Summary of Major Provisions
Payment policies and rates for Outpatient Hospital and ASCs.

I. Background & Legislative Requirements
   A. 2016 Payment Rate

II. Updates Affecting Payment Rates
   A. Adjustments
   B. Outlier Payment Thresholds
   C. IPPS Update
   D. ASC

III. Summary of Other Provisions
   A. Packaging
      1. Comprehensive APCs (C-APCs)
      2. Device
      3. Two-Midnight Rule
      4. Care Planning and Management
      5. Hospital Outpatient Quality Indicators

IV. Code Changes Affecting APC Assignment
   A. New Technology
   B. Restructuring

V. Outpatient E&M Encounters

VI. Inpatient Only
Background

Balanced Budget Act of 1997 added section 1833(t) to Title XVIII of the Social Security Act required annual review.

- Rate-per-service according to the APC group assigned to a service.
- Includes:
  - Most outpatient hospital services
  - Exclusions outlined in 42CFR §419.22
Restructuring APCs

- Annual review required of certain components of APCs to include:
  - Revise groupings
  - Relative payment weights
  - Changes in medical practice and technologies and
  - New cost data and other relevant information and factors.

- Changes to nine clinical families based on following:
  1. Improved clinical homogeneity;
  2. Improved resource homogeneity;
  3. Reduce resource overlap in longstanding APCs; and
  4. Greater simplicity and improved understandability of APC structure.
Recalibration of APC Weights

- CMS goal to use the most appropriate cost information in setting the APC relative payment weights.
- Construction of database.
- Matched to most recent cost report data filed by hospital in CMS claims data.
- Established the geometric mean natural cost of a single procedure claim was ≤ $55.
- Created “pseudo” single procedure claims.
- Certain services (codes) on bypass list.
- Continued composite APCs for multiple imaging services.

(70309 - 70311)
2016 PAYMENT RATES
2016 Payments

- Decrease of 0.3%
  - Based on inpatient market basket percentage increase of 2.4% for inpatient services paid under IPPS
  - Multi-factor productivity adjustment of 0.5%
  - 0.2% Affordable Care Act adjustment
  - 2.0% reduction to redress the inflation in OPPS payment rates resulting from underestimated laboratory test costs packaged in 2015
- 2.0% reduction in payment to hospitals failing to comply with hospital outpatient quality reporting requirements by applying a 0.980 reporting factor to the OPPS payments thus reducing their conversion factor.
- Under OPPS, not all covered separately *billable* services are separately *payable*. 
A budget neutrality adjustment factor of 0.9993 wage index changes. (70352)

Estimated payments for outliers were maintained at 1.0 percent of total OPPS payments for CY 2016 (70365)

Conversion Factor Updates | 2016
---|---
Market Basket Update | +2.4%
Affordable Care Act (ACA) Multifactor Productivity Reduction (MFP) | -0.5%
OPD adjustment to fee schedule increase factor | -0.2%
Reduction caused by error in calculation relating to packaged payment for lab tests. | -2.0%
Overall Net Update | -0.3%
National Unadjusted Payment Rate ($0.029 increase) | $74.173

Note: Hospitals that fail to meet the Hospital Outpatient Quality Reporting requirements will receive an additional 2.0% reduction in the conversion factor to $72.68954.
UPDATES AFFECTING OPPS PAYMENTS
Summary of Adjustments

- Upward adjustment of 7.1% to OPPS payment to Rural Hospitals
- **Cancer Hospital**: continue to provide additional payments needed to result in a payment-to-cost (PCR) equal to 0.92 for each cancer hospital.
- **Drugs, Biologicals and Radiopharmaceuticals**: non-pass-through status are set at average sales price (ASP) plus 6%. (70426 - 70448)
- **Skin Substitutes**: Those with pass-through status will be assigned high-cost category. Those that are new or without pricing data will be assigned to high/low cost category based on ASP +6%. (70
- **Packaging Policies**: expanding the set of conditionally packaged ancillary services to include 3 new APCs.
- **Contrast Agents**: Packaged into APC 5722-Level 2 Diagnostic Tests and Related Services and 5593 - Level 3 Nuclear Medicine (70342)
Summary of Adjustments - continued

- Conditionally packaged outpatient laboratory tests (regardless of the date of service) on a claim with a service assigned a status indicator of “S”, “T” or “V” unless an exception applies or laboratory test is unrelated to another hospital outpatient department (HOPD) on the claim.
  - New status indicator “Q4”
  - L1 modifier will continue to be used for “unrelated” tests
- Comprehensive APCs: 25 C-APCs in 2015, no extensive changes in 2016 however 9 new C-APCs created.
- New process of Device Pass-through payment: Added rulemaking component to the current quarterly device pass-through payment application process. The addition of rulemaking to the device pass-through application process will help achieve the goals of increased transparency and stakeholder input. (70415 - 70426)
Other Adjustments

- **Community Mental Health Centers (CMHC)** Payment policy continues to use an OPPS labor-related share of 60 percent of the national OPPS payment for the CY 2016 OPPS. (70359)

- **Cancer Hospital Payment** - CMS will continue its policy to provide additional payments to Cancer hospitals consistent with payment-to-cost ratios (PCR) with payment adjustments. Target PCR of 0.90 will be used to determine the CY2016 cancer hospital payment adjustment paid at cost report settlement. (70363)

- **Drugs, Biologicals and Radiopharmaceuticals** - Payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals that do not have pass-through status remains at average sales price (ASP) plus 6%.

- **Blood and Blood Products** - continue to establish payment rates for blood and blood products using our blood-specific CCR methodology. However, 3 new HCPCS codes for pathogen reduced blood products have a different rate and are identified with comment indicator “NI” in Addendum B. (70323)
Other Adjustments - continued

- **Brachytherapy sources:** The CY 2016 geometric mean cost of brachytherapy sources described by HCPCS code C2616 is approximately $16,760, compared with approximately $16,160 for CY 2015. The CY 2016 geometric mean cost is based on a greater number of providers, days, and units in comparison to CY 2014 and CY 2015. (70323-70324) Table 6

- **Outliers - outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the final fixed-dollar threshold of $3,100 are met.** (70364)
Outlier Payment Thresholds

- CY 2014 fixed-dollar threshold of $2,900 and CY 2015 fixed-dollar threshold of $2,775
- CY 2016, estimated fixed dollar threshold is $3,200
- For CMHCs, if a CMHC’s cost for partial hospitalization services, paid under either APC 5851 or 5852 (renumbered from APC 0172 and APC 0173), exceeds 3.40 times the payment rate for APC 0173, the outlier payment will be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 5852 payment rate. (70365)
IPPS Changes

- Wage Index
  - 2.0% reduction to the conversion factor of the Outpatient Department fee schedule increase factor
  - CMS updated the labor market area data to use the OMB 2013 delineations, using 2010 Census data
    - Previous MSAs were based on 2000 Census data
  - Urban hospital 0.4% reduction
  - Rural hospital 0.6% reduction
  - For APC costs, 60 percent of estimated claims costs for a geographic area wage variation was calculated using the same FY 2015 pre-reclassified wage index that the IPPS uses to standardize costs.
• **ASC payment update**: payment increased by 0.3% for ASCs that meet the quality reporting requirements under the ASCQR.
  • Revised process for assigning ASC payment indicators for Category I and III CPT codes by assigning the ASC payment indicator before they are used for payment purposes.

• **ASC Quality Reporting (ASCQR)**
  • Aligning policies regarding paid claims to be included in calculation for all claims-based measures,
  • modifying policy for public reporting and
  • Disregard IHS hospital outpatient departments that bill as ASCs to be ASCs for purposes of ASCQR.
SUMMARY OF OTHER PROVISIONS
Comprehensive APCs

- A comprehensive APC (C-APC) treats all services individually reported HCPCS codes as one comprehensive service for the provision of a primary service into which all other services reported on the claim are packaged.
- When a primary service is reported on a hospital outpatient claim, payment is made for all other items and services reported on the hospital outpatient claim as they are an integral, ancillary, supportive, dependent, and adjunctive to the primary service. C-APC represents a single Medicare payment and a single co-payment under OPPS.
- The APCs are organized such that each group is homogeneous both clinically and in terms of resource use. Using this classification system, distinct groups of similar services were established.
- In 2016, 9 new C-APCs were added. (70325)
Device Packaging

- CMS goal is to continue to package implantable devices, implantable prosthetics, and medical and surgical supplies into payment for the primary procedure.
- Prosthetic supplies are currently excluded from payment under the OPPS and are paid under the DMEPOS Fee Schedule, even when provided in the HOPD.
- Many implantable prosthetic devices are part of a device system that include the implantable part or parts and also certain non-implantable prosthetic supplies. Collectively, all parts are integral to the overall function of the medical device, whether implanted or external to the patient.
- Prosthetic supplies provided in the HOPD are reclassified and are included in payment as “medical and surgical supplies”.
- In 2016, CMS created one cost center for “Medical Supplies Charged to Patients” and one cost center for “Implantable Devices Charged to Patients,” essentially splitting the then current cost center for “Medical Supplies Charged to Patients” into one cost center for low-cost medical supplies and another cost center for high-cost implantable devices in order to mitigate some of the effects of charge compression. (70312)
In CY 2014, 39 device dependent APCs were identified.

For CY 2015, the device dependent APCs were consolidated into 26 of the available 28 C-APCs. (70421 - Table 41)

For CY 2016, (70422) Table 42 Device Intensive APCs

Table 42.pdf
Two-midnight Rule (70305)

- Provision within IPPS Final Rule
- CMS allows exceptions to the two-midnight rules for specified procedures (inpatient only)
- OPPS Final Rule amends the two-midnight rule to allow the treating physician or other practitioner to use his or her judgement to make exceptions to the two-midnight rule requirement, subject to medical review by a QIO (Quality Improvement Organization) rather than a recovery audit contractor (RAC).
- CMS notes that stays less than 24 hours should rarely be considered inpatient stays.
Care Planning and Management

• **Advanced Care Planning**… first 30 minutes, CPT 99497 conditionally packaged with status indicator “Q1” when furnished with another service paid under OPPS.
  - CPT code 99498 (Advance care planning each add ’l 30 minutes) is an add-on code and is unconditionally packaged with status indicator “N”.

• **Chronic Care Management (CCM)** - added additional requirements for hospitals. a hospital would be able to bill CPT code 99490 for CCM services only when furnished to a patient who has been either admitted to the hospital as an inpatient or has been a registered outpatient of the hospital within the last 12 months and for whom the hospital furnished therapeutic services. (70450)
1. Removing OP-15; Use of Brain CT in the ED for Atraumatic Headache.
2. Changing deadline for withdrawing from November 1 to August 31.
3. Transitioning to new payment determination timeframe using 3 quarters of data
4. Changing validation scoring process to reflect changes in APU
5. Changing data submission timeframe for measures submitted via CMS web-based tool to January 1 through May 15
6. Fixing typographical error to correct name of the extension and exception policy to extension and exemption policy
7. Changing the deadline for submitting a reconsideration request and
8. Amending 42CFR 419-46(f)(1) and 42 CFR 419-46(e)(2) to replace the term fiscal year with calendar year.
Comprehensive APCs

CY 2016
Comprehensive APCs

- Comprehensive payment policy that “packages” items, services, procedures into a single payment started in CY 2015.
- Comprehensive APC (C-APC) is a classification of a primary service and all adjunctive services provided to support the delivery of the primary service.
- Certain HCPCS codes were identified as a primary service and then assigned to a C-APC. These codes were then assigned a “J1” status indicator.
- When that HCPCS code appeared on a claim, all items and services were considered as being integral, ancillary, supportive, dependent and adjunctive to the primary service (adjunctive services).
- Payment for the “adjunctive services” were packaged into the payment for the primary service.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>APC Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>5222</td>
<td>Level 2 Pacemaker and Similar Procedures</td>
<td>AICDP</td>
</tr>
<tr>
<td>5223</td>
<td>Level 3 Pacemaker and Similar Procedures</td>
<td>AICDP</td>
</tr>
<tr>
<td>5224</td>
<td>Level 4 Pacemaker and Similar Procedures</td>
<td>AICDP</td>
</tr>
<tr>
<td>5231</td>
<td>Level 1 ICD and Similar Procedures</td>
<td>AICDP</td>
</tr>
<tr>
<td>5232</td>
<td>Level 2 ICD and Similar Procedures</td>
<td>AICDP</td>
</tr>
<tr>
<td>5093</td>
<td>Level 3 Breast/Lymphatic Surgery and Related Procedures</td>
<td>BREAS</td>
</tr>
<tr>
<td>5165</td>
<td>Level 5 ENT Procedures</td>
<td>ENTXX</td>
</tr>
<tr>
<td>5166</td>
<td>Level 6 ENT Procedures</td>
<td>ENTXX</td>
</tr>
<tr>
<td>5211</td>
<td>Level 1 Electrophysiologic Procedures</td>
<td>EPHYS</td>
</tr>
<tr>
<td>5212</td>
<td>Level 2 Electrophysiologic Procedures</td>
<td>EPHYS</td>
</tr>
<tr>
<td>5213</td>
<td>Level 3 Electrophysiologic Procedures</td>
<td>EPHYS</td>
</tr>
<tr>
<td>5492</td>
<td>Level 2 Intraocular Procedures</td>
<td>EYEXX</td>
</tr>
<tr>
<td>5493</td>
<td>Level 3 Intraocular Procedures</td>
<td>EYEXX</td>
</tr>
<tr>
<td>5494</td>
<td>Level 4 Intraocular Procedures</td>
<td>EYEXX</td>
</tr>
<tr>
<td>5331</td>
<td>Complex GI Procedures</td>
<td>GIXXX</td>
</tr>
<tr>
<td>5415</td>
<td>Level 5 Gynecologic Procedures</td>
<td>GYNXX</td>
</tr>
<tr>
<td>5416</td>
<td>Level 6 Gynecologic Procedures</td>
<td>GYNXX</td>
</tr>
<tr>
<td>5361</td>
<td>Level 1 Laparoscopy</td>
<td>LAPXX</td>
</tr>
<tr>
<td>5362</td>
<td>Level 2 Laparoscopy</td>
<td>LAPXX</td>
</tr>
<tr>
<td>5462</td>
<td>Level 2 Neurostimulator and Related Procedures</td>
<td>NSTIM</td>
</tr>
<tr>
<td>5463</td>
<td>Level 3 Neurostimulator and Related Procedures</td>
<td>NSTIM</td>
</tr>
<tr>
<td>5464</td>
<td>Level 4 Neurostimulator and Related Procedures</td>
<td>NSTIM</td>
</tr>
<tr>
<td>5213</td>
<td>Level 3 Musculoskeletal Procedures</td>
<td>ORTHO</td>
</tr>
<tr>
<td>5123</td>
<td>Level 4 Musculoskeletal Procedures</td>
<td>ORTHO</td>
</tr>
<tr>
<td>5125</td>
<td>Level 5 Musculoskeletal Procedures</td>
<td>ORTHO</td>
</tr>
<tr>
<td>5471</td>
<td>Implantation of Drug Infusion Device</td>
<td>PUMPS</td>
</tr>
<tr>
<td>5627</td>
<td>Level 7 Radiation Therapy</td>
<td>RADTX</td>
</tr>
<tr>
<td>5375</td>
<td>Level 5 Urology and Related Services</td>
<td>UROXX</td>
</tr>
<tr>
<td>5376</td>
<td>Level 6 Urology and Related Services</td>
<td>UROXX</td>
</tr>
<tr>
<td>5377</td>
<td>Level 7 Urology and Related Services</td>
<td>UROXX</td>
</tr>
<tr>
<td>5191</td>
<td>Level 1 Endovascular Procedures</td>
<td>VASCX</td>
</tr>
<tr>
<td>5192</td>
<td>Level 2 Endovascular Procedures</td>
<td>VASCX</td>
</tr>
<tr>
<td>5193</td>
<td>Level 3 Endovascular Procedures</td>
<td>VASCX</td>
</tr>
<tr>
<td>5881</td>
<td>Ancillary Outpatient Services When Patient Expires</td>
<td>N/A</td>
</tr>
<tr>
<td>8011</td>
<td>Comprehensive Observation Services</td>
<td>N/A</td>
</tr>
</tbody>
</table>
• APC 8009 deleted and C-APC 8011 for observation services.
• For “qualifying” extended assessment and management encounters will be assigned to new C-APC 8011 with a “J2” status indicator. (J2 will designate specific combinations of services, that when performed in combination with each other and reported on a hospital outpatient claim, would be deemed as adjunctive services (components of a comprehensive service)
• Claims with a HCPCS code assigned SI “T” will be excluded.
• Claims must contain 8 or more units of HCPCS code G0378 (Observation services, per hour)
Observation - Comprehensive APC

- Claims contain services described by one of the following HCPCS codes:
  - G0379 - Direct referral of patient for observation
  - 99284 - Emergency department visit Level 4
  - 99285 - Emergency department visit - Level 5
  - G0384 - type B Emergency Department visit - Level 5
  - 99291 - Critical Care
  - G0463 - Hospital outpatient clinic visit

- Claims do not contain services described by HCPCS code with a SI of “J1”.
- Affects claims that contain services provided on the same date of service for G0378 or 1 day before. (70333-70336)
Exclusions from C-APCs - 2016

- Ambulance
- Brachytherapy
- Diagnostic and mammography screenings
- PT, OT and Speech Therapy
- Pass-through drugs and biologicals and devices
- Preventive services defined in 42 CFR 410.2:
  - Annual wellness visits providing personalized prevention plan services
  - Initial preventive physical examinations
  - Pneumococcal, influenza, and hepatitis B vaccines and administrations
  - Pap smear screenings and pelvic examination screenings
  - Low Dose Computed Tomography
  - Prostate cancer screening tests
  - Colorectal cancer screening tests
  - Diabetes outpatient self-management training services
  - Bone mass measurements
  - Glaucoma screenings
  - Medical nutrition therapy services
  - Cardiovascular screening blood tests
  - Diabetes screening tests
  - Ultrasound screenings for abdominal aortic aneurysm
  - Additional preventive services (as defined in section 1861(ddd)(1) of the Act);
Packaging

- Adjunctive services
- Revenue codes
- Conditional Packaging
  - Single Major Procedures
- Status indicators
- Other forms of packaging
  - Medicare Benefit Policy Manual
  - Claims Processing Manual
  - CCI edits
  - Medically unlikely edits
  - OCE
- Review, re-evaluation, restructure and reassign APCs
Packaged Revenue Codes

- Package the costs assigned to revenue codes with charges without assigned HCPCS codes.
- Table 4 - CY 2016 Packaged Revenue Codes (70319-70320)

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25X</td>
<td>Pharmacy; General Classification</td>
</tr>
<tr>
<td>26X</td>
<td>IV Therapy; General Classification</td>
</tr>
<tr>
<td>27X</td>
<td>Medical/Surgical Supplies and Devices; General Classification</td>
</tr>
<tr>
<td>28X</td>
<td>Oncology</td>
</tr>
<tr>
<td>33X</td>
<td>Radiology-Therapeutic and/or Chemotherapy Administration</td>
</tr>
<tr>
<td>34X</td>
<td>Nuclear Medicine</td>
</tr>
<tr>
<td>36X</td>
<td>Operating Room</td>
</tr>
<tr>
<td>37X</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>39X</td>
<td>Administration, Processing and Storage Blood and Blood Components</td>
</tr>
<tr>
<td>41X</td>
<td>Respiratory Services</td>
</tr>
<tr>
<td>62X</td>
<td>Medical Surgical Supplies</td>
</tr>
<tr>
<td>63X</td>
<td>Pharmacy – Extension of 25X</td>
</tr>
<tr>
<td>68X</td>
<td>Trauma Response Levels I-IV</td>
</tr>
<tr>
<td>70X</td>
<td>Cast Room</td>
</tr>
<tr>
<td>71X</td>
<td>Recovery Room,</td>
</tr>
<tr>
<td>72X</td>
<td>Labor Room/Delivery</td>
</tr>
<tr>
<td>73X</td>
<td>EKG/ECG; Telemetry</td>
</tr>
<tr>
<td>760</td>
<td>Specialty Services; treatment Rooms, Observation Hours, Other</td>
</tr>
<tr>
<td>77X</td>
<td>Preventive Services</td>
</tr>
<tr>
<td>80X</td>
<td>Dialysis</td>
</tr>
<tr>
<td>90X</td>
<td>Other Therapeutic Services</td>
</tr>
</tbody>
</table>
Conditional Packaging

- In CY 2015 CMS started conditionally packaged payment for ancillary services assigned to APCs with a geometric mean cost of less than or equal to $100 (prior to application of the conditional packaging status indicator).
- The ancillary services that were identified as primarily minor diagnostic tests and procedures were often performed with a primary service.
- The conditionally packaged service(s) were assigned status indicator “Q1” (separately payable unless performed on the same date as a HCPCS codes with a status indicator of “S”, “T”, or another “Q1”
Single Major Procedure Packaging

- Comprehensive APC payment policy includes all covered OPD services on a hospital outpatient claim reporting a primary service that is assigned to status indicator “J1,” and excludes services that cannot be covered as OPD services or that cannot by statute be paid under the OPPS.

- Payment for outpatient department services that are similar to therapy services and delivered either by therapists or non-therapists are packaged as part of the comprehensive service (sometimes therapy).
Two Times Rule

- Under the OPPS, hospital outpatient services are paid on a rate-per-service basis, where the service may be reported with one or more HCPCS codes.
- Payment varies according to the APC group to which the independent service or combination of services is assigned.
- Each APC relative payment weight represents the hospital cost of the services included in that APC.
- Subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost for an item or service in the group is more than 2 times greater than the lowest cost for an item or service within the same group (referred to as the “2 times rule”).
2 Times Rules Exception Criteria

• Resource homogeneity;
• Clinical homogeneity;
• Hospital outpatient setting utilization;
• Frequency of service (volume); and
• Opportunity for upcoding and code fragments.

• The highest payment for any code combination for services assigned to a C-APC would be the highest paying C-APC in the clinical family. (70328)
Complexity Adjustments

- Qualifying “J1” code combinations or combinations of “J1” services and certain add-on codes that are subsequent to the primary code from the originating C-APC, will receive a complexity adjustment.

- The complexity adjustment arises when the code combination represents a complex, costly form or version of the primary service according to the following criteria:
  - Frequency of 25 or more claims reporting the code combination (frequency threshold); and
  - Violation of the 2 times rule (cost threshold).

- Therefore, the highest payment for any code combination for services assigned to a C-APC would be the highest paying C-APC within the clinical family. (70328)

- Table 8 (70331) FINAL CY 2016 Packaged CPT Add-on Codes Evaluated for a Complexity Adjustment Table 8.pdf
Other Packaging

- Packaging occurs with other services/procedure that are not C-APCs with the most expensive medical devices
- Ancillary services with a SI of “X” are conditionally packaged if the geometric mean cost ≤ $100.
- The $100 geometric mean cost initial selection criteria for the packaging policy is not a hard and fast threshold above which ancillary services will not be conditionally packaged; “a basis for selecting this initial set of APCs, which will likely be updated and expanded in future years”.
Status Indicators (SI)

- Status indicators are assigned to HCPCS codes and define how the service associated with that SI will be paid.
- Indicate whether the services is payable under OPPS or another payment system.
- If payable under OPPS, the SI also defines how and whether a service will be paid.
- In CY 2016, two new SI are being added; “J2” and “Q4”.
  - “J2” is used to identify certain combinations of services that will be paid under the new proposed C-APC 8011 (Comprehensive Observation Services).
  - “Q4” is used to identify conditionally packaged laboratory tests.
NEW CPT AND LEVEL II HCPCS CODES
New Code Process

- CPT codes (Category I and III) are established by the American Medical Association (AMA).
- Level II HCPCS codes are established by the CMS HCPCS Workgroup.
- Code changes that affect payment are updated annual rule making and are published quarterly through OPPS Change Requests (CR).
- Codes published in the quarterly update appear in Addendum B with the status indicator of “NP”
New CPT Codes

- For new codes that describe wholly new services, versus revised codes that describe services for which APC and status indicator assignments are already established, CMS does not receive the new codes in time to propose payment rates in the proposed rule published in July.
- For the new and revised CPT codes that are publicly available and provided in time for evaluation in the CY 2016 OPPS/ASC proposed rule, APCs and SI will be assigned.
- For new codes that are not received in time for the proposed 2016 OPPS/ASC proposed rule, G codes, interim APCs and SI would be and the new CPT codes would be implemented the following year (2017). Table 16 (70369) outlined the requisite time frames.
# Category II CPT Codes

## TABLE 17 - Final CY 2016 APC and SI Assignments for Level II HCPCS Codes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C2623</td>
<td>C2623</td>
<td>Catheter, transluminal angioplasty, drug-coated, non-laser</td>
<td>H</td>
<td>2623</td>
</tr>
<tr>
<td>C9445</td>
<td>J0596</td>
<td>Injection, c1 esterase inhibitor (recombinant), Ruconest, 10 units</td>
<td>G</td>
<td>9445</td>
</tr>
<tr>
<td>C9448 *</td>
<td>J8655</td>
<td>Netupitant 300 mg and palonosetron 0.5 mg</td>
<td>G</td>
<td>9448</td>
</tr>
<tr>
<td>C9449</td>
<td>J9039</td>
<td>Injection, blinatumomab, 1 microgram</td>
<td>G</td>
<td>9449</td>
</tr>
<tr>
<td>C9450</td>
<td>J7313</td>
<td>Injection, fluocinolone acetonide intravitreal implant, 0.01 mg</td>
<td>G</td>
<td>9450</td>
</tr>
<tr>
<td>C9451</td>
<td>J2547</td>
<td>Injection, peramivir, 1 mg</td>
<td>G</td>
<td>9451</td>
</tr>
<tr>
<td>C9452</td>
<td>J0695</td>
<td>Injection, ceftolozane 50 mg and tazobactam 25 mg</td>
<td>G</td>
<td>9452</td>
</tr>
<tr>
<td>Q9975 **</td>
<td>J7205</td>
<td>Injection, factor viii fc fusion (recombinant), per iu</td>
<td>G</td>
<td>1656</td>
</tr>
<tr>
<td>---------------------</td>
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<td>------------------</td>
<td>-----</td>
</tr>
<tr>
<td>C2613</td>
<td>C2613</td>
<td>Lung biopsy plug with delivery system</td>
<td>H</td>
<td>2613</td>
</tr>
<tr>
<td>C9453</td>
<td>J9299</td>
<td>Injection, nivolumab, 1 mg</td>
<td>G</td>
<td>9453</td>
</tr>
<tr>
<td>C9454</td>
<td>J2502</td>
<td>Injection, pasireotide long acting, 1 mg</td>
<td>G</td>
<td>9454</td>
</tr>
<tr>
<td>C9455</td>
<td>J2860</td>
<td>Injection, siltuximab, 10 mg</td>
<td>G</td>
<td>9455</td>
</tr>
<tr>
<td>Q5101 *</td>
<td>Q5101 *</td>
<td>Injection, Filgrastim (G–CSF), Biosimilar, 1 microgram</td>
<td>G</td>
<td>1822</td>
</tr>
<tr>
<td>Q9976</td>
<td>J1443</td>
<td>Injection, ferric pyrophosphate citrate solution, 0.1 mg iron</td>
<td>E</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9977</td>
<td>Q9977 **</td>
<td>Compounded Drug, Not Otherwise Classified</td>
<td>D</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9978</td>
<td>J8655</td>
<td>Netupitant 300 mg and palonosetron 0.5 mg</td>
<td>G</td>
<td>9448</td>
</tr>
<tr>
<td>0392T</td>
<td>0392T</td>
<td>Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e. magnetic band)</td>
<td>J1</td>
<td>5362</td>
</tr>
<tr>
<td>0393T</td>
<td>0393T</td>
<td>Removal of esophageal sphincter augmentation device</td>
<td>Q2</td>
<td>5361</td>
</tr>
</tbody>
</table>
OPPS Changes

CODE CHANGES WITHIN APCs
# TABLE 20 & 21 - CY 2016 New Technology APC

<table>
<thead>
<tr>
<th>New APC</th>
<th>APC Group Title</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1575</td>
<td>New Technology—Level 38 ($10,000–$15,000)</td>
<td>S</td>
</tr>
<tr>
<td>1576</td>
<td>New Technology—Level 39 ($15,000–$20,000)</td>
<td>S</td>
</tr>
<tr>
<td>1577</td>
<td>New Technology—Level 40 ($20,000–$25,000)</td>
<td>S</td>
</tr>
<tr>
<td>1578</td>
<td>New Technology—Level 41 ($25,000–$30,000)</td>
<td>S</td>
</tr>
<tr>
<td>1579</td>
<td>New Technology—Level 42 ($30,000–$40,000)</td>
<td>S</td>
</tr>
<tr>
<td>1580</td>
<td>New Technology—Level 43 ($40,000–$50,000)</td>
<td>S</td>
</tr>
<tr>
<td>1581</td>
<td>New Technology—Level 44 ($50,000–$60,000)</td>
<td>S</td>
</tr>
<tr>
<td>1582</td>
<td>New Technology—Level 45 ($60,000–$70,000)</td>
<td>S</td>
</tr>
<tr>
<td>1583</td>
<td>New Technology—Level 46 ($70,000–$80,000)</td>
<td>S</td>
</tr>
<tr>
<td>1584</td>
<td>New Technology—Level 47 ($80,000–$90,000)</td>
<td>S</td>
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<tr>
<td>1585</td>
<td>New Technology—Level 48 ($90,000–$100,000)</td>
<td>S</td>
</tr>
<tr>
<td>1589</td>
<td>New Technology—Level 38 ($10,000–$15,000)</td>
<td>T</td>
</tr>
<tr>
<td>1590</td>
<td>New Technology—Level 39 ($15,000–$20,000)</td>
<td>T</td>
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<tr>
<td>1591</td>
<td>New Technology—Level 40 ($20,000–$25,000)</td>
<td>T</td>
</tr>
<tr>
<td>1592</td>
<td>New Technology—Level 41 ($25,000–$30,000)</td>
<td>T</td>
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<tr>
<td>1593</td>
<td>New Technology—Level 42 ($30,000–$40,000)</td>
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<tr>
<td>1594</td>
<td>New Technology—Level 43 ($40,000–$50,000)</td>
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<td>1595</td>
<td>New Technology—Level 44 ($50,000–$60,000)</td>
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<td>New Technology—Level 45 ($60,000–$70,000)</td>
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<tr>
<td>1597</td>
<td>New Technology—Level 46 ($70,000–$80,000)</td>
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</tr>
<tr>
<td>1598</td>
<td>New Technology—Level 47 ($80,000–$90,000)</td>
<td>T</td>
</tr>
<tr>
<td>1599</td>
<td>New Technology—Level 48 ($90,000–$100,000)</td>
<td>T</td>
</tr>
</tbody>
</table>
Restructuring APCs

• In CY 2015, HCPCS code C9740, Transprostatic Urethral Implant, was assigned New Technology APC 1564 Level 27 ($4,500 - $5,000). In CY 2016, reassigned to APC 1565 Level 28 ($5,000-$5,500), a device-intensive APC.

• HCPCS C9739, Cystoscopy, with insertion of transprostatic implant; 1-3 implants, from APC 5374 to C-APC 5375.

• CPT 0100T describes the implantation of a retinal prosthesis assigned to ACPC 0673. The retinal prosthesis is assigned C1841. C1841 has pass-through status that is expiring on Dec. 31, 2015.

  • CPT 0100T assigned to APC 1599 with a payment of $95,000 for CY 2016 which includes the payment for the prosthetic device. C1841 will appear as a status of “N”. (70379)
Restructuring APCs (continued)

- Airway Endoscopy Procedures. Currently split into upper airway procedures and lower airway procedures. For CY 2016 APCs were restructured (70381). Addendum B

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Short Descriptor</th>
<th>2016 SI</th>
<th>APC</th>
<th>APC group title</th>
</tr>
</thead>
<tbody>
<tr>
<td>31295</td>
<td>Sinus endo w/balloon dil</td>
<td>T</td>
<td>5154</td>
<td>Level 4 Airway Endoscopy</td>
</tr>
<tr>
<td>31296</td>
<td>Sinus endo w/balloon dil</td>
<td>T</td>
<td>5154</td>
<td>Level 4 Airway Endoscopy</td>
</tr>
<tr>
<td>31297</td>
<td>Sinus endo w/balloon dil</td>
<td>T</td>
<td>5154</td>
<td>Level 4 Airway Endoscopy</td>
</tr>
<tr>
<td>31515</td>
<td>Laryngoscopy for aspiration</td>
<td>T</td>
<td>5152</td>
<td>Level 2 Airway Endoscopy</td>
</tr>
<tr>
<td>31626</td>
<td>Bronchoscopy w/markers</td>
<td>T</td>
<td>5154</td>
<td>Level 4 Airway Endoscopy</td>
</tr>
<tr>
<td>31628</td>
<td>Bronchoscopy/lung bx each</td>
<td>T</td>
<td>5153</td>
<td>Level 3 Airway Endoscopy</td>
</tr>
<tr>
<td>31652</td>
<td>Bronch ebus sampng 1/2 node</td>
<td>T</td>
<td>5153</td>
<td>Level 3 Airway Endoscopy</td>
</tr>
<tr>
<td>31653</td>
<td>Bronch ebus sampng 3/&gt; node</td>
<td>T</td>
<td>5153</td>
<td>Level 3 Airway Endoscopy</td>
</tr>
</tbody>
</table>
Cardiac Contractility Modulation (CCM) Therapy

• CPT code 408T (Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes) to APC 5231 (Level 1 ICD and Similar Procedures) with SI “J1”.

• CPT code 0409T (Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only) to APC 5231 (Level 1 ICD and Similar Procedures) with SI “J1”
Cardiac Contractility Modulation (CCM) Therapy

- CPT code 0412T (Removal of permanent cardiac contractility modulation system; pulse generator only) to APC 5221 (Level 1 Pacemaker and Similar Procedures), SI “Q2”

- CPT code 0414T (Removal and replacement of permanent cardiac contractility modulation system pulse generator only) to APC 5231 (Level 1 ICD and Similar Procedures) with SI “J1”.
Physician or other qualified health care professional services for outpatient cardiac rehabilitation;

- CPT code 93797 without continuous ECG monitoring (per session));
- CPT code 93798 with continuous ECG monitoring (per session));

- Intensive cardiac rehabilitation;
  - HCPCS G0422 with or without continuous ECG monitoring with exercise, per session);
  - HCPCS code G0423 (with or without continuous ECG monitoring without exercise, per session).

- All four of the cardiac rehabilitation codes (CPT codes 93797 and 93798 and HCPCS code G0422 and G0423) to new APC 5771 (Cardiac Rehabilitation). (70382, 70383)
Additional Changes

- **Cardiac telemetry.** (CPT 93229) from APC 5724 to APC 5722 (79384)

- **Audiometry.** All procedures in APCs 5761 and 5762 reassigned to APCs 5721, 5722, 5723 and 5724; Level 1, 2, 3 and 4 respectively, Diagnostic Tests and related Services. (70384-70386)

- **Excisional/Biopsy and Incision and Drainage Procedures.** Table 27 summarizes the changes in APC assignment (70387)

- **Gastrointestinal (GI) Procedures.** Existing groupings no longer applicable. In CY 2016, Reorganized into upper and lower GI procedures with multiple levels in each. (70389 - 70392)
Restructure and Consolidations

- Multiple changes in CY 2015. In CY 2016, APCs restructured and consolidated the APCs that include radiology and nuclear medicine services. Table 31 outlines the **Imaging-related Procedure Codes** with commenter recommendations and final assignments. (70394-470395)

- Table 32 - CY 2016 Imaging Related Procedures APCs (70397). Multiple Level grouping of services.

- **Orthopedic Related Procedures** - Table 33 (70399)

- **Radiology Oncology Procedures**. (70401)

- Fractionated Stereotactic Radiosurgery (SRS) (70403)

- **Skin Procedures** (70403) and **Negative Pressure Wound Therapy Services** (NPWT) (70405 - 70408)
Restructure and Consolidations

- Urology (70409 - 70411)
- Vascular Procedures (70411)
- Magnetic Resonance Guided Focused Ultrasound Surgery (70413)
OPPS Payment

HOSPITAL OUTPATIENT VISIT
E&M Encounters Changes

- Alphanumeric HCPCS code, G0463 (Hospital outpatient clinic visit for assessment and management of a patient), for hospital use only representing any clinic visit under the OPPS.
- HCPCS code G0463 was assigned to APC 0634. Reassigned to APC 5012 (Level 2 Examinations and Related Services). *No longer a distinction between new and established patients.*
- In CY 2015 Emergency Department (ED) and Critical Care codes were not affected. For ED encounters, the current policy will continue of Type A and 5 HCPCS codes for Type B Ed encounters. Critical Care will also continue.
Chronic Care and PHP

- Chronic Care Management (CCM) Specific guidelines for hospitals. (70450 - 70453).
- Partial Hospitalization Services - previously four PHP APC per diem rates. For CY 2016, there are four APCs; two APCs for PHP services provided at a CMHC and two APCs for PHP services provided at hospital-based PHPs. (70453 - 70467)
INPATIENT ONLY PROCEDURES
Inpatient Only List

• The established criteria upon which we make such a determination are as follows:
  1. Most outpatient departments are equipped to provide the services to the Medicare population.
  2. The simplest procedure described by the code may be performed in most outpatient departments.
  3. The procedure is related to codes that we have already removed from the inpatient list.
  4. A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis.
  5. A determination is made that the procedure can be appropriately and safely performed in an ASC, and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC list.
Inpatient Only Procedures

- CMS identified 7 procedures that could be removed.
  - CPT code 0312T (Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming);
  - CPT code 20936 (Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from the same incision);
  - CPT code 20937 (Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision));
Inpatient Only Procedures (continued)

- CPT code 20938 (Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricotical (through separate skin or fascial incision));
- CPT code 22552 (Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace);
- CPT code 54411 (Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including the irrigation and debridement of infected tissue); and
- CPT code 54417 (Removal and replacement of non-inflatable (semirigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative sessions, including irrigation and debridement of infected tissue)
Conclusion

• Final CY 2016 Rule
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html.

CMS Hospital Outpatient Page
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html