Oregon HFMA
February 2017 Meeting

Valerie A. Rinkle, President

Valorize Consulting LLC

Valerie.Rinkle@ValorizeConsulting.com

541-840-8280

Valorize consulting LLC

Val-o-rize *(verb)* : To add value or validity

Agenda

2017 Hospital Prospective Payment System Updates

Introductory remarks

Part I: Key IPPS Updates

- Market basket updates, MS-DRG changes and new technology pass-throughs
- Inpatient quality reporting and value-based purchasing program changes
- Other provisions, such as the MOON

Part II: Key OPPS Updates

- Major OPPS payment policy changes
- Section 603 & the Cures' Act
- Other key changes

Regulatory Overview

- The pace of regulatory changes is accelerating
  - Details matter more than ever!
- Three (3) proposed and final rules must be tracked for changes applicable to health systems:
  1. IPPS proposed & final – April & July; effective on FFY schedule
  2. OPPS proposed & final – July & Nov; effective on CY schedule
  3. MPFS proposed & Final – July & Nov; effective CY schedule

Note: This is in addition to any other "special" rules released

- PAMA and MACRA implementing rules
- CMS is aggressively moving forward with its value-based purchasing agenda:
  - Evidenced with CJR and Cardiac mandatory programs
  - Also with Part B Drug Proposal
- CMS is updating and changing Conditions of Participation:
  - antibiotic stewardship
  - discharge planning
  - Emergency services

Change in Administration

- Speculation about changes due to new Administration
  - New HHS Secretary
  - New CMS Administrator

- Regardless of personnel and changes in focus/direction/global policy - rulemaking ala the regulatory calendar is mandated & will continue

Basic Payment System Information

- MedPAC payment basics series http://www.medpac.gov/-documents-/payment-basics
- CMS websites
  - IPPS
  - OPPS
  - Other payment systems

Part I - IPPS

- Inflationary updates
- MS-DRG changes & recalibration
- New technology add-on payments
- Key inpatient quality reporting and value-based purchasing program changes
- The Medicare Outpatient Observation Notice or MOON

Updates to the National Standardized Amounts

- 2.7% market basket update less the following reductions:
  - One-quarter reduction to the market basket increase prior to application of any other statutory adjustments for hospitals that fail to submit quality information (.7 %reduction)
  - Three-fourths reduction of the market basket increase prior to the application of any other statutory adjustments for hospitals that do not meet the electronic health record (EHR) meaningful use requirements (2.1% reduction)
  - .3% reduction due to the multi-factor productivity (MFP) adjustment
  - .75% reduction from the Affordable Care Act (ACA)
  - 1.5% documentation and coding (DCA) recoupment reduction
  - 0.2% permanent reversal and a one-time 0.6% adjustment for 2-midnight = 0.8%
  - Total 0.95%
- Reduction trends

Federal Fiscal Year	Market Basket Percentage	ACA Payment Reductions	Multifactor Productivity Adjustment	Documentation & Coding	Total Update Percentage
2014	2.5	-0.3	-0.5	-0.8	0.9
2015	2.9	-0.2	-0.5	-0.8	1.4
2016	2.4	-0.2	-0.5	-0.8	0.9
2017	2.7	-0.75	-0.3	-1.5	0.15

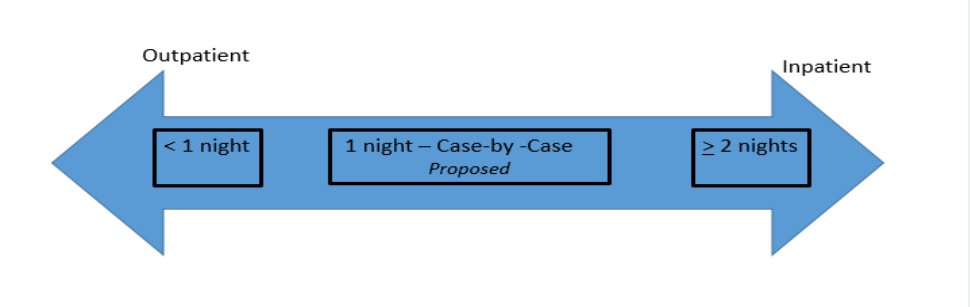
Final 2017 IPPS Standardized Amounts

- CMS published corrections as of September 29, 2016 to the FY 2017 rates - be sure to download updated files Correction Notice Standardized Amounts
- Operating & Capital Amounts - watch the formulas!
- Update amounts in payment calculation and grouper software programs - is every system calculating the same amount or used for the same purpose?
- Note “adjustments” to market basket updates
  - Coding & Documentation (next slide)
  - Productivity Adjustments
  - 2-midnight rule adjustment (see following slides)

Coding & Documentation Adjustments

- Section 631 of the American Taxpayer Relief Act of 2012 requires CMS to recover $11 billion by 2017 to fully recoup documentation and coding overpayments related to the transition to the MS-DRGs that began in FY 2008
- For FY 2017, CMS is proposing to complete the recoupments begun in FY 2014 by making a final -1.5 percent adjustment
- Hospitals who do not engage in documentation improvement are paying the price with reduced payment rates
- Robust CDI programs are no longer optional
  - CDI programs must expand to the ambulatory setting
  - EHRs provide new opportunity to address recurring issues

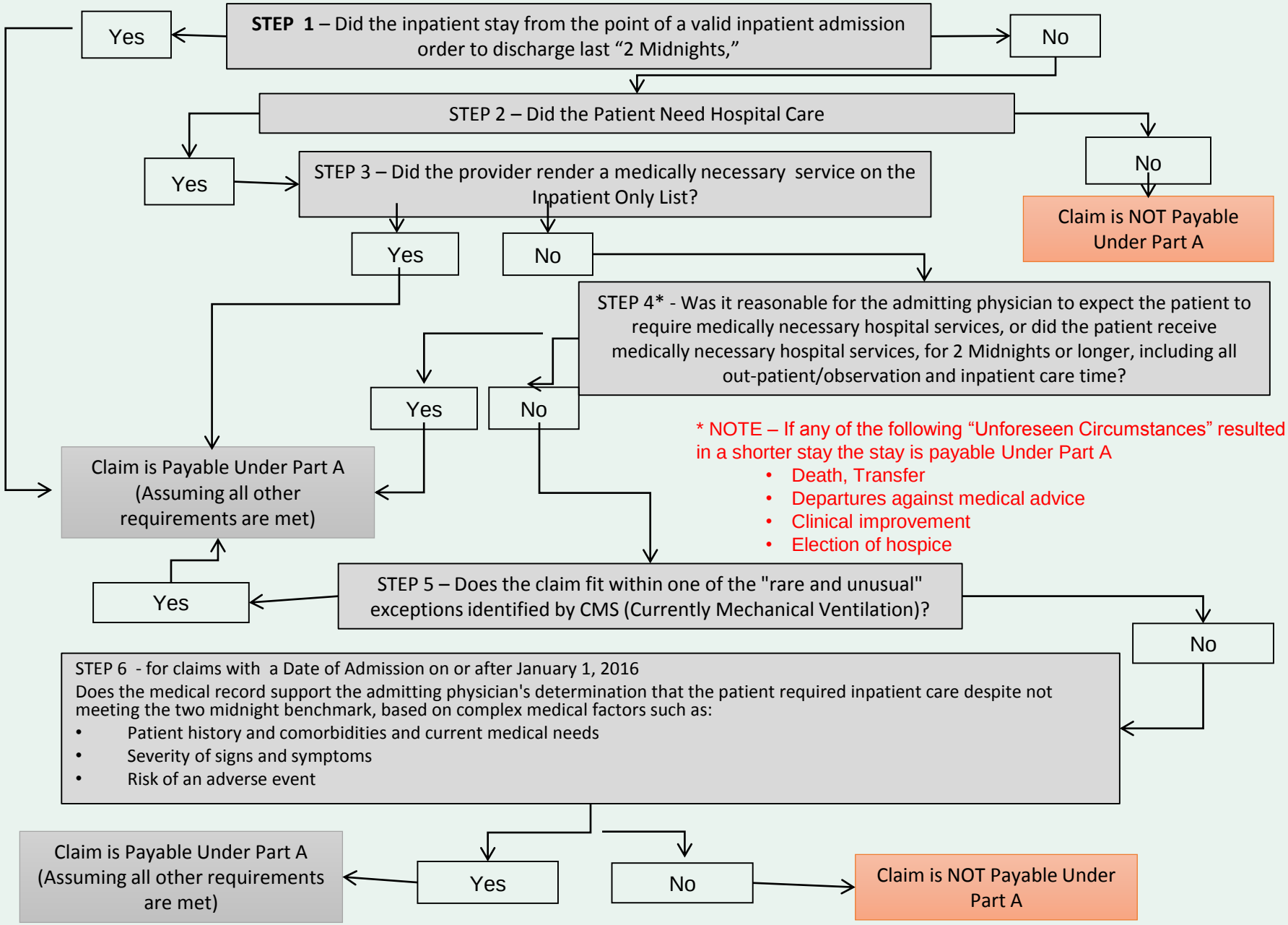
2-Midnight Rule



- Presumption - 2 nights of inpatient care after valid inpatient order = Part A covered stay when substantiated by documentation
- Benchmark - 2 nights of hospital care per valid orders (i.e., 1 night as outpatient followed by 2nd night of inpatient care) = Part A covered stay when substantiated by documentation
- For CY 2016, CMS allowed a 1 night inpatient stay per a valid order to meet Part A coverage on a case-by-case basis based on the physician's judgement and documentation
- QIOs perform reviews of medical necessity of 1-night stays
- CMS had to halt QIO reviews and re-train them
- Hospitals should follow the CMS training guide to ensure they meet the 2-midnight rule
  - See inpatient hospital review web site, policy decision guideline download at the end of the web page Inpatient Hospital Review webpage

Long-Stay Outpatients and the 2-Midnight Rule

- If an outpatient receives care for 24 hours (one midnight has been crossed), regardless of whether the outpatient was in post-operative recovery or extended recovery following a surgical procedure or whether a physician ordered observation, if the patient continues to need hospital level care, best practice is to obtain a valid inpatient admission order as this meets the two midnight benchmark
  - Note: patient is unlikely to meet InterQual or Milliman after one night of hospital care, but this does not invalidate need for hospital care for the second night and therefore, ability to meet the 2-midnight benchmark
  - Consider transfer cases as well
- The two midnight rule allows for this but remember that the physician's judgment and rationale for why the patient continues to need hospital level care must be documented in the medical record
- Having case management aware of this and having them work with physicians is key



Revised May 3, 2016 1:47pm

IPPS Updates – Annual Recalibration

- DRG weights are re-calibrated on annual basis using claims and cost report data
- Excludes Medicare managed care claims & critical access hospitals
- Cost report data from 12/31/13 HCRIS data file
- MedPAR data trimmed to remove statistical outliers & incomplete claims
- Once trimmed, charges applied to cost to charge ratios from cost report to determine “cost” of services (see next slide)

IPPS Updates – National Average CCRs

Cost Center	Revenue Codes	FY2016 Final CCRs	FY2017 Final CCRs
Routine	10x, 11x, 12x, 13x, 14x, 15x, 16x-19x	0.480	0.457
Special Care	20x, 21x	0.393	0.375
Drugs	25x, 26x, 63x	0.191	0.194
Supplies	270-274, 277, 279, 290-299, 621-623	0.297	0.297
Implants	275, 276, 278, 624	0.337	0.331
Therapy	42x, 43x, 44x, 47x	0.332	0.321
Respiratory	41x, 46x	0.177	0.170
Surgery	36x, 71x	0.199	0.191
L&D (only for 8 MS_DRGs)	72x	0.404	0.410
Anesthesia	37x	0.106	0.089
Cardiology	48x except 481, 73x	0.118	0.112
Cardiac Cath Lab	481	0.124	0.118
Clinical Laboratory	30x, 31x, 74x, 75x, 86x	0.125	0.120
Radiology	28x, 32x, 331-335, 339, 342-344, 40x	0.159	0.153
CT	35x	0.041	0.038
MRI	61x	0.085	0.079
Emergency Room	45x	0.183	0.171
Blood & Blood Products	38x, 39x	0.336	0.323
Other	68x, and most other rev codes	0.368	0.365

Inaccurate Cost Center Mappings for National CCRs

- Important to understand how hospital cost centers group or roll to these 19:
  - GI/Endoscopy (075x) & EEG group to Clinical Laboratory Services?
  - Lithotripsy (079x) is grouped with “Other” services rather than Operating Room?
  - Trauma (068x) is grouped with “Other” rather than Emergency Department when it is grouped with Emergency Department on the OPPS side
  - Think about how management/expense of these cost centers are related and think about commenting to CMS
- Isn’t it important to make it logical and “right” - CMS will not analyze impact unless more professional associations comment to correct the mappings!

Payment Formula Considerations: Outliers

- Final fixed-loss outlier threshold for FFY 2017 is $23,570
- Operating Outlier Formula = MS-DRG Payment + IME + DSH + New Tech + $23,570
- There is also the capital outlier component
- Remember - for coverage, Medicare requires physician certification of inpatient outlier cases

MS-DRG Changes, ICD-10 Update, and Relative Weight Updates

- MS-DRG grouper version 34 for FFY 2017 with 754 MS-DRGs
- ICD-9 codes mapped to ICD-10 codes to replicate the same MS-DRG groupings between the two code sets continues to be the basis of version 34 of the MS-DRGs
- CMS finalized many corrections called “replication errors” due to things like ICD-10 codes being missed in the mapping and due to the code freeze prior to ICD-10 implementation resulting in close to 6,000 code changes
- FFY 2017 MS-DRG relative weights computed from the latest claims and cost reporting data
    - Claims from FFY 2015 MedPAR file which has discharges from Oct 1, 2014- Sept 30, 2015
    - Cost report data from the March 31, 2016 update of the FFY 2014 HCRIS file

Examples of Key MS-DRG & Coding Changes

- About 2,000 diagnosis codes added to ICD-10-CM
- More than 3,500 procedure codes added to ICD-10-PCS
- MS-DRG classification changes include:
  - Bypass procedures of the veins (MS-DRGs 405, 406, and 407)
  - Endovascular embolization or occlusion of head and neck procedures (MS-DRGs 270, 271, and 272)
  - Localized swelling, mass, and lump, trunk (ICD-10-CM code R22.2)
  - Other cardiothoracic procedures without MCC (MS-DRGs 228, 229, eliminating 230)
  - Pacemaker procedures (for MS-DRGs 242, 243, and 244)
  - Sequelae of stroke (ICD-10-CM category I69)
- Certain ICD-10 codes weren't included at all in the MS-DRGs when needed
- Certain ICD-10 codes were mislabeled as operating room (OR) procedures when they historically were not treated as such

Appeal Rights & Coding Corrections

- MS-DRG and MCE coding and grouping logic changes are prospective
- CMS also states with regard to Endovascular Mechanical Thrombectomy 03CG3ZZ (Extirpation of matter from intracranial artery, percutaneous approach) which is non-covered in the FY2016 MCE and will be changed to covered in V34 “that contractors began reprocessing affected claims at providers’ request in March 2016. We recommend that providers who have experienced claims processing issues work with their local MACs to resolve any outstanding claims.”
- Inconsistent - 0FFDXZZ Fragmentation in Pancreatic Duct, External Approach remains non-covered in the v34 MCE, but there is no NCD or LCDs that state why this procedure code is non-covered.
- Check denials closely - work with your MAC if you believe the services were covered prior to FY2016 under ICD-9 MS-DRGs. Protect your appeal rights by following instructions to bill any non-covered procedures on a separate 110 No Pay claim. Let your MAC as well as OAHHS/AHA know
- Also let CMS know - Did you know stakeholders must submit ICD changes to MSDRGClassificationChange@cms.hhs.gov. by December 6, 2016 for FY2018 consideration? So any changes identified in 2017 will need to wait to the end of the year to submit to CMS for FY2019!

NEW TECHNOLOGY ADD-ON PAYMENTS

2016 New Technology	Continued for 2017
Kcentra™	No
Argus® II Retinal Prosthesis System	No
CardioMEMS™ HF (Heart Failure) Monitoring System	Yes
MitraClip® System	No
Responsive Neurostimulator (RNS®) System	No
Blinatumomab (BLINCYTO®Trade Brand)	Yes
Lutonix® Drug Coated Balloon PTA Catheter and In.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter	Yes
2017 New Technology	**Codes**
MAGEC® Spinal Bracing and Distraction System (MAGEC® Spine)	XNS0032, XNS0432, XNS3032, XNS3432, XNS4032, and XNS4432
Idarucizumab	XW03331
Defitelio® (Defibrotide)	XW03392 and XW04392
GORE® EXCLUDER® Iliac Branch Endoprosthesis (IBE)	04VC0EZ; 04VC0FZ; 04VC3EZ; 04VC3FZ; 04VC4EZ; 04VC4FZ; 04VD0EZ; 04VD0FZ; 04VD3EZ; 04VD3FZ; 04VD4EZ; and 04VD4FZ
Vistogard™	T45.1X1A, T45.1X1D, T45.1X1S, T45.1X5A, T45.1X5D, and T45.1X5S in combination with ICD-10-PCS procedure code XW0DX82

New Technology Add-On

- If the costs of the discharge (determined by applying cost-to-charge ratios (CCRs)) exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of:
  - 50 percent of the estimated costs of the new technology or medical service (if the estimated costs for the case including the new technology or medical service exceed Medicare's payment); or
  - 50 percent of the difference between the full DRG payment and the hospital's estimated cost for the case
- Unless the discharge qualifies for an outlier payment, the additional Medicare payment is limited to the full MS-DRG payment plus 50 percent of the estimated costs of the new technology or new medical service

Quality and Value Based Purchasing Initiatives

- CMS either rewards or penalizes applicable hospitals based on adherence or success with the following initiatives:
    - Inpatient quality reporting (IQR) program
    - Value-based purchasing (VBP) program
    - Hospital acquired conditions reduction (HACs) program
    - Hospital readmission reduction (HRRP) program
    - Electronic Health Record (EHR)/meaningful use program
- These initiatives are aimed at improving the quality and value of the services provided by hospitals and purchased by Medicare
- Two studies are underway to address sociodemographic status (SDS) risk factors that stakeholders insist need to be accounted for in CMS' scoring methodologies. These studies are being conducted by the National Quality Forum (NQF) and the Assistant Secretary for Planning and Evaluation (ASPE).

Hospital Readmission Reduction Program

- ACA provision to reduce MS-DRG payments for Medicare discharges on or after October 1, 2012 to account for excess readmissions of certain conditions

- 6 measures being assessed in FFY 2017 (first 5 were measured for FFY 2016): (1) Acute Myocardial Infarction (AMI), (2) Heart Failure (HF), (3) Pneumonia (PN), (4) Elective Total Hip Arthroplasty (THA) & Total Knee Arthroplasty (TKA); (5) Chronic Obstructive Pulmonary Disease (COPD) and new for 2017, (6) Coronary Artery Bypass Graft (CABG) Surgery

- For FY 2017, the "applicable period" will be the 3-year period from July 1, 2012 through June 30, 2015.

    - Excess readmissions ratio is hospital-specific for each applicable condition. A hospital's excess readmissions ratio must be less than or equal to 1 to avoid a payment reduction.
    - The payment reduction factor is the greater of a ratio that compares a hospital's aggregate dollars for excess readmissions to aggregate dollars for all discharges or a floor which remains at **.97.** 3% is the largest reduction a hospital can face.

- New scoring method called, the Winsorized Z-score, finalized. The Z-score method uses a continuous measure rather than forcing results into deciles and is intended to resolve some of the existing scoring anomalies that exist today.

Changes to the Performance Period for PSI-90

- PSI-90 is a composite patient safety indicator used in IQR, VBP and HAC programs
- The measure steward is the Agency for Healthcare Research and Quality (AHRQ) and the ICD-10 version of PSI-90 is not expected to be available until late CY 2017 after a year's worth of ICD-10 claims data. Note: AHRQ issued a mid-July 2016 update to PSI-90 that adjusted the list of major OR procedures
- CMS finalized altering the performance period for this measure across the various quality programs
  - The current performance period is 2 years (7/1/14-6/30/16) for the quality programs
  - AHRQ is concerned with merging/adding performance data under the two code sets
  - Finalized proposal is to use 15 months data under ICD-9 for the 2018 performance period (7/1/14-9/30/15) in the quality programs
  - CMS is still evaluating options for the 2019 performance period that also includes ICD-9 & ICD-10 data.

Claims & Coding Matter More than You Know

- Socio-economic Conditions Impacting Healthcare
  - Homelessness = **Z59.0** (I10-CM) Homelessness
  - **No assistance at home for care - Z74.2** (I10-CM) Need for assistance at home and no other household member able to render care
  - **Z91.130** Patient's unintentional underdosing of medication regimen due to age-related debility
  - **Z91.11** Patient's noncompliance with dietary regimen
  - **Z91.120** Patient's intentional underdosing of medication regimen due to financial hardship
- **Z60.2** Problems related to living alone
- **Z74.01** Bed confinement status
- **F0FZCFZ** Caregiver Training in Gait Training/Functional Ambulation using Assistive, Adaptive, Supportive or Protective Equipment
- Y92.1
  - Institutional (nonprivate) residence as the place of occurrence of the external cause
  - *Institutional (nonprivate) residence as the place of occurrence of the external cause*
- Y92.12
  - Nursing home as the place of occurrence of the external cause
  - *Home for the sick as the place of occurrence of the external cause*
  - *Hospice as the place of occurrence of the external cause*

The Medicare Outpatient Observation Notice (MOON)

- Reminder, on August 6, 2015 the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) was passed.
- Rulemaking for the MOON is in the 2017 IPPS proposed and final rules
- The NOTICE act requires hospitals and critical access hospitals (CAHs) to inform beneficiaries (including Medicare health plan enrollees) receiving observation services as outpatients for more than 24 hours that they are an outpatient and NOT an inpatient, and the implications of that status.
- Hospitals and CAHs must begin using the MOON **no later than March 8, 2017**
- MOON Notice Link

The MOON (Cont.)

- Transmittal 3695 on January 20, 2017 MOON Instructions
- Action steps & suggestions for providers:
  - Download and review the required MOON notice and instructions.
  - Review the timing requirements – that is, a MOON must be delivered to outpatients receiving observation services over 24 hours and before discharge or 36 hours - not to every outpatient in a bed!
  - If orders for inpatient admission are obtained prior to 24 hours in observation, only the IMM needs to be delivered - this can reduce confusion and staff resources
  - Review the process and staff you will utilize to deliver the MOON. Note that the explanations required to be provided to patients may be beyond the competencies of staff you currently use to deliver other notices to patients (such as, patient access staff)
  - Finally, determine whether the organization will write off self-administered drugs (SADs) per the October 2015 OIG notice because many hospitals will be explaining to patients with the MOON that while the SADs are not covered, the hospital elects not to bill and pursue payment from patients on a voluntary basis.

Part II - OPPS

- General Updates to OPPS
- Major Policy Changes
  - Section 603 & Cures' Act
  - Expansion of C-APCs
  - Packaging Policy Changes
  - Device-Intensive Procedures
- Other Changes

Final Market Basket Update and Conversion Factors

- CY 2017 conversion factors:
  - Market basket increase of 2.7%
  - Reduction of 0.3% for multifactor productivity
  - Reduction of 0.75% from the Affordable Care Act
  - Other adjustments (i.e., pass-through spending, packaging unrelated lab tests)
  - Net result is a 1.65% update over the current conversion factor
- *$73.725** – current 2016 conversion factor for hospitals that meet quality reporting requirements – **$75.011 final for CY 2017**
- *$72.251** – current 2016 conversion factor for hospitals failing to meet quality reporting requirements – **$73.501 final for CY 2017**

**2% sequestration reduction in effect until Congress acts and is not reflected in the conversion factors listed here.*

Protected Hospitals

- Children's hospitals and cancer centers have a permanent hold-harmless protection
- CMS will continue to apply a payment adjustment to 11 cancer centers' OPPS payments using a payment-to-cost ratio (PCR) that is equivalent to the average PCR of all other OPPS hospitals; a PCR of 0.91 has been finalized for CY 2017
- Rural SCHs and EACHs will continue receiving a 7.1% payment adjustment for OPPS services, excluding separately payable drugs, biologicals and devices paid under the pass-through payment policy, and items paid at cost

HCPCS/CPT Codes With Status Indicator and/or APC Assignment Change for 2017

Comparison of Changed SI & APC Assignments 2016 to 2017																					
		A	B	C	D	E1	E2	G	J1	J2	K	L	M	N	Q1	Q2	Q3	Q4	S	T	V	Total
	Column = Deleted in Oct 2016 and row = new for 2017	17	11	9	1	17	2	23	28		3	2	176	40		6		6	15	16		372
A					15																	15
B					7								2	2						1		12
C					7				2					5								14
D	2																					2
E				1	8	1551	18				3		5	2				1	1			1590
G					17						11			4								32
H														1								1
J1					15				346													361
J2										1												1
K					2								5	13								20
M			6		101	46																153
N					24		11				13					2			2			52
Q1					1										135				4			140
Q2					4											88						92
Q3															1		108					109
Q4		1																				1
R							1															1
S			1		4				1						1				172	48		227
T					15				1846					1						287		2149
U							1															1
V																			5		2	7
Y					2																	2
Total	2	18	18	10	223	1614	33	23	2223	1	30	2	188	68	137	96	108	7	199	352	2	5354

Reminders About Section 603 from the Balanced Budget Act of 2015

- Section 603 directed CMS to no longer pay hospitals the OPPS rate for services furnished in new (i.e., not billing under hospital CCN as of 11/2/15) off-campus provider-based departments (PBDs) beginning January 1, 2017 except under certain circumstances – *the Cures Act expands these circumstances as discussed in subsequent slides*
- Section 603 states that **"applicable items and services**" furnished in an off-campus provider-based department (PBD) as of the statute's effective date of 11/2/15 will not be considered covered outpatient department (OPD) services for purposes of the OPPS rates (*the Cures Act expands this somewhat)* and will instead be paid under **the "applicable payment system" – which it left up to CMS to determine**

Section 603 Per the CY 2017 OPPS Final Rule

- CMS did NOT finalize most of what it proposed as result of the comments received:
  - NO limits on service expansion in excepted locations but CMS intends to monitor volume & mix of services provided at excepted PBDs
  - NO use of the proposed 19 APC clinical families
  - NO change in billing from the UB-04 to the CMS 1500
  - Payment NOT being made to the physician so no need for hospitals to enter into agreements with physicians or change their structures to receive payment
  - Payments NOT being made using the MPFS rates but instead an interim final decision taken to set the “MPFS” payment at 50% of the OPPS rate
- Other finalized items
  - OPPS payment policies like packaging and C-APCs will apply
  - Paying hospitals directly will enable them to show non-excepted PBD expense & revenue on cost reports and maintain 340B eligibility
  - CMS stated it does not have the statutory authority to allow additional exceptions to Section 603 and that would have to occur through legislative, hence the Cures Act

21st Century Cures Act

- Enacted into law on December 13, 2016

- Sections 16001 and 16002 amend section 1833(t)(21) of the Social Security Act (the Act) and provide additional criteria by which off-campus departments of a provider can be excepted from application of Section 603.

  - Section 16001: *Continuing Medicare payment under HOPD prospective payment system for services furnished by mid-build off-campus outpatient departments of providers.*

  - Section 16002: *Treatment of cancer hospitals in off-campus outpatient department of a provider policy.*

- CMS released guidance titled, “Note Regarding Implementation of Sections 16001 and 16002 of the 21st Century Cures Act”

Section 603 Excepted and Non-Excepted Locations As a Result of the CY 2017 OPPS Final Rule and the Cures Act

- Excepted sites
  - Dedicated emergency departments (defined at 42 CFR 489.24(b) at least 1/3rd visits must be for emergent/urgent conditions on an unscheduled basis)
  - On-campus departments located within 250 yards of the main hospital
  - Off-campus PBDs located within 250 yards of a remote inpatient hospital location - modifier -PO
  - Off-campus PBDs furnishing services under hospital CCN on or before Nov 2, 2015 - modifier -PO
  - Off-campus PBDs per the Cures Act (mid-build and certain cancer centers) - modifier -PO
- Non-Excepted Sites
  - Locations NOT billing services in an off-campus PBD on or before November 2, 2015 - modifier PN
  - CAHs with non-excepted off-campus PBDs will also be impacted

CMS Terminology	Plain English ☺
Excepted	**Grandfathered (OPPS paid services)**
Nonexcepted	**Non-grandfathered (non-OPPS paid services)**

Change in Ownership & Relocation

- Change in ownership is allowed as long as the main provider is also being transferred and the Medicare provider agreement of the entity being sold is accepted in its entirety by the new owner
  - A single off-campus PBD changing ownership would result in loss of excepted status
- Excepted status can be retained if the relocation is due to “extraordinary” circumstances such as:
    - Natural disasters
    - Major patient/public safety issues
- Exception requests for relocation can be submitted to your regional office
  - ***Application review process*** provides information concerning timelines for relocation exception requests due to extraordinary circumstance and priority review for relocation exception requests related to relocations occurring prior to January 1, 2017 and recent natural disasters.
  - ***Suggested Minimum Information*** describes minimum information applicants should present to their Regional Office.
  - ***Regional Office staff contacts*** details specific Regional Office contacts for each of the ten CMS Regional Offices.

“Interim Final” Payment System

- Site of Service Specific - form of MPFS applied only to HOPD services billed with modifier -PN
- Payment rate = 50% of OPPS payments and includes all OPPS packaging policies
- I/OCE specification logic = all OPPS processing occurs as normal & last step is to reduce payment by 50% for any payable line items with modifier -PN
- No ”fee schedule” will be published

Summary of Billing & Payment Mechanisms

Location of Outpatient Service	Hospital Claim	Professional Fee (PF) Claim	Payment Systems
On-campus PBD	No modifier	POS = 22	• OPPS for hospital • MPFS facility RVUs for PF
Off-campus excepted PBD	Modifier PO	POS = 19	• OPPS for hospital • MPFS facility RVUs for PF
Off-campus non-excepted PBD	Modifier PN	POS = 19	• Special “MPFS” rate of 50% of OPPS for hospital • MPFS facility RVUs for PF
Freestanding physician office practice	NA - no hospital claim	POS = 11	• NA for hospital • MPFS at non-facility RVUs for PF

Comprehensive APCs (C-APCs)

- **Review**
  - C-APCs are like “mini-DRGs” where a single APC payment is made for the vast majority of billed items and services on the claim
  - C-APC payments are based on the costs of most billed services on the claim “packaged” to the cost of the primary service (some exceptions exist)
  - 25 C-APCs first introduced in CY 2015 and assigned new SI of “J1”
  - 10 additional C-APCs across 14 clinical families were added in CY 2016, including a C-APC for observation services (assigned SI of “J2”)
  - Most add-on procedure codes are packaged but some are used to determine if a complexity adjustment warrants higher payment (see Addendum J)
- **For CY 2017**
  - 25 new C-APCs finalized, with more than 1,800 status indicator “T” procedures changing to J1 in the areas of nerve procedures, airway endoscopy, and excision/biopsy/incision and drainage procedures

New and Existing C-APCs for CY 2017

TABLE 1.—CY 2017 C-APCs

C-APC	CY 2017 APC Title	Clinical Family	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 & Related Procedures	BREAS	
5094	Level 4 Breast/Lymphatic Surgery & 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	
5222	Level 2 Pacemaker and Similar Procedures	AICDP	
5223	Level 3 Pacemaker and Similar Procedures	AICDP	

C-APC Clinical Family Descriptor Key:

AENDO = Airway Endoscopy
AICDP = Automatic Implantable Cardiac Defibrillators, Pacemakers, and Related Devices.
BREAS = Breast Surgery
COCHL = Cochlear Implant
EBIDX = Excision/ Biopsy/ Incision and Drainage
ENTXX = ENT Procedures
EPHYS = Cardiac Electrophysiology
EXEYE = Extraocular Ophthalmic Surgery
GIXXX = Gastrointestinal Procedures
GYNXX = Gynecologic Procedures
INEYE = Intraocular Surgery
LAPXX = Laparoscopic Procedures
NERVE = Nerve Procedures
NSTIM = Neurostimulators
ORTHO = Orthopedic Surgery
PUMPS = Implantable Drug Delivery Systems
RADTX = Radiation Oncology
SCTXX = Stem Cell Transplant
UROXX = Urologic Procedures
VASCX = Vascular Procedures
WPMXX = Wireless PA Pressure Monitor

**New C-APC for CY 2017*

Hospital Quality Data Initiative

- No changes for measures applicable to 2019 payment year (2017 reporting)
- 7 new measures finalized for the 2020 payment year (2018 reporting)
  - 2 claims-based measures:
    - OP-35: Admissions and observation/emergency department visits for patients receiving outpatient chemotherapy
    - OP-36: Hospital visits after hospital outpatient surgery (NQF #2687)
  - 5 survey-based measures that are part of the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS):
    - (1) OP-37a: OAS CAHPS – about facilities and staff
    - (2) OP-37b: OAS CAHPS – communication about procedure
    - (3) OP-37c: OAS CAHPS – preparation for discharge and recovery
    - (4) OP-37d: OAS CAHPS – overall rating of facility
    - (5) OP-37e: OAS CAHPS – recommendation of facility
  - Beginning with CY 2018 payment determination, CMS will publicly display data on *Hospital Compare*, or other CMS website

QUESTIONS?