CMS Issues 2017 Proposed Hospital Inpatient and Long-Term Care Rule: What Spine Surgeons Should Know

[CMS-1655-P] - Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates

Overview

On April 18, the Centers for Medicare and Medicaid Services (CMS) released the proposed 2017 Hospital Inpatient and Long-Term Care Hospital (LTCH) payment and policy rule. The proposed rule, which would apply to approximately 3,330 acute care hospitals and approximately 430 LTCHs, would affect discharges occurring on or after October 1, 2016.

The Hospital Inpatient Prospective Payment System (IPPS) pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospitals' costs, including the patient's condition and the cost of hospital labor in the hospital's geographic area. CMS generally sets payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness. A hospital receives a single payment for the case based on the payment classification (MS-DRGs under the IPPS) assigned at discharge. (Please note physician payment is made via the Physician Fee Schedule, which is not addressed under this proposed rule.)

Overall, CMS is proposing a 0.9 increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful electronic health record users.

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Comment Deadline

CMS is accepting comments on the proposed rule until June 17, 2016 at Regulations.gov. CMS will issue the final rule on August 1, 2016.

Resources

CMS Fact Sheet
Full Text of Proposed Rule
Proposed Rule Data Files
Proposed Rule Tables

Provisions Related to Spine

Specific to hospital payment and policy for inpatient spine surgery, CMS is proposing:

The SFusion Payment Measure

CMS is proposing to include three clinical episode-based payment measures in the Hospital Inpatient Quality Reporting Program beginning in 2019 including the Spinal Fusion Clinical Episode-Based Payment (SFusion Payment) Measure. CMS is developing clinical episode-based payment measures, which are clinical groupings of healthcare services that can be used to assess providers' resource use. CMS believes that including condition and procedure-specific payment measures will provide hospitals with the necessary data to implement targeted cost and quality improvements and provide both overall hospital-level and detailed information on high-cost and high-prevalence conditions and procedures to better inform hospital spending.

CMS selected the procedures for which to develop clinical episode-based payment measures based on the following criteria:

1. the condition constitutes a significant share of Medicare payments and potential savings for hospitalized patient during and surrounding a hospital stay;
2. there was a high degree of agreement among consulting clinical experts that standardized Medicare payments fo services provided during this episode can be linked to the care provided during the hospitalization;
3. episodes of care for the condition are comprised of a substantial proportion of payments and potential savings fo post-acute care, indicating episode payment differences are driven by utilization outside of the MS-DRG payme
4. episodes of care for the condition reflect high variation in post discharge payments, enabling differentiation among hospitals; and
5. the medical condition is managed by general medicine physicians or hospitalists and the surgical conditions are managed by surgical subspecialists, enabling comparison between similar practitioners.

The proposed SFusion Payment measure includes the set of medical services related to a hospital admission for a spinal fusion, including treatment, follow-up, and post-acute care and assesses the payment for services clinically related to the spinal fusion procedure initiated during an episode that spans three days prior to the Medicare patient's hospital admissi for surgery and extends 30 days following the Medicare patient's discharge from the hospital.

The measure includes five clinical subtypes:

1. Anterior Fusion – Single
2. Anterior Fusion – 2 Levels
3. Posterior/Posterior-Lateral Approach Fusion – Single
4. Posterior/Posterior-Lateral Approach Fusion – 2 or 3 Levels
5. Combined Fusions

CMS will calculate the SFusion Payment measure using Medicare Part A and Part B claims for Medicare patients hospitalized for spinal fusion. CMS will sum the Medicare payment amounts for clinically related Part A and Part B services during the episode window and attribute them to the hospital where the episode occurred. CMS will standardize and risk-adjust the episode-based measure in order to compare episodes over time without the need to adjust for inflatio The numerator is the episode amount, calculated as the average of the ratios of the observed episode payment over the expected episode payment (as predicted in risk adjustment), multiplied by the average observed episode payment level across all providers nationally. The denominator for a provider's measure is the episode weighted national median of episode amounts across all providers.

Reassignment of Decompression Laminectomy Codes

CMS is proposing to reassign the ICD-10-PCS procedure codes listed in the following table from MS-DRGs 515 through 517 to MS-DRGs 028 through 030 and MS-DRGs 518 through 520 under the ICD-10 MS-DRGs Version 34 fo clinical coherence purposes. Currently, under ICD-10-PCS, the procedure describing a decompression laminectomy is coded for the "release" of a specified area of the spinal cord. These decompression codes are assigned to MS-DRGs 028 029, and 030 and to MS-DRGs 518, 519, and 520 in the ICD-10 MS-DRGs Version 33. CMS received comments that codes describing release of specific peripheral nerve are assigned to MS-DRGs 515, 516, and 517. The comments stated that ICD-10-PCS procedure code 00NY0ZZ (Release lumbar spinal cord, open approach) is assigned to MS-DRGs 028 through 030 and MS-DRGs 518 through 520. However, ICD-10-PCS procedure code 01NB0ZZ (Release lumbar nerve, open approach) is assigned to MS-DRGs 515 through 517. CMS is accepting comments on the proposed reassignment.

ICD-10-PCS Procedure Code	Description
01N00ZZ	Release cervical plexus, open approach
01N03ZZ	Release cervical plexus, percutaneous approach
01N04ZZ	Release cervical plexus, percutaneous endoscopic approach
01N10ZZ	Release cervical nerve, open approach
01N13ZZ	Release cervical nerve, percutaneous approach
01N14ZZ	Release cervical nerve, percutaneous endoscopic approach
01N80ZZ	Release thoracic nerve, open approach
01N83ZZ	Release thoracic nerve, percutaneous approach
01N84ZZ	Release thoracic nerve, percutaneous endoscopic approach
01N90ZZ	Release lumbar plexus, open approach
01N93ZZ	Release lumbar plexus, percutaneous approach
01N94ZZ	Release lumbar plexus, percutaneous endoscopic approach
01NA0ZZ	Release lumbosacral plexus, open approach
01NA3ZZ	Release lumbosacral plexus, percutaneous approach
01NA4ZZ	Release lumbosacral plexus, percutaneous approach
01NB0ZZ	Release lumbar nerve, open approach
01NB3ZZ	Release lumbar nerve, percutaneous approach
01NB4ZZ	Release lumbar nerve, percutaneous endoscopic approach

MS-DRG	Description
515	Other musculoskeletal system & connective tissue OR procedures with major complication/comorbidity (2017 proposed payment: $18,610)
516	Other musculoskeletal system & connective tissue OR procedures with complication/comorbidity (2017 proposed payment: $12,348)
517	Other musculoskeletal system & connective tissue OR procedures without major complication/comorbidity or complication/comorbidity (2017 proposed payment: $10,695)
028	Spinal procedures with major complication/comorbidity (2017 proposed payment: $32,925)
029	Spinal procedures with complication/comorbidity or neurostimulators (2017 proposed payment: $19,087)
030	Spinal procedures without major complication/comorbidity or complication/comorbidity (2017 proposed payment: $11,248)
518	Back & neck procedures except spinal fusion with major complication/comorbidity or disc device/neurostimulator (2017 proposed payment: $17,299)
519	Back and neck procedures except spinal fusion with complication/comorbidity (2017 proposed payment: $10,197)
520	Back and neck procedures except spinal fusion without major complication/comorbidity or complication/comorbidity (2017 proposed payment: $7,300)

Removal of Lordosis Codes from Secondary Diagnosis List

CMS is proposing to remove four lordosis diagnosis codes from the secondary diagnosis list while maintaining the four codes in the logic for the principal diagnosis list to resolve a replication issue. CMS discovered four diagnosis codes related to lordosis in MS-DRGs 456, 457, and 458 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or Infection or Extensive Fusions with major complication/comorbidity, with complication/comorbidity, and without major complication/comorbidity or complication/comorbidity). These MS-DRGs contain specific logic that requires a principal diagnosis describing a spinal curvature, a malignancy, or infection or a secondary diagnosis that describes a spinal curvature disorder related to another condition. Under the ICD-10 MS-DRGs Version 33, the following diagnosis codes were listed on the principal diagnosis list and the secondary diagnosis list for MS-DRGs 456, 457, and 458 and CMS is proposing to remove these codes from the secondary diagnosis list while maintaining them on the primary diagnosis list:

- M40.50 – Lordosis, unspecified, site unspecified
- M40.55 – Lordosis, unspecified, thoracolumbar region
- M40.56 – Lordosis, unspecified, lumbar region
- M40.57 – Lordosis, unspecified, lumbosacral region

CMS is accepting comments on this proposal.

New Technology Add-On Payments

CMS is proposing to evaluate nine applications for new technology add-on payments including MAGEC® Spinal Bracing and Distraction System and Titan Spine Endoskeleton® nanoLOCK™ Interbody Device based on established newness, cost and clinical improvement criteria. CMS does not believe these two applications meet the established criteria for add-on payment, but is accepting comments on the proposals.

Addition of Reposition Codes to MDC 8 in MS-DRGs 515, 516 and 517

CMS is proposing to add the following ICD-10-PCS procedure codes to Major Diagnostic Category 8 in MS-DRGs 515, 516 and 517 to address a replication issue. In the ICD-9-CM MS-DRGs Version 32, procedures that involve the percutaneous repositioning of an area in the vertebra were identified with procedure code 81.66 (Percutaneous vertebral augmentation). This procedure code is designated as an OR procedure and is assigned to Major Diagnostic Category 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue) in MS-DRGs 515, 516, and 517. The following four codes were inadvertently omitted from the ICD-10 MS-DRG logic; to resolve this issue, CMS is proposing to add these four codes to Major Diagnostic Category 8 in MS-DRGs 515, 516, and 517 and is accepting comments on this proposal.

- 0PS33ZZ – Reposition cervical vertebra, percutaneous approach
- 0PS43ZZ – Reposition thoracic vertebra, percutaneous approach
- 0QS03ZZ – Reposition lumbar vertebra, percutaneous approach
- 0QS13ZZ – Reposition sacrum, percutaneous approach