well as potential resources to help CMS determine how to facilitate the billing of the non-excepted off-campus PBD items and services like claim forms. These changes could go beyond what appears in a cost report, and potentially impact covered entities' 340B drug programs or other programs.

Hospital Outpatient Quality Reporting (OQR) Program

The Hospital Outpatient Quality Reporting (OQR) Program has been modeled after the quality reporting program for hospital inpatient services known as the Hospital Inpatient Quality Reporting (IQR) Program. A quality reporting program exists for each payment system. Both OQR and ASQR Quality Reporting Programs were discussed in detail in the CY 2011 and CY 2014 final rules. The intent is to align the clinical quality measure requirements of the various quality reporting programs.

CMS has proposed to add seven new measures for CY 2020; two are claims-based measures and the other five are survey-based measures provided by the Outpatient and Ambulatory Surgery Consumer Assessment of Health Care Providers and Systems (OAS CAHPS).

The new measures are as follows:

- OP-25: Safe Surgery Checklist Use
- OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures
- OP-37a: OAS CAHPS – About Facilities and Staff
- OP-37b: OAS CAHPS – Communication About Procedure
- OP-37c: OAS CAHPS – Preparation for Discharge and Recovery
- OP-37d: OAS CAHPS – Overall Rating of Facility
- OP-37e: OAS CAHPS – Recommendation of Facility

In addition to these proposed measures, CMS would like input on future measurement topics, electronic clinical quality measures (eCQM) implementation, and Safe Use of Opioids-Concurrent Prescribing eCQM for future consideration in the OQR Program.

CMS proposes to continue to apply the 2 percent reduction for those hospitals that fail to meet the Hospital OQR Program requirements for the full CY 2017.

Ambulatory surgical center payment update

CMS is proposing a 1.2 percent increase to the ASC payment rates. This is comprised of a projected 1.7 percent Consumer Price Index for All Urban Consumers (CPI-U) update, less the same .5 percent multifactor productivity adjustment required by the ACA. This is projected to be an increase in ASC payments of $214 million over CY 2016.

Ambulatory Surgical Center Quality Reporting Program (ASCQR)

In this proposed rule, CMS adds seven new measures to CY 2020 payment determinations — two measures require data submission via a CMS web-based tool, and the remaining five from Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey based measures.

The two new web-based tool submission measures are:

- ASC-13: Normothermia Outcome
- ASC-14: Unplanned Anterior Vitrectomy

The three composite survey-based measures and the two global survey-based measures are derived from the OAS CAHPS Survey:

- ASC-15a: OAS CAHPS – About Facilities and Staff
- ASC-15b: OAS CAHPS – Communication About Procedure
- ASC-15c: OAS CAHPS – Preparation for Discharge and Recovery
- ASC-15d: OAS CAHPS – Overall Rating of Facility
- ASC-15e: OAS CAHPS – Recommendation of Facility

In addition to these measures, CMS is looking for comments on a measure that addresses Toxic Anterior Segment Syndrome (TASS). This measure assesses the number of ophthalmic anterior segment surgery patients diagnosed with TASS within two days of surgery. Although most cases of TASS can be treated, the inflammation associated with it can cause serious damage to the intraocular tissue, resulting in vision loss.

Hospital Value-Based Purchasing (VBP) Program

CMS is proposing to remove the HCAHPS Pain Management series of questions from the HCAHPS survey when determining a hospital's VBP score, effective with the Fiscal Year 2018 program year.

Medicare and Medicaid Electronic Health Record (EHR) Incentive Program

In an effort to reduce administrative burden and enable hospitals and critical access hospitals (CAHs) to focus more on patient care, CMS is proposing to eliminate the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) Objectives and Measures for eligible hospitals and CAHs for modified stage two and stage three for 2017 and subsequent years. In addition, CMS suggests reducing measure thresholds for eligible hospitals and CAHs for 2017 and 2018. They are also requesting input on more stringent future measures, as well as a significant hardship exception for new participants transitioning to the Merit-Based Incentive Payment System (MIPS) in 2017.

Transplant performance thresholds

Solid organ transplant programs are subject to a specialized system of oversight, which includes:

1. An organized national system of organ donation and allocation
2. Formalized policy development and inspection
3. Medicare conditions of participation that hold transplant programs accountable for patient and graft (organ) survival for at least one year after each recipient's transplant
4. A CMS system of on-site survey and certification for Medicare participating transplant centers.

It is through the various oversight and registry tracking that CMS has been able to work with certified transplant programs to improve outcomes and measures when data recognizes areas for improvement. Since 2007, one-year, post-transplant outcomes have improved for all organ types. Through July 2015, CMS has completed a mitigating factors review process for a portion of the programs that had been cited for condition-level, patient or graft volume, or outcome requirements that fell below the CMS standards.

Along with these outcome improvements overall, CMS has recognized that it has become much more difficult for an individual transplant program to meet the CMS outcomes standard. CMS is concerned that transplant programs may elect not to use certain available organs out of fear that their use would adversely impact their outcome statistics. In addition, the discard rate has increased with more recoveries and a higher percentage of unused organs. CMS has proposed revisions to performance thresholds.

Organ procurement organization (OPOs) changes

The role of the Organ Procurement Organization (OPO) is to ensure the maximum possible number of transplantable human organs are available to seriously ill patients who are on a waiting list for an organ transplant. They serve as a partner in procurement, distribution, and transplantation of human organs in a safe and equitable manner for all potential recipients.

Changes proposed in this area include the following:

- Definition of "eligible death"
- Aggregate donor yield for OPO outcome performance measures
- Eliminating most of the paper documentation requirements for organ preparation and transport

How we can help

The health care industry continues to change dramatically. Access to accurate information is the first step in positioning your organization for future success. The CLA Regulatory Advisor is a resource that will help keep you informed as new legislation is enacted.

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About CliftonLarsonAllen

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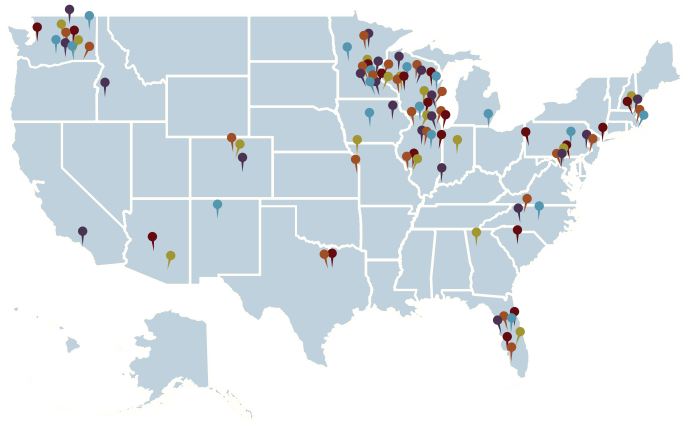

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