**2016 Hospital Outpatient and Ambulatory Surgical Center Final Rule**

On October 30, 2015, The Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2016 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) [final rule](https://www.federalregister.gov/articles/2015/11/13/2015-27943/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment). The final rule updates Medicare payment policies and rates for:

* hospital outpatient departments (HOPDs);
* ASCs; and
* partial hospitalization services provided by community mental health centers (CMHCs).

Additionally, the final rule makes refinements to quality reporting programs in these outpatient settings and makes changes to the Two Midnight Rule. The final rule goes into effect on January 1, 2016. CMS is accepting public comments on the final rule until 5 p.m. EST on December 29, 2015.

**Overall Impact of Final Rule**

For 2016, CMS estimates a decrease in total payment under the OPPS by -0.4%. Under this rule, CMS estimates that total payments for 2016 to the approximate 4,000 facilities paid under the OPPS will decrease by approximately $133 million compared to 2015 payments. For 2016, CMS estimates an increase in payment rates under the ASC payment system by 0.3%. CMS estimates that total payments to ASCs 2016 will increase by approximately $128 million compared to 2015 Medicare payments.

**Ambulatory Payment Classifications**

Ambulatory Payment Classifications (APCs) are the federal government’s method of paying facilities for outpatient services under the Medicare program. Each APC is composed of services/procedures which are similar in clinical intensity, resource utilization and cost. Procedure codes grouped under a specific APC result in an annually updated Medicare “prospective payment” for that particular APC. Since this payment is a prospective and fixed payment to the hospital, the hospital caries the risk for potential “profit or loss” with each APC payment it receives. The payments are calculated by multiplying the APCs relative weight by the OPPS conversion factor and then there is a minor adjustment for geographic location. The payment is divided into Medicare’s portion and patient co-pay; co-pays vary between 20 and 40% of the APC payment rate.

As part of a comprehensive review of the current structure of APCs, CMS is finalizing its plan to restructure nine clinical APC families including those that contain orthopedic procedures. The APC groupings for orthopedic procedures were identified because CMS is concerned that the current groupings are too narrow and do not appropriately reflect similar costs and clinical characteristics in the context of the OPPS. The current APCs for orthopedic-related procedures are primarily divided according to anatomy and the type of musculoskeletal procedure. CMS no longer sees a reason to separate musculoskeletal procedures into APC groupings differentiated by procedures that do not involve the hand or foot (which include spine procedures) from procedures that do include the hand or foot. For 2016, CMS is finalizing its plan to the restructure the twenty-four APCs containing orthopedic surgery procedures into ten APCs.

It should be noted that CMS revised its initial proposal in response to commenters to the proposed rule who were concerned that the proposed four levels of musculoskeletal APCs resulted in extremely wide cost ranges. In response to these comments on the proposed rule, CMS added a fifth level to the musculoskeletal APC grouping. Several procedures that were proposed to be assigned to APC 5123 (Level 3 Musculoskeletal Procedures) are now reassigned APC 5124 (Level 4 Musculoskeletal Procedures) for 2016. Similarly, several procedures that were proposed to be assigned to APC 5124 (Level 4 Musculoskeletal Procedures) are now reassigned to new APC 5125 (Level 5 Musculoskeletal Procedures) for 2016. CMS is revising the APC assignment for the procedure described by CPT**®**27279 from APC 5124 to APC 5125. The geometric mean cost of APC 5125 is approximately $11,027, which is higher than the proposed geometric mean cost of APC 5124 of approximately $9,789.

The table below lists the final 2016 APCs that result from the restructuring and consolidation of the current orthopedic-related procedure APCs along with the final payment rates. See the attached spreadsheet for more detailed information on APC payment rates and procedures assigned to each APC.

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| **CY 2016 APC**  | **CY 2016 APC Group Title**  |
| 5101  | Level 1 Strapping and Cast Application  |
| 5102  | Level 2 Strapping and Cast Application  |
| 5111  | Level 1 Closed Treatment Fracture and Related Services  |
| 5112  | Level 2 Closed Treatment Fracture and Related Services  |
| 5113  | Level 3 Closed Treatment Fracture and Related Services  |
| 5121  | Level 1 Musculoskeletal Procedures  |
| 5122  | Level 2 Musculoskeletal Procedures  |
| 5123  | Level 3 Musculoskeletal Procedures  |
| 5124  | Level 4 Musculoskeletal Procedures  |
| 5125  | Level 5 Musculoskeletal Procedures  |

**Comprehensive Ambulatory Payment Classifications (C-APCS)**

A C-APC is an APC that provides for an encounter-level payment for a designated primary procedure and generally, all adjunctive and secondary services provided in conjunction with the primary procedure. There are currently 25 C-APCs for 2015, which mostly include procedures that include the implantation of costly medical devices. For 2016, CMS is finalizing its plan to establish 10 additional C-APCs to be paid under the existing C-APC payment policy. There will now be three musculoskeletal APCs designated as C-APCs (listed in the table below)--those newly added in 2016 are denoted with an asterisk:

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| **CY 2016 C-APC+**  | **CY 2016 APC Group Title**  | **Clinical Family**  | **New C-APC**  |
| 5123  | Level 3 Musculoskeletal Procedures  | ORTHO  | \*  |
| 5124  | Level 4 Musculoskeletal Procedures  | ORTHO  |  |
| 5125  | Level 5 Musculoskeletal Procedures  | ORTHO  | \*  |

**Change in OPPS Device Pass-Through Process**

Device pass-through payments are intended to enable initial access to certain new medical devices. CMS currently accepts and reviews applications for device pass-through on a quarterly basis through a subregulatory process. CMS is finalizing its plan to evaluate device pass-through applications through annual rulemaking in addition to the quarterly subregulatory review process. In addition, CMS is implementing a newness criterion for device pass-through applications under which applications must be submitted within three years of FDA approval/clearance or the date of market availability if there is a documented, verifiable delay in market availability after FDA approval or clearance.

**Device-Intensive Procedures Under the OPPS**

Under the OPPS, device-intensive APCs are defined as those APCs with a device offset greater than 40%. In assigning device-intensive status to an APC, the device costs of all of the procedures within the APC are calculated and the geometric mean device offset of all of the procedures must exceed 40%. Almost all of the procedures assigned to device-intensive APCs utilize devices, and the device costs for the associated HCPCS codes exceed the 40% threshold. The no cost/full credit and partial credit device policy applies to device-intensive APCs; a related device policy is the requirement that procedures assigned to certain (formerly device-dependent) APCs require the reporting of a device code on the claim. APC 5125 (Level 5 Musculoskeletal Procedures) is the only musculoskeletal APC classified as device-intensive.

CMS is finalizing its plan that only the procedures that require the implantation of a device that are assigned to a device-intensive APC will require a device code on the claim. CMS is also finalizing its plan that the claims processing edits are such that any device code, when reported on a claim with a procedure assigned to a device-intensive APC will satisfy the edit. Additionally, CMS is finalizing its plan to continue to reduce the OPPS payment for device-intensive APCs by the full or partial credit a provider receives for a replaced device. CMS is also finalizing the proposal to no longer specify a list of devices to which the OPPS payment adjustment for no cost/full credit and partial credit devices would apply and instead, apply this APC payment adjustment to all replaced devices furnished in conjunction with a procedure assigned to a device-intensive APC when the hospital receives a credit for a replaced specified device that is 50% or greater than the cost of the device.

**Changes to the Inpatient Only List**
For 2016, CMS is removing nine procedures from the Inpatient-Only List. In order to remove a procedure from the Inpatient-Only List, CMS must determine the following:

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 CMS has already removed from the inpatient only list;
4. A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis; and
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.

Of the nine procedures CMS is removing from the Inpatient-Only List, four relate to spine:

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| **Code**  | **Long Descriptor**  |
| 20936  | Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision  |
| 20937  | Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)  |
| 20938  | Autograft for spine surgery only (includes harvesting the graft); structural bicortical or tricortical (through separate skin or fascial incision)  |
| 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  |

**Additions to the List of ASC Covered Surgical Procedures**

CMS is adding seventeen procedures to the ASC list of covered surgical procedures. CMS determined that these procedures would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and would not be expected to require active medical monitoring and care of the beneficiary at midnight following the procedure. Of the seventeen procedures, four relate to spine:

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| **Code**  | **Long Descriptor**  | **ASC Payment Indicator**  |
| 0171T  | Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level  | J8 - Device-intensive procedure; paid at adjusted rate. |
| 0172T  | Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; each additional level  | N1 - Packaged service/item; no separate payment made. |
| 63046 | Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine and/or nerve root(s), eg spinal or lateral recess stenosis, single vertebral segment; thoracic | G2 - Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight. |
| 63055 | Transpedicular approach with decompression of spinal cord, equine and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic | G2 - Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight. |

**Device-Intensive Procedures in ASCs**

CMS redefined ASC device-intensive procedures for 2015 as those procedures that are assigned to any APC with a device offset percentage greater than 40% based on the standard OPPS APC rate setting methodology. Payment rates for ASC device-intensive procedures are based on a modified payment methodology.

CMS is finalizing its plan to apply the full credit/partial credit (FB/FC) device adjustment policy to all device-intensive procedures in an ASC in 2016. The device-intensive procedures related to spine for 2016 are listed in the table below. For 2016, CMS will reduce the payment for the procedures listed in the table by the full device offset amount if a device is furnished without cost or with full credit. ASCs must append the HCPCS modifier ‘‘FB’’ to the HCPCS code for a surgical procedure listed in the table when the device is furnished without cost or with full credit. In addition, for 2016, CMS will reduce the payment for the procedures listed in the table below by one-half of the device offset amount if a device is provided with partial credit, if the credit to the ASC is 50% or more (but less than 100%) of the device cost. The ASC must append the HCPCS “FC” modifier to the HCPCS code for a surgical procedure listed in the table below when the facility receives a partial credit of 50% or more (but less than 100%) of the cost of a device.

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| **Code**  | **Short Descriptor**  | **Final CY 2016 ASC Payment Indicator**  | **Final CY 2016 OPPS APC**  | **Final CY 2016 Device Offset Percentage**  | **Final FB/FC Policy Will Apply**  |
| 0171T  | Lumbar spine proces distract  | J8 - Device-intensive procedure; paid at adjusted rate. | 5125  | 53.97%  | Y  |
| 22551 | Neck spine fuse & remov bel c2  | J8 - Device-intensive procedure; paid at adjusted rate. | 5125 | 53.97%  | Y |
| 22554 | Neck spine fusion  | J8 - Device-intensive procedure; paid at adjusted rate. | 5125 | 53.97%  | Y |
| 27279 | Arthrodesis sacroiliac joint  | J8 - Device-intensive procedure; paid at adjusted rate. | 5125 | 53.97%  | Y |

**Two Midnight Rule**

For 2016, CMS is finalizing its proposal to update the Two-Midnight rule. CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria to use when determining whether inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A. In general, the original Two-Midnight rule states that:

* Inpatient admissions would generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supported that reasonable expectation.
* Medicare Part A payment was generally not appropriate for hospital stays expected to last less than two midnights. Cases involving a procedure identified on the inpatient-only list or that were identified as “rare and unusual exception” to the Two-Midnight benchmark by CMS were exceptions to this general rule and were deemed to be appropriate for Medicare Part A payment.

Beginning in 2016, for stays expected to last less than two midnights – CMS is adopting the following policies:

* For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.
* CMS is reiterating the expectation that it would be unlikely for a beneficiary to require inpatient hospital admission for a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for a period of time that is only for a few hours and does not span at least overnight. CMS will monitor the number of these types of admissions and plans to prioritize these types of cases for medical review.

CMS is making no changes for stays over the two-midnight benchmark:

* For hospital stays that are expected to be two midnights or longer, CMS’ policy is unchanged; that is, if the admitting physician expects the patient to require hospital care that spans at least two midnights, the services are generally appropriate for Medicare Part A payment. This policy applies to inpatient hospital admissions where the patient is reasonably expected to stay at least two midnights, and where the medical record supports that expectation that the patient would stay at least two midnights. This includes stays in which the physician’s expectation is supported, but the length of the actual stay was less than two midnights due to unforeseen circumstances such as unexpected patient death, transfer, clinical improvement or departure against medical advice.

The final rule also includes changes to CMS’ approach to educating hospitals and enforcement of the Two Midnight rule. Specifically, CMS began using Beneficiary and Family Centered Care (BFCC) QIOs, rather than Medicare Administrative Contractors or Recovery Auditors, to conduct the initial medical reviews of providers who submit claims for short stay inpatient admissions on October 1, 2015. Beginning in 2016, BFCC-QIOs will begin reviewing inpatient cases under the revised Two Midnight Rule. BFCC-QIO reviews of short inpatient hospital claims focus on educating doctors and hospitals about the Part A payment policy for inpatient admissions. BFCC-QIOs will refer providers to the Recovery Auditors based on patterns of practices, such as high rates of claims denial after medical review or failure to improve after QIO assistance has been rendered.

**Next Steps:**

CMS is accepting public comments on the final rule until 5 p.m. EST on December 29, 2015. The final rule goes into effect on January 1, 2016.

**Important Links:**

Full Text of Final Rule: <https://www.federalregister.gov/articles/2015/11/13/2015-27943/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment>

CMS Fact Sheet on Final Rule:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-3.html>

CMS Fact Sheet on Two Midnight Rule Section of Final Rule: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-4.html>

Final Rule - OPPS Addenda and Attachments: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html>

Final Rule - ASC Addenda and Attachments: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>

Submit Individual Comments to the Final Rule at: <http://www.regulations.gov/#!documentDetail;D=CMS-2015-0075-0632>

Note: Click on the blue “Comment Now!” button in the upper right hand corner.