
CMS Issues 2018 Proposed Hospital Outpatient and ASC Rule: A Summary for Spine Surgeons

Overview

On July 13, 2017, the Centers for Medicare & Medicaid Services (CMS) released the 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System policy changes, quality provisions, and payment rates proposed rule. CMS is accepting comments on the proposed rule through September 11, 2017. The final rule is expected to be released by November 1, 2017.

(Please note that physician payment is made under the Physician Fee Schedule; hospitals are paid for outpatient services under the OPPS and ASCs are paid under the ASC payment system, both detailed in this rulemaking.)

Proposed OPPS and ASC Payment Updates

CMS proposes to update OPPS rates by 1.75 percent for 2018. After considering all other policy changes proposed under the OPPS, including estimated spending for pass-through payments, CMS estimates a 2.0 percent payment increase for hospitals paid under the OPPS in 2018. ASC payments are annually updated by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). The Medicare statute specifies a multi-factor productivity (MFP) adjustment to the ASC annual update. For 2018, the CPI-U update is projected to be 2.3 percent. The MFP adjustment is projected to be 0.4 percent, resulting in an MFP-adjusted CPI-U update factor of 1.9 percent.

OPPS Ambulatory Payment Classifications

CMS assigns codes to an Ambulatory Payment Classification (APC) under the OPPS. The APC assignment determines the payment rate for an item, procedure, or service. Most spine procedures in the hospital outpatient setting are assigned to one of the following APCs:

[CMS-1678-P] - Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

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Comment Deadline

CMS is accepting comments on the proposed rule until September 11, 2017 at [Regulations.gov](http://www.regulations.gov). CMS will issue the final rule in early November 2017.

Resources

- [CMS Fact Sheet](#)
- [Full Text of Proposed Rule](#)
- [OPPS Data Files](#)
- [ASC Data Files](#)

APC	Group Title	SI	Relative Weight	Payment Rate
5111	Level 1 Musculoskeletal Procedures	T	2.7924	\$213.57
5112	Level 2 Musculoskeletal Procedures	J1	16.4859	\$1,260.89
5113	Level 3 Musculoskeletal Procedures	J1	32.6955	\$2,500.65
5114	Level 4 Musculoskeletal Procedures	J1	70.4108	\$5,385.23
5115	Level 5 Musculoskeletal Procedures	J1	129.6065	\$9,912.69
5116	Level 6 Musculoskeletal Procedures	J1	198.4094	\$15,174.95

(Note: Status Indicator “T” means a paid service under the OPSS with separate APC payment and status indicator “J1” means that hospital Part B services are paid through a comprehensive APC.)

New Spine Code Assignment

CMS is accepting public comments on the assignment of the following new CPT code under the OPSS and ASC Payment Systems:

CPT Code	Descriptor	Proposed OPSS Status Indicator	Proposed ASC Payment Indicator
2093X	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure)	N – Packaged; no separate payment	N1 - Packaged service/item; no separate payment made

Additions to the List of ASC-Covered Surgical Procedures

CMS is proposing to add the following spine codes to the list of ASC Covered Surgical Procedures:

CPT Code	Long Descriptor	Proposed ASC Payment Indicator	Proposed 2018 Payment Rate
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	J8 – Device-intensive procedure; paid at adjusted rate	\$11,033.98
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection); second level, cervical (list separately in addition to code for primary procedure)	N1 – Packaged service/item; no separate payment	Packaged; no separate payment

ASC Quality Reporting Program

CMS is proposing to adopt a new ASC quality measure, ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures for the 2022 payment determination and subsequent years. The measure outcome is all-cause, unplanned hospital visits within seven days of an orthopedic procedure performed at an ASC. For the purposes of this measure, “hospital visits” include emergency department visits, observation stays, and unplanned inpatient admissions.

CMS intends to conduct a dry run before the official data collection period or any public reporting so that ASCs may review their results and familiarize themselves with the measure methodology. The dry run would generate confidential feedback reports for ASCs, including patient-level data indicating whether the patient had a hospital visit and, if so, the type of visit (emergency department visit, observation stay, or unplanned inpatient admission), the admitting facility, and the principal discharge diagnosis. General information about the dry run as well as confidential facility-specific reports would be made available for ASCs to review. These confidential results are not publicly reported and do not affect payment. However, after the dry run, measure results would have a payment impact and be publicly reported beginning with the 2022 payment determination and for subsequent years.

Request for Information

CMS has requested public comments on the following three topics:

1. Flexibilities and Efficiencies - CMS is seeking comments and ideas from the public on regulatory, sub-regulatory, policy, practice, and procedural changes to better accomplish its goals of maintaining efficiency and flexibility in the Medicare program.
2. Payment Disparities between Care Settings – CMS is seeking feedback on ways to identify and eliminate inappropriate payment differentials for similar services delivered in the inpatient and outpatient settings.
3. Physician Owned Hospitals – CMS is seeking comments on the appropriate role of physician-owned hospitals in the delivery system and on the impact of the current requirements of the physician self-referral law regarding physician-owned hospitals.

Next Steps

CMS is accepting comments on the proposed rule through September 11, 2017. Comments should be submitted at [regulations.gov](http://www.regulations.gov) using the “Comment Now!” button on the right side of the page. A final rule is expected to be released by November 1, 2017.

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