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2017 OPPS Rule Changes

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Outpatient Prospective Payment System

- Ambulatory Payment Classifications (APCs)
  - Outpatient Payment Groups
    - APCs use Level I CPT™ and Level II HCPCS codes to identify and group services
    - CPT/HCPCS codes classified into a single payment classification with a fixed payment amount
  - Codes in the same APC must have
    - Comparable clinical aspects
    - Comparable resource consumption

Tools-OPPS

To understand OPPS and any of the annual changes CMS makes to amend the payment system

- Be familiar with two files issued by CMS:
  - Yearly with the final rule change
  - Quarterly updates with maintenance changes
- Have a basic understanding of the CMS claim processing logic contained within:
  - Outpatient Code Editor (OCE)

Tools-OPPS (cont.)

1) Addendum B - A data file reporting all CPT/HCPCS codes accepted for billing on the outpatient hospital claim
   - Addendum B contains:
     - The APC, the CPT status indicator, APC weight, APC #, national payment rate and patient coinsurance rate associated with the APC
   - https://wwwcmsgov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

Tools-OPPS (cont.)

2) Addendum D1 - A complete listing of OPPS status indicators used in OPPS
   - Indicators are assigned to each CPT/HCPCS
     - Indicators carry imbedded intelligence in that they define policy, reimbursement and processing logic used by the OPPS grouping and pricing systems
   - https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1656-FC-2017-OPPS-FR-Addenda.zip

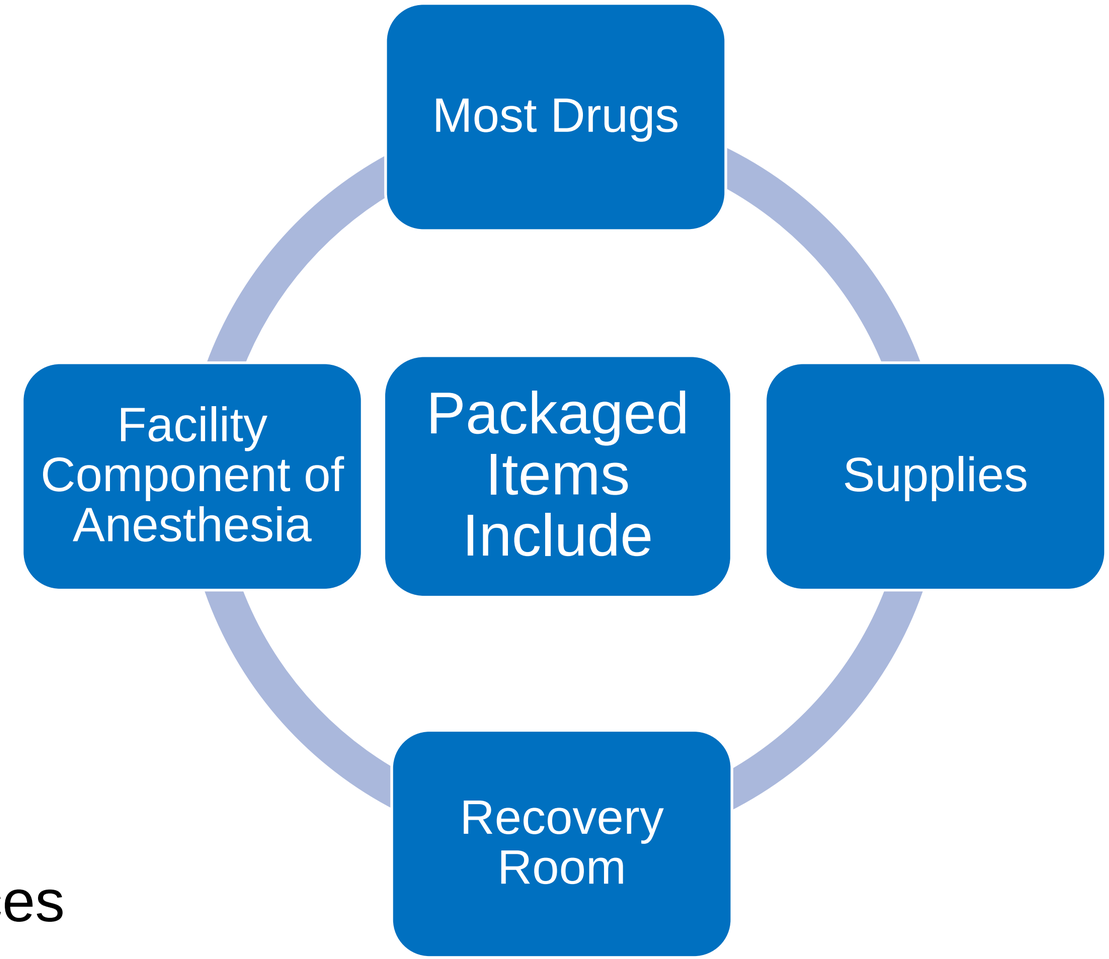
Tools-OPPS (cont.)

- Outpatient Code Editor
  - The Outpatient code editor (OCE) is a software program created by Medicare that "scrubs" outpatient institutional claims prior to grouping and pricing
    - Claim and line level consistency and validation editing
    - Dates, revenue codes, occurrence codes, condition codes
    - CPT/HCPCS along with Modifier usage
    - Missing services
      - PHP without PHP HCPCS
    - Service code evaluation
      - Revenue code usage
    - Gender and procedure conflicts
    - NCCI / MUE
      - Modifier reporting
    - Statutory coverage criteria
  - https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Index.html

Historical Logic: Unconditional Packaging

The OPPS/APC packaging:

Unconditional packaged services:



Unconditionally packaged services carry the unique status indicator of "*N*"

- OPPS Status indicator *N*: No additional payment included in the line item with APCs for incidental services

Historical Logic: Conditional Packaging

- **Conditional Packaging**: The concept of not paying separately for services considered integral, supportive, dependent, or adjunctive to a primary service

  - Status indicators (SI's) associated with conditionally packaged care (addendum D1) are:
    - Status indicator Q1 -STV-Packaged Codes
    - Status indicator Q2 – T-Packaged Codes
    - Status indicator Q3 - Codes That May Be Paid Through a Composite APC
    - Status indicator Q4 - Conditionally packaged laboratory tests
      - *In other circumstances, such as those services otherwise billed alone, the payment is made under the CLFS*

  - Conditionally packaged items and services are separately payable when provided as a primary service

APC (SI's) - Subject to Packaging

HCPCS	Code Short Descriptor	SI	APC	Relative Wt	Payment Rate
65222	Remove foreign body from eye	**Q1**	5734	1.3336	$ 100.02
65430	Corneal smear	**Q1**	5735	3.5147	$ 263.61
65778	Cover eye w/membrane	**Q2**	5502	10.3275	$ 774.57
65779	Cover eye w/membrane suture	**Q2**	5504	36.9972	$ 2,774.83
70336	Magnetic image jaw joint	**Q3**	5523	3.0121	$ 225.91
70450	Ct head/brain w/o dye	**Q3**	5522	1.5031	$ 112.73
80076	Hepatic function panel	**Q4**			
80081	Obstetric panel	**Q4**			
80150	Assay of amikacin	**Q4**			

2017 OPPS Rule Changes

2017 OPPS Rule Highlights

* In the 2017 OPPS rule change, we continue to see CMS implementing changes to this ever-evolving complex payment system

- CMS created additions to the list of Comprehensive APCs (C-APCs) - 25 new bundles
- Other changes
  - Chronic Care Management (CCM) benefits provided to hospital outpatient
  - Revision of device intensive procedure policies to calculate payment offsets at the HCPCS level instead of the APC level
  - Discontinuation of the L1 modifier for unrelated lab tests, exclusion of advanced lab from packaging logic including molecular lab
  - Changes and additions to APC status indicators
- Provider Based Billing - BBA 603

2017 OPPS Rule Highlights

- Packaging occurs now at the claim level instead of the line level dates of service
  - Ancillary service packaging— CMS stated intention over time is to package more ancillary services when they are billed on a claim with another service
  - Pay for them separately only when performed alone
- CMS has discontinued the unrelated laboratory test payment policy and eliminated the L1 modifier option
  - OCE will package all laboratory tests appearing on a claim with other outpatient primary services

2017 Comprehensive APC (C-APCs)

Twenty-five (25) new C-APCs have been added, totaling 62 APCs resulting in 2,750 HCPCS codes classified to these special classifications (primarily major surgery)

Comprehensive APC will be paid a single payment when a primary procedure is performed and all other services related and reported on the claim will be packaged with few exceptions

STATUS INDICATOR = J1 and J2

Comprehensive APC definition: a primary service payment inclusive of integral, supportive, dependent and adjunctive services and items provided to support the delivery of the primary service

Comprehensive APC Status Indicators

Status Indicator	Item/ Code/Service	Definitions
J1	Hospital Part B services paid through a comprehensive APC	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 are considered as being integral, ancillary, supportive, dependent and adjunctive to the primary service (adjunctive services). • Payment for the "adjunctive services" are packaged into the payment for the primary service. Examples • Inpatient only procedures • High cost Procedures

Comprehensive APC Status Indicators (cont.)

Status Indicator	Item/ Code/Service	Definitions
J2	Hospital Part B services that may be paid through a comprehensive APC	1. Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. 2. Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1." 3. In other circumstances, payment is made through a separate APC payment or packaged into payment for other services. Example: Comprehensive Observation Services

C-APCs SIs

HCPCS	Code Short Descriptor	SI	APC	Relative Wt	Payment Rate
93653	Ep & ablate supravent arrhyt	J1	5213	223.8001	$16,785.23
93654	Ep & ablate ventric tachy	J1	5213	223.8001	$16,785.23
93656	Tx atrial fib pulm vein isol	J1	5213	223.8001	$16,785.23
99281	Emergency dept visit	J2	5021	0.8182	$ 61.37
99282	Emergency dept visit	J2	5022	1.4862	$ 111.47

"Observation" as a C-APC

- C-APC 8011 for observation services carries a status indicator J2
  - "Qualifying" extended assessment and management encounters will be assigned to new C-APC 8011
    - The "J2" status indicator
      - J2 designates specific combinations of services performed in combination with each other and reported on a single hospital outpatient claim are deemed as adjunctive services; components of a comprehensive service
- Claims with a HCPCS code assigned SI "T" are excluded
- Claims must contain 8 or more units of HCPCS code G0378 (observation services, per hour) for comprehensive packaging

Comprehensive APC (C-APC Packaging)

- Comprehensive APCs use the expanded definition of "packaging"
  - Payment is packaged for adjunctive and secondary items, services and procedures
    - Including diagnostics and therapeutic services such as rehab*, evaluation and assessments, uncoded ancillary, drugs, supplies and equipment
  - Identification of the most costly procedure at the claim level resulting in:
    - A single prospective payment

* *Repetitive, recurring account billing will continue to be allowed and accepted; UB-04 Occurrence Span code 74 (IOM 100-04, Section 60)*

C-APC Packaging Exceptions

- Certain services are excluded from C-APC logic and will remain separately payable
  - Ambulance
  - Diagnostic and screening mammography
  - Brachytherapy
  - PT, OT and ST services provided under a plan of care
    - Allowed to be billed separately as a recurring account
  - Preventive services
    - Self-administered drugs
      - Drugs that are usually self-administered and do not function as supplies in the provision of the comprehensive service
    - Services assigned to OPPS status indicator ‘‘F’’ (Hepatitis B vaccines and corneal tissue acquisition)
    - Certain Part B inpatient services
      - Ancillary Part B inpatient services payable under Part B when the primary ‘‘J1’’ service for the claim is not a payable Part B inpatient service (for example, exhausted Medicare Part A benefits, beneficiaries with Part B only)

C-APC Complexity Adjustments

- Expanded logic for complexity adjustments
  - When a code combination represents a complex costly form or version of the primary service
    - CMS developed a list of "family" related HCPCS codes
      - Two or more status indicator J1 procedures reported on the same claim or certain combinations of primary with add-on codes
        - System will default to the highest APC in the family group

C-APC Complexity Adjustments Examples

Primary HCPCS Code	Primary Short Descriptor	Primary SI	Primary APC Assignment	Secondary J1 or Add-on HCPCS Code	Secondary Short Descriptor	Secondary SI	Secondary APC Assignment	Complexity Adjusted APC Assignment
10121	Remove foreign body	J1	5072	10121	Remove foreign body	J1	5072	5073
10121	Remove foreign body	J1	5072	10140	Drainage of hematoma/fluid	J1	5072	5073
10121	Remove foreign body	J1	5072	11044	Deb bone 20 sq cm/<	J1	5072	5073
10121	Remove foreign body	J1	5072	11404	Exc tr-ext b9+marg 3.1-4 cm	J1	5072	5073
10121	Remove foreign body	J1	5072	15782	Dermabrasion other than face	J1	5072	5073
10121	Remove foreign body	J1	5072	26011	Drainage of finger abscess	J1	5072	5073
10121	Remove foreign body	J1	5072	26055	Incise finger tendon sheath	J1	5112	5073
10121	Remove foreign body	J1	5072	26080	Explore/treat finger joint	J1	5112	5073
10121	Remove foreign body	J1	5072	26115	Exc hand les sc < 1.5 cm	J1	5072	5073

Miscellaneous OPPS Updates

- New Modifier FX-film x-rays
  - 20% reduction in payment
- Partial Hospitalization (PHP) APC has been reduced to a single APC
  - CMS will monitor that 20 hours a week of PHP is provided
- Addition of an E2 status indicator
  - Items and services for which pricing information and claims data is not available
- Seven procedures have been removed from the "inpatient only" list
  - See addendum E of the OPPS final rule
- Device intensive procedures
  - Payment calculation changes
  - See addendum P of the OPPS final rule
- New methodology for calculating payments for skin substitutes
- Several pharmacy, lab and radiology HCPCS and CPT code narrative changes, new additions and status indicator changes
- APC recalibration and weighting changes

Provider Based Rules
Under Bipartisan Budget 603

What is a Provider Based Entity (PBE)

- An entity that furnishes health care services to Medicare beneficiaries and is not integrated with any other entity:
  - As a main provider
  - A department of a provider
  - Remote location of a hospital, satellite facility, or provider-based entity
- A department of a hospital located on and off campus

Why the Interest….

- CMS noted-
  - An increase in independent physician movement to hospital employment
  - An increase in provider based billing for remote rural hospitals
  - An increase in payments for facility overhead
  - Patients paying increased coinsurance due to the billing mechanism
    - Split bill, two out of pocket expenses for patient
      - Part B coinsurance

Section 603 – Change in Reimbursement

- Provider based definitions:
  - **Excepted** (grandfathered) departments
    - Dedicated emergency rooms
    - Type A (traditional) and B (not 24/7) emergency rooms
    - On campus provider based departments - located within 250 yards of main provider or a provider remote location
    - Off campus locations that have billed for provider based services before 11/2/15
  - **Non-excepted** departments
    - Practices located off campus not billing services on or before 11/2/15
    - Change in reimbursement for this type of provider based department

Section 603 and the Cures Act

- Relocation of an excepted provider-based department
  - The address of the excepted provider-based department on November 1, 2015 is vital to participation
  - Any change in the address moves the practice to non-excepted status
    - This includes simply changing suite numbers
  - Exception may be available for extraordinary circumstances beyond the hospital's control
    - Unsafe building – public safety issues
    - Building code requirement concerns
    - Natural disasters
  - Case by case basis evaluated by Regional Office
    - Considered rare and unique

Section 603 and Cures Act (cont.)

- Change of ownership of an excepted provider-based department
  - The provider-based department will keep excepted status if the new owner accepts assignment under the current provider agreement
  - Should the provider agreement be terminated, the provider-based department moves to non-excepted status
- Expansion of services within an excepted provider-based department
  - No limitation for 2017
  - No guidance yet on expansion of space related to expansion of services
    - Stay tuned for further CMS guidance
  - The attestation and certification statement are subject to audit by CMS
  - If approved, the practice would receive the excepted payment (full OPPS) beginning in 2018

BBA 603 - CMS 1500 Billing

- Place of Service supporting provider based
  - On-campus provider-based department = POS 22
  - Off-campus provider-based department = POS 19

BBA 603 - CPT Modifiers

- CPT/HCPCS Modifier for grandfathered off-campus provider-based department services
  - Modifier PO effective January 1, 2016 for off-campus practice reporting and will continue to be used for excepted locations.
    - Required for all services billed in an excepted off-campus provider-based department.

- CPT/HCPCS Modifier for non-excepted off-campus provider-based departments
  - Modifier PN effective January 1, 2017 for non-excepted off-campus practices.
    - Required for all services provided in a non-excepted off-campus provider-based department
    - Triggers a 50% reduction of the APC (OPPS) payment.

Questions or Comments

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