Issue Brief

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KEY POINTS

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MISSOURI HOSPITAL ASSOCIATION

CMS Releases Final Updates to the CY 2018 Hospital Outpatient and ASC Prospective Payment Systems

The Centers for Medicare and Medicaid Services issued its final rule updating payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments and in ambulatory surgical centers beginning Jan. 1, 2018.

A copy of the rule is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23932.pdf.

The rule will appear in the Federal Register on Nov. 13. A new link to the rule will be available on Nov. 13.

COMMENT

Once again, the document has a well written executive summary, but there is much material that the executive summary simply does not provide or convey in sufficient detail. One must read the rule to understand the magnitude of changes being proposed.

The final rule is nearly twice as long as the 664-page proposed rule.

CMS has provided a well written fact sheet. The fact sheet is at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-01.html.

As usual, the addenda are only available on the CMS web site at: The OPPS material is at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html The ASC payment system information is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

PAYMENT FOR DRUGS AND BIOLOGICALS PURCHASED THROUGH THE 340B DRUG PRICING PROGRAM

This item is probably the most controversial of any item in the final rule. CMS proposed to pay separately payable, non-pass-through drugs — other than vaccines purchased — at a discount through the 340B drug pricing program at the average sales price minus 22.5 percent rather than ASP plus 6 percent. CMS is adopting its proposal. Rural sole community hospitals, critical access hospitals, children's hospitals, and certain cancer hospitals are excluded from the reimbursement changes in 2018.

CMS says it is implementing this policy in a budget neutral manner by offsetting the projected decrease in drug payments of $1.6 billion by redistributing an equal amount for non-drug items and services across the OPPS.

Part B drugs or biologicals excluded from the 340B payment adjustment include vaccines (assigned status indicator "L" or "M") and drugs with OPPS

transitional pass-through payment status (assigned status indicator "G") will continue to be paid at ASP+6 percent.

Effective Jan. 1, 2018, biosimilar biological products not on pass-through payment status that are purchased through the 340B program or through the 340B PVP will be paid at ASP minus 22.5 percent of the reference product's ASP. Biosimilar biological products on drug pass-through payment status will continue to be paid ASP+6 percent of the reference product.

To effectuate the payment adjustment for 340B-acquired drugs, CMS is implementing modifier "JG", effective January 1, 2018. Hospitals paid under the OPPS, other than a type of hospital excluded from the OPPS — such as CAHs or those hospitals paid under the Maryland waiver — or excepted from the 340B drug payment policy for CY 2018, are required to report modifier "JG" on the same claim line as the drug HCPCS code to identify a 340B-acquired drug. For CY 2018, rural SCHs, children's hospitals and PPS-exempt cancer hospitals will be excepted from the 340B payment adjustment. Nonetheless, these hospitals will be required to report informational modifier "TB" for 340B-acquired drugs, and will continue to be paid ASP+6 percent.

I. OPPS PAYMENT POLICY CHANGES

A. OPPS Payment Update

CMS is increasing the OPPS payment rates by 1.35 percent. The amount is based on a hospital market basket increase of 2.7 percent minus both a 0.6 percentage point adjustment for the multi-factor productivity and a 0.75 percentage point adjustment required by law. After considering all other policy changes under the final rule, including estimated spending for pass-through payments, CMS estimates an overall impact of a 1.4 percent payment increase.

CMS will continue to implement the statutory 2.0 percentage point reduction in payments for hospitals failing to meet the hospital outpatient quality reporting requirements, by applying a reporting factor of 0.980 to the OPPS payments and copayments for all applicable services.

Based on this update, CMS estimates that total payments to OPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) for CY 2018 is approximately $70 billion, an increase of approximately $5.8 billion compared to estimated CY 2017 OPPS payments. In a better measure, CMS says further that total OPPS payments for CY 2018, including beneficiary cost-sharing, to the approximate 3,900 facilities paid under the OPPS (including general acute care hospitals, children's hospitals, cancer hospitals, and CMHCs) will increase by approximately $690 million compared to CY 2017 payments, excluding estimated changes in enrollment, utilization, and case-mix.

B. Conversion Factor

CMS is using a conversion factor of $78.636 using geometric mean costs; that is, the OPD fee schedule increase factor of 1.35 percent for CY 2018, a required wage index budget neutrality adjustment of approximately 0.9997, a cancer hospital payment adjustment of 1.0008, an adjustment for drugs purchased under the 340B Program of 1.0319, and an adjustment of 0.2 percentage point of projected OPPS spending for the difference in the pass-through spending and outlier payments. The proposed CF was $76.483.

C. Wage Index Changes

The OPPS labor-related share will remain at 60 percent of the national OPPS payment.

CMS believes that "using the final fiscal year IPPS post-reclassified wage index, inclusive of any adjustments, as the wage index for the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount is reasonable and logical, given the inseparable and subordinate status of the HOPD within the hospital overall."

Under the IPPS, the imputed floor policy was set to expire effective Oct. 1. CMS has decided to extend the imputed floor policy for one additional year, through FY 2018.

CMS is finalizing its proposal to implement the frontier State floor under the OPPS in the same manner as it has since CY 2011.

For CY 2018, CMS will continue its policy of allowing non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county (section 505 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003). CMS is including the out-migration adjustment information in Addendum L

For Community Mental Health Centers, CMS will continue to calculate the wage index by using the post-reclassification IPPS wage index based on the CBSA where the CMHC is located.

D. Statewide Average Default CCRs

CMS has updated the default ratios for CY 2018 using the most recent cost report data. The statewide values are presented in Table 9 of the rule.

E. Rural Adjustment

CMS will continue the 7.1 percent adjustment to the OPPS payments to certain rural sole community hospitals, including essential access community hospitals. This adjustment applies to all services paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to cost.

F. Payment Adjustment for Certain Cancer Hospitals for CY 2018

Section 16002(b) of the 21st Century Cures Act requires that the payment adjustment for certain cancer hospitals (11 hospitals), for services furnished on or after Jan. 1, 2018, the target payment-to-cost ratio (PCR) adjustment be reduced by 1.0 percentage point less than what would otherwise apply.
The table below indicates the estimated percentage increase in OPPS payments to each cancer hospital for CY 2018.

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Estimated CY 2018 Hospital-Specific Payment Adjustment for Cancer Hospitals to Be Provided at Cost Report Settlement		
Provider Number	Hospital Name	Estimated Percentage Increase in OPPS Payments for CY 2018 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	31.5%
050660	USC Norris Cancer Hospital	16.4%
100079	Sylvester Comprehensive Cancer Center	22.9%
100271	H. Lee Moffitt Cancer Center & Research Institute	21.7%
220162	Dana-Farber Cancer Institute	44.2%
330154	Memorial Sloan-Kettering Cancer Center	46.9%
330354	Roswell Park Cancer Institute	20.0%
360242	James Cancer Hospital & Solove Research Institute	27.5%
390196	Fox Chase Cancer Center	7.6%
450076	M.D. Anderson Cancer Center	74.9%
500138	Seattle Cancer Care Alliance	52.2%

G. Hospital Outpatient Outlier Payments

CMS will continue its policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS. A portion of that 1.0 percent, an amount equal to less than 0.01 percent of outlier payments — or 0.0001 percent of total OPPS payments — will be allocated to CMHCs for the Partial Hospital Program outlier payments. CMS estimates that a fixed-dollar threshold of $4,150, combined with the multiple threshold of 1.75 times the APC payment rate, will allocate 1.0 percent of aggregated total OPPS payments to outlier payments. The proposed amount was $4,325.

CMS says the difference in its calculation of the final fixed-dollar threshold of $4,150 and the proposed fixed-dollar threshold of $4,350 is largely attributed to finalized proposals related to reducing payments for drugs purchased under the 340B drug program for CY 2018

For CMHCs, if a CMHC's cost for partial hospitalization services, paid under APC 5853, exceeds 3.40 times the payment rate, the outlier payment will be calculated as 50 percent of the amount by which the cost exceeds 3.40 times APC 5853.

II. OPPS AMBULATORY PAYMENT CLASSIFICATION (APC) GROUP POLICIES

A. OPPS Treatment of New CPT and Level II HCPCS Codes

CPT and Level II HCPCS codes are used to report procedures, services, items and supplies under the hospital OPPS. Specifically, CMS recognizes the following codes on OPPS claims:

- Category I CPT codes, which describe surgical procedures and medical services
- Category III CPT codes, which describe new and emerging technologies, services, and procedures

- Level II HCPCS codes, which are used primarily to identify products, supplies, temporary procedures, and services not described by CPT codes

The final rule identifies:

- The treatment of 5 new level II HCPCS codes that were effective April 1, 2017. Table 12.

The treatment of 23 new HCPCS codes that were effective July 1, 2017. Table 13.

The final status indicators, APC assignments, and payment rates for the new CPT codes that are effective Jan. 1, 2018, can be found in Addendum B.

B. OPPS Changes – Variations within APCs

The following table lists the APCs that CMS will exempt from the 2 times rule for CY 2018.

APC Exceptions to the 2 Times Rule for CY 2018	
CY 2018 APC	CY 2018 APC Title
5112	Level 2 Musculoskeletal Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5691	Level 1 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5732	Level 2 Minor Procedures
5771	Cardiac Rehabilitation
5823	Level 3 Health and Behavior Services

C. New Technology APCs

For CY 2017, there were 51 New Technology APC levels, ranging from the lowest cost band assigned to APC 1491 (New Technology - Level 1A ($0-$10)) through the highest cost band assigned to APC 1906 (New Technology - Level 51 ($140,001-$160,000)).

CMS will, as proposed, narrow the increments for New Technology APCs 1901 – 1906 from $19,999 cost bands to $14,999 cost bands.

CMS will add New Technology APCs 1907 and 1908 (New Technology Level 52 ($145,001-$160,000)).

The table below includes the complete list of the modified and additional New Technology APC groups for CY 2018.

CY 2018 Additional New Technology APC Groups			
CY 2018 APC	CY 2018 APC Title	CY 2018 SI	Updated or New APC
1901	New Technology - Level 49 ($100,001-$115,000)	S	Updated
1902	New Technology - Level 49 ($100,001-$115,000)	T	Updated
1903	New Technology - Level 50 ($115,001-130,000)	S	Updated
1904	New Technology - Level 50 ($115,001-$130,000)	T	Updated
1905	New Technology - Level 51 ($130,001-$145,000)	S	Updated
1906	New Technology - Level 51 ($130,001-$145,000)	T	Updated
1907	New Technology - Level 52 ($145,001-$160,000)	S	New
1908	New Technology - Level 52 ($145,001-$160,000)	T	New

The payment rates for New Technology APCs 1901 through 1908 can be found in Addendum A.

Currently, there are four CPT/HCPCS codes that describe magnetic resonance image guided high intensity focused ultrasound procedures. The table below lists the final CY 2018 status indicator and APC assignments for the magnetic resonance image guided high intensity focused ultrasound procedures.

CY 2018 Status Indicator (SI) and APC Assignment for the Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) Procedures							
CPT/ HCPCS Code	Long Descriptor	CY 2017 OPPS SI	CY 2017 OPPS APC	CY 2017 OPPS Payment Rate	CY 2018 OPPS SI	CY 2018 OPPS APC	CY 2018 OPPS Payment Rate
0071T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume less than 200 cc of tissue	J1	5414	$2,084.59	J1	5414	Refer to OPPS Addendum B
0072T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume greater or equal to 200 cc of tissue.	J1	5414	$2,084.59	J1	5414	Refer to OPPS Addendum B

continued

0071T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume less than 200 cc of tissue.	J1	5414	$2,084.59	J1	5414	Refer to OPPS Addendum B
0072T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume greater or equal to 200 cc of tissue.	J1	5414	$2,084.59	J1	5414	Refer to OPPS Addendum B

- Retinal Prosthesis Implant Procedure

For CY 2018, CMS is reassigning the Argus® II procedure to APC 1904 (New Technology - Level 50 ($115,001 - $130,000)). This APC assignment will establish a payment rate for the Argus® II procedure of $122,500.50, which is the arithmetic mean of the payment rates for the service for CY 2016 and CY 2017.

- Pathogen Test for Platelets

Replacement Code for HCPCS Code Q9987 as of January 1, 2018				
CY 2017 HCPCS Code	CY 2018 HCPCS Code	CY 2018 Long Descriptor	Final CY 2018 SI	Final CY 2018 APC
Q9987	P9100	Pathogen(s) test for platelets	S	1493

- Fractional Flow Reserve Derived from Computed Tomography (FFRCT)

For CY 2018, the AMA CPT Editorial Panel established four new CPT codes for fractional flow reserve derived from computed tomography.

CMS is reassigning CPT code 0503T from packaged status (status indicator "N") to New Technology APC 1516 (New Technology - Level 16 ($1401 - $1500)), with a payment rate of $1,450.50 for CY 2018.

D. OPPS APC-Specific Policies

CMS discusses specific policies regarding the following:

1. Blood-Derived Hematopoietic Cell Harvesting;
2. Brachytherapy Insertion Procedures (C-APCs 5341 and 5092);
3. Care Management Coding Changes Effective January 1, 2018 (APCs 5821 and 5822);
4. Cardiac Telemetry (APC 5721);
5. Collagen Cross-Linking of Cornea (C-APC 5503);
6. Cryoablation Procedure for Lung Tumors (C-APC 5361;
7. Diagnostic Bone Marrow Aspiration and Biopsy (C-APC 5072);

8. Discussion of Comment Solicitation in the Proposed Rule on Intraocular Procedure APCs;
9. Endovascular APCs (C-APCs 5191 through 5194);
10. Esophagogastroduodenoscopy (EGD) (C-APC 5362);
11. Hemorrhoid Treatment by Thermal Energy (APC 5312);
12. Ileoscopy Through Stoma with Stent Placement (C-APC 5303);
13. Laparoscopic Nephrectomy (C-APC 5362);
14. Multianalyte Assays with Algorithmic Analyses (MAAA);
15. Musculoskeletal APCs (APC 5111 through 5116);
16. Nasal/Sinus Endscopy Procedures (C-APC 5155)
17. Nuclear Medicine Services (APCs 5592 and 5593);
18. Percutaneous Transluminal Mechanical Thrombectomy (C-APC 5192);
19. Peripherally Inserted Central Venous Catheter (PICC) (APC 5182);
20. Pulmonary Rehabilitation Services (APCs 5732 and 5733) and Cardiac Rehabilitation Services (APC 5771);
21. Radiology and Imaging Procedures and Services;
22. Sclerotherapy (APC 5054);
23. Skin Substitutes (APCs 5053, 5054, and 5055)
24. Subdermal Drug Implants for the Treatment of Opioid Addiction (APC 5735)
25. Suprachoroidal Delivery of Pharmacologic Agent (APC 5694);
26. Transperineal Placement of Biodegradeable Material (C-APC 5375);
27. Transcranial Magnetic Stimulation (TMS) Therapy (APCs 5721 and 5722);
28. Transurethral Waterjet Ablation of the Prostate (C-APC 5375);
29. Transurethral Water Vapor Thermal Therapy of the Prostate (C-APC 5373);

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

III. OPPS PAYMENT FOR DEVICES

- Pass-Through Payments for Devices

The pass-through payment status of the device categories for HCPCS codes C2623, C2613, and C1822 will end on Dec. 31. Beginning in CY 2018, CMS will package the costs of these devices into the costs related to the procedure with which each device is reported in the hospital claims data.

CMS received five applications for Device Pass-Through Payment for CY 2018 by the March 1, 2017 deadline. None are approved. The five are:

- Architect® Px
- Dermavest and Plurivest Human Placental Connective Tissue Matrix (HPCTM)
- Fl Graft®/Fl graft Neogenesis®
- Kerecis™ Omega3 Wound (Skin Substitute)
- X-WRAP®

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- Device-Intensive Procedures

Procedures that have an individual HCPCS code-level device offset of greater than 40 percent are identified as device-intensive procedures and are subject to all the policies applicable to procedures assigned device-intensive status under CMS' established methodology, including policies on device edits and device credits.
The full listing of the final CY 2018 device-intensive procedures is included in Addendum P.

- Payment Policy for Low-Volume Device-Intensive Procedures

The payment rate for any device-intensive procedure that is assigned to a clinical APC with fewer than 100 total claims for all procedures in the APC is calculated using the median cost instead of the geometric mean cost. The CY 2018 final rule median cost for the procedure described by CPT code 0308T is $17,550.18. The final CY 2018 payment rate (calculated using updated median cost and the claims that reported the device consistent with CMS' device edit policy for device-intensive procedures) is $17,560.07.

IV. OPPS PAYMENT CHANGES FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS

- Drugs and Biologicals with Expiring Pass-Through Payment Status in CY 2017

CMS is finalizing its proposal, without modification, to expire the pass-through payment status of 19 drugs and biologicals listed in the rule's table 69 on Dec. 31.All of these drugs and biologicals will have received OPPS pass-through payment for at least 2 years and no more than 3 years by Dec. 31. These drugs and biologicals were approved for pass-through payment status on or before Jan. 1, 2016.

The packaged or separately payable status of each of these drugs or biologicals is listed in Addendum B.

- Drugs, Biologicals, and Radiopharmaceuticals with New or Continuing Pass-Through Payment Status in CY 2018

Fifty drugs and biologicals that continue to have pass-through payment status for CY 2018 or have been granted pass-through payment status as of January 2018 are shown in Table 70 of the rule.

The APCs and HCPCS codes for these drugs are assigned status indicator "G" in Addenda A and B.

- Provisions for Reducing Transitional Pass-Through Payments for Policy-Packaged Drugs, Biologicals, and Radiopharmaceuticals to Offset Costs Packaged into APC Groups

CMS will continue to apply the same policy packaged offset policy to payment for pass-through diagnostic radiopharmaceuticals, pass-through contrast agents, pass-through stress agents, and pass-through skin substitutes as it did in CY 2017. The rule's table 71 contains the list of APCS to which a policy–packaged drug or radiopharmaceutical offset are applicable in CY 2018.

OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Payment Status

CMS is continuing its packaging threshold for CY 2018 of $120, the same as the current amount.

- High Cost/Low Cost Threshold for Packaged Skin Substitutes

Under the OPPS, payment for skin substitutes — products used to aid in wound healing — is packaged into the payment for their associated surgical procedures. These products are assigned to either a "high cost group" or a "low cost group" depending on how costly they are relative to certain cost thresholds. Consistent with current policy, CMS proposed to assign skin substitutes with a geometric mean unit cost or a per day cost that exceeds either the MUC threshold or the PDC threshold to the high cost group. In addition, for CY 2018, CMS is finalizing its proposal that a skin substitute product that does not exceed either the CY 2018 MUC or PDC threshold for CY 2018, but was assigned to the high cost group for CY 2017, will be assigned to the high cost group for CY 2018. The goal of this policy is to maintain similar levels of payment for skin substitute products for CY 2018 while CMS analyzes the current skin substitute payment methodology to determine whether refinements to the existing methodologies may be warranted.

Table 72 of the rule displays the CY 2018 high cost or low cost category assignment for each skin substitute product. CMS has identified 10 skin substitute products that would otherwise have been assigned to the low cost group for CY 2018, but will instead be assigned to the high cost group under its policy to include in the high cost group for CY 2018 any skin substitute that was in the high cost group for CY 2017. The skin substitute products affected by this policy are identified with an asterisk in table 72.

V. ESTIMATE OF OPPS TRANSITIONAL PASS-THROUGH SPENDING FOR DRUGS, BIOLOGICALS, RADIOPHARMACEUTICALS, AND DEVICES

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals and categories of devices for a given year to an "applicable percentage," currently not to exceed 2.0 percent of total program payments estimated to be made for all covered services under the OPPS furnished for that year.

CMS estimates that total pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2018 and those device categories, drugs, and biologicals that first become eligible for pass-through payment during CY 2018 is approximately $28.06 million. Therefore, CMS estimates that pass-through spending in CY 2018 will not amount to 2.0 percent of total projected OPPS CY 2018 program spending.

VI. OPPS PAYMENT FOR HOSPITAL OUTPATIENT VISITS AND CRITICAL CARE SERVICES

CMS is not making any changes to its current clinic and emergency department hospital outpatient visits payment policies.

VII. PAYMENT FOR PARTIAL HOSPITALIZATION SERVICES

A partial hospitalization program is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute

mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia and substance use disorders.

CMS is continuing to use CMHC APC 5853 (Partial Hospitalization (three or More Services Per Day)) and hospital-based PHP APC 5863 (Partial Hospitalization (three or More Services Per Day)).

The CY 2018 geometric mean per diem cost for all CMHCs for providing three or more services per day (APC 5853) is **$143.22**. The proposed amount was $128.81
The geometric mean per diem cost for hospital-based PHP providers that provide three or more services per service day (hospital-based PHP APC 5863) is **$208.09** The proposed rate was $213.60.

VIII PROCEDURES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES

CMS is removing, as proposed, the procedures described by the following codes from the inpatient only (IPO) list for CY 2018: (1) CPT code 27447 (Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)); beginning in CY 2018 the TKA procedure will be assigned to C-APC 5115 with status indicator "J1", and (2) and CPT code 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed).

CMS is also removing CPT codes 43282, 43772, 43773, 43774 from the IPO list.
CMS is adding one procedure to the IPO list in response to public comments – CPT code 92941.

In addition, CMS is precluding the Recovery Audit Contractors from conducing "site of service" reviews of outpatient total knee arthroplasty procedures for a period of two years.

IX. NONRECURRING POLICY CHANGES

- Enforcement Instruction for the Supervision of Outpatient Therapeutic Services in Critical Access Hospitals (CAHs) and Certain Small Rural Hospitals

For several years, there has been a moratorium on the enforcement of the direct supervision requirement for CAHs and small rural hospitals, with the latest moratorium on enforcement expiring on Dec. 31, 2016. In this final rule, CMS is reinstating the non-enforcement of direct supervision requirements for outpatient therapeutic services for CAHs and small rural hospitals with 100 or fewer beds for CYs 2018 and 2019.

- Payment Changes for Film X-Ray Services and Payment Changes for X-Rays Taken Using Computed Radiography TechnologyZ

CMS is finalizing its proposal to establish a new modifier "FY" (X-ray taken using computed radiography technology/cassette-based imaging) as permitted by section 1833(t)(16)(F)(iv) of the Act. The payment reduction will be taken when this modifier is reported with the applicable HCPCS code(s) to describe imaging services that are taken using computed radiography technology. The applicable HCPCS codes describing imaging services can be found in Addendum B.

- Revisions to the Laboratory Date of Service Policy

For a clinical diagnostic laboratory test, the date of service is typically the date the specimen was collected, unless certain conditions are met. CMS considered potential modifications to the DOS policy that would allow laboratories to bill Medicare directly for molecular pathology tests and certain advanced diagnostic laboratory tests which are excluded from the OPPS packaging policy and ordered less than 14 days following the date of the patient's discharge from the hospital.

CMS is adding an additional exception to its current laboratory DOS regulations at § 414.510(b)(5) so that the DOS for molecular pathology tests and tests designated by CMS as Criterion (A) ADLTs is the date the test was performed only if:

- The test was performed following a hospital outpatient's discharge from the hospital outpatient department
- The specimen was collected from a hospital outpatient during an encounter (as both are defined in § 410.2)
- It was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter
- The results of the test do not guide treatment provided during the hospital outpatient encounter
- The test was reasonable and medically necessary for the treatment of an illness.

X. CY 2018 OPPS PAYMENT STATUS AND COMMENT INDICATORS

Payment status indicators that CMS assigns to HCPCS codes and APCs serve an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code.

The complete list of the payment status indicators and their definitions that apply for CY 2018 is displayed in Addendum D1

XI. UPDATES TO THE AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEM

a. Calculation of the ASC Conversion Factor and the ASC Payment Rates

ASC payments are annually updated by the percentage increase in the Consumer Price Index for all urban consumers. The Medicare statute specifies a multi-factor productivity adjustment to the ASC annual update. For CY 2018, the CPI-U update is projected to be 1.7 (proposed at 2.3) percent. The MFP adjustment is projected to be 0.5 percent, resulting in a MFP-adjusted CPI-U update factor of 1.2 percent.

The final ASC conversion factor of $45.575, for ASCs that meet the quality reporting requirements, is the product of the CY 2017 conversion factor of $45.003 multiplied by a wage index budget neutrality adjustment of 1.0007 and the MFP-adjusted CPI–U payment update of 1.2 percent.

For ASCs that do not meet the quality reporting requirements, CMS is reducing the CPI–U update of 1.7 percent by 2.0 percentage points and then applying the 0.5 percentage point MFP adjustment, resulting in a -0.8 percent MFP adjusted CPI–U update factor for CY 2018. The final ASC conversion factor of $44.663 for ASCs that do not meet the quality reporting

requirements is the product of the CY 2017 conversion factor of $45.003 multiplied by the wage index budget neutrality adjustment of 1.0007 and the MFP-adjusted CPI–U payment update of -0.8 percent.

Addenda AA and BB display the updated ASC payment rates for CY 2018.

b. Treatment of New and Revised Level II HCPCS Codes
The rule's table 80 lists 6 Level II HCPCS codes that were implemented April 1, 2017. The final payment rates for these codes can be found in Addendum BB.

CMS is finalizing the seven proposed payment indicators for new Category III CPT code and Level II HCPCS codes that were newly recognized as ASC covered surgical procedures or covered ancillary services in July 2017. They are shown in the rule's table 81.

c. Update to the List of ASC Covered Surgical Procedures and Covered Ancillary Services
CMS has identified two covered surgical procedures, CPT code 37241 (Vascular embolize/occlude venous) and CPT code 67227 (Destruction extensive retinopathy), that CMS believes meet the criteria for designation as office-based. CMS is permanently designating these items as office-based for CY 2018. Details are in Table 83.

CMS is also finalizing its proposal, without modification, to designate 10 procedures listed in table 84 as temporary office-based.

CMS will also designate CPT code 38222 as a temporary office-based for CY 2018 as displayed in table 85.

d. Changes to List of ASC Covered Surgical Procedures Designated as Device-Intensive for CY 2018
CMS is designating ASC covered surgical procedures displayed in Addendum AA as device-intensive and subject to the device-intensive procedure payment methodology for CY 2018. The CPT code, the CPT code short descriptor, the final CY 2018 ASC payment indicator, and an indication of whether the full credit/partial credit device adjustment policy will apply are included in the ASC policy file labeled "CY 2018 ASC Procedures to which the No Cost/Full Credit and Partial Credit Device Adjustment Policy Applies," which is available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Policy-Files.html.

e. Proposed Additions to the List of ASC Covered Surgical Procedures
CMS is finalizing its proposal to add the three procedures described by CPT codes 22856, 22858, and 58572 to the ASC list of covered surgical procedures. The procedures that are being added include the code long descriptors and the final CY 2018 payment indicators, are displayed in table 86.

f. New Technology Intraocular Lenses (NTIOLs)
CMS received no requests for new technology intraocular lenses.

XII. REQUIREMENTS FOR THE HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

CMS is finalizing the removal of six measures for this setting beginning with the CY 2020 payment determination. The measures being removed are:

- OP-21: Median Time to Pain Management for Long Bone Fracture, which measures the median time from emergency department (ED) arrival to time of initial oral, nasal, or parenteral pain medication (opioid and non-opioid) administration for emergency department patients with a principal diagnosis of long bone fracture.
- OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures, which assesses the aggregate count of selected, higher volume, surgical procedures performed in Hospital Outpatient Departments.
- OP-1: Median Time to Fibrinolysis, which assesses the median time from ED arrival to administration of fibrinolytic therapy in ED patients with ST-segment elevation on the ECG performed closest to ED arrival and prior to transfer. This measure was proposed to be removed beginning with the CY 2021 payment determination, but is being finalized for removal beginning with the CY 2020 payment determination in response to public comments requesting earlier removal.
- OP-4: Aspirin at Arrival, which assesses the rate of patients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the ED. This measure was proposed to be removed beginning with the CY 2021 payment determination, but is being finalized for removal beginning with the CY 2020 payment determination in response to public comments requesting earlier removal.
- OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional, which assesses the time from ED arrival to provider contact for emergency department patients. This measure was proposed to be removed beginning with the CY 2021 payment determination, but is being finalized for removal beginning with the CY 2020 payment determination in response to public comments requesting earlier removal.
- OP-25: Safe Surgery Checklist Use, which assesses whether a hospital 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. This measure was proposed to be removed beginning with the CY 2021 payment determination, but is being finalized for removal beginning with the CY 2020 payment determination in response to public comments requesting earlier removal.

Additionally, CMS is finalizing the proposal to delay the mandatory implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey under the Hospital OQR Program beginning with the CY 2018 data collection.

CMS also provides clarification on the procedures for validation of chart-abstracted measures to note that 50 outlier hospitals, based on poor measure scoring, will be targeted for validation. CMS is finalizing: policy to formalize the chart-abstracted measures validation educational review procedures, updates to include a corrections process and corresponding regulatory updates to reflect these policies. In addition, CMS is finalizing its proposal to align the first quarter for which to submit data for hospitals that did not participate in the previous year's Hospital OQR Program and make corresponding regulatory updates.

CMS is also finalizing a proposal to align the naming of the Extraordinary Circumstances Exceptions policy with other quality reporting programs and corresponding regulatory updates to reflect these policies. CMS is also finalizing, with modification, its proposal to publicly report OP-18c: Median Time from Emergency Department Arrival to Emergency Department Departure for Discharged Emergency Department Patients – Psychiatric/Mental Health Patients. Lastly, CMS is not finalizing its proposal to extend the Notice of Participation deadline and make corresponding changes to the CFR.

The tables below outline the Hospital OQR Program measure set CMS is adopting for the CY 2020 payment determination and subsequent years.

Newly Finalized Hospital OQR Program Measure Set for the CY 2020 Payment Determination and Subsequent Years	
NQF #	**Measure Name**
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0289	OP-5: Median Time to ECG†
0514	OP-8: MRI Lumbar Spine for Low Back Pain
None	OP-9: Mammography Follow-up Rates
None	OP-10: Abdomen CT – Use of Contrast Material
0513	OP-11: Thorax CT – Use of Contrast Material
None	OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
None	OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)
0491	OP-17: Tracking Clinical Results between Visits†
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
None	OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
0499	OP-22: Left Without Being Seen†
0661	OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
0431	OP-27: Influenza Vaccination Coverage among Healthcare Personnel
0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients*
0659	OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use*
1536	OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery**
2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
1822	OP-33: External Beam Radiotherapy for Bone Metastases
None	OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2687	OP-36: Hospital Visits after Hospital Outpatient Surgery

continued

None	OP-37a: OAS CAHPS – About Facilities and Staff***
None	OP-37b: OAS CAHPS – Communication About Procedure***
None	OP-37c: OAS CAHPS – Preparation for Discharge and Recovery***
None	OP-37d: OAS CAHPS – Overall Rating of Facility***
None	OP-37e: OAS CAHPS – Recommendation of Facility***

† NQF endorsement for this measure was removed.
** Measure name was revised to reflect NQF title.*
*** Measure voluntarily collected as set forth in section XIII.D.3.b. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66946 through 66947).*
**** Measure reporting delayed beginning with CY 2018 reporting and for subsequent years.*

XIII. REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM

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.

Data for the two measures are collected via administrative claims and, CMS says, do not add provider burden to the program. The measures finalized for addition are:

- ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures, 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.

The adoption of one measure proposed in the CY 2018 OPPS/ASC proposed rule, ASC-16: Toxic Anterior Segment Syndrome (TASS), is not being finalized.
CMS is finalizing proposals to remove a total of three measures for the CY 2019 payment determination and subsequent years. 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.

Beginning with the CY 2020 payment determination (CY 2018 data collection), CMS is finalizing the proposal to delay the mandatory implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey under the ASCQR Program.

Additionally, CMS is finalizing its proposal to expand the CMS online data submission tool, QualityNet, to also allow for batch submission of ASCQR Program measure data beginning with data submitted during CY 2018, and make corresponding regulatory updates. Batch submission is submission of data for multiple facilities simultaneously using a single, electronic file containing data from multiple facilities submitted via one agent QualityNet account. Logistics on batch data submission will be included in the Specifications Manual. Lastly, CMS is finalizing a proposal to align the naming of the Extraordinary Circumstances Exceptions (ECE) policy and make corresponding regulatory updates to reflect this policy.

ASCQR Program Measure Set Finalized for the CY 2021 Payment Determination and Subsequent Years		
ASC #	**NQF #**	**Measure Name**
ASC-1	0263	Patient Burn
ASC-2	0266	Patient Fall
ASC-3	0267	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4	0265†	All-Cause Hospital Transfer/ Admission
ASC-8	0431	Influenza Vaccination Coverage among Healthcare Personnel
ASC-9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
ASC-10	0659	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use
ASC-11	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery*
ASC-12	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
ASC-13	None	Normothermia Outcome
ASC-14	None	Unplanned Anterior Vitrectomy
ASC-15a	None	OAS CAHPS – About Facilities and Staff**
ASC-15b	None	OAS CAHPS – Communication About Procedure**

continued

ASC-15c	None	OAS CAHPS – Preparation for Discharge and Recovery**
ASC-15d	None	OAS CAHPS – Overall Rating of Facility**
ASC-15e	None	OAS CAHPS – Recommendation of Facility**

† CMS notes that NQF endorsement for this measure was removed.
** Measure voluntarily collected effective beginning with the CY 2017 payment determination.*
***Measure proposed for delay in reporting beginning with the CY 2020 payment determination (CY 2018 data collection) and until further action in future rulemaking.*
**** New measure proposed for the CY 2021 payment determination and subsequent years.*