CMS Issues 2017 Proposed Hospital Outpatient and ASC Rule: A Summary for Spine Surgeons

[CMS-1656-P] - Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program

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Comment Deadline

CMS is accepting comments on the proposed rule until September 6, 2016 at Regulations.gov. CMS will issue the final rule in early November 2016.

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Overview

On July 6, 2016, the Centers for Medicare & Medicaid Services (CMS) released the 2017 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 6, 2016. The final rule is expected to be released in early November 2016.

(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 1.55 percent. After considering all other policy changes proposed under the OPPS, including estimated spending for pass-through payments, CMS estimates a 1.6 percent payment increase for hospitals paid under the OPPS in 2017. 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 2017, the CPI-U update is projected to be 1.7 percent. The MFP adjustment is projected to be 0.5 percent, resulting in an MFP-adjusted CPI-U update factor of 1.2 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:

APC	Group Title	SI	Relative Weight	Payment Rate
5111	Level 1 Musculoskeletal Procedures	T	2.6324	$197.19
5112	Level 2 Musculoskeletal Procedures	J1	16.2678	$1,218.60
5113	Level 3 Musculoskeletal Procedures	J1	32.3707	$2,424.86
5114	Level 4 Musculoskeletal Procedures	J1	69.4046	$5,199.03
5115	Level 5 Musculoskeletal Procedures	J1	126.7004	$9,491.00
5116	Level 6 Musculoskeletal Procedures	J1	192.8206	$14,444.00

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

New Spine Code Assignments

CMS is accepting public comment on the assignment of new CPT codes under the OPPS and ASC Payment System including comments on the proposed OPPS Ambulatory Payment Classification (APC) assignment, proposed OPPS status indicator assignment, and the proposed ASC payment indicator assignment of the following new spine codes:

CPT Code	Descriptor	Proposed OPPS APC Assignment	Proposed OPPS Status Indicator	Proposed ASC Payment Indicator
228X1	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	5116 - Level 6 Musculoskeletal Procedures	J1 - Hospital Part B services paid through a comprehensive APC	J8 - Device-intensive procedure; paid at adjusted rate
228X2	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level		N - Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment	N1 - Packaged service/item; no separate payment made
228X4	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	5116 - Level 6 Musculoskeletal Procedures	J1 - Hospital Part B services paid through a comprehensive APC	J8 - Device-intensive procedure; paid at adjusted rate

228X5	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level		N - Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment	N1- Packaged service/item; no separate payment made
22X81	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace		N - Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment	Excluded from Payment in ASC
22X82	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges) when performed to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect		N - Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment	Excluded from Payment in ASC
22X83	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect		N - Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment	Excluded from Payment in ASC
630X1	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	5114 - Level 4 Musculoskeletal Procedures	J1 - Hospital Part B services paid through a comprehensive APC	J8 - Device-intensive procedure; paid at adjusted rate

Removal of Spine Codes from the Inpatient-Only List

CMS is proposing to remove the following spine codes from the inpatient-only list:

- CPT 22840 (Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure));
- CPT 22842 (Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure));
- CPT 22845 (Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure));
- CPT 22858 (Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure))

Since these are add-on codes, CMS is proposing to package them with their associated procedure and assign status indicator "N" (i.e. Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.)

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
20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from the same incision (List separately in addition to code for primary procedure)	N1
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	N1
20938	Autograft for spine surgery only (includes harvesting the graft); structural, biocortical or tricortical (through separate skin fascial incision)	N1
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical C2, each additional interspace (List separately in addition to code for separate procedure)	N1
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)	N1
22842	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)	N1
22845	Anterior instrumentation; 2 to 3 vertebral segments	N1
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methlmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)	N1

(Note: Payment Indicator "N1" means the code is packaged into another service/item and no separate payment is made.)
CMS believes that CPT code 22858 (Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure) should continue to be excluded from the ASC list of covered surgical procedures because the procedure would generally be expected to require at least an overnight stay.

Device-Intensive Procedure Policies

CMS is proposing the following two policies regarding device-intensive procedures:

- *Methodology for Assignment of Device-Intensive Status*: Currently, device-intensive procedures are those procedures assigned to a device-intensive APC, which are APCs with a device offset greater than 40 percent. The device offset amount for an APC is the portion of the APC payment amount that is associated with the cost of devices used in procedures assigned to the APC. The device portion of a device-intensive procedure's payment is the same in both the hospital outpatient department and ASC setting. With the recent reorganization of the APCs to include a greater number of procedures, some APCs contain procedures that have high device costs but do not meet the 40 percent device-intensive threshold. Given this outcome, CMS believes that it should change the device-intensive calculation methodology and instead calculate the device offset amount at the CPT code level rather than at the APC level so that device-intensive status is assigned to all device-intensive procedures that exceed the 40 percent threshold.

- *Proposed New Payment Policy for Low Volume Device-Intensive Procedures:* CMS is proposing that the payment rate for any device-intensive procedure that is assigned to an APC with fewer than 100 total claims for all procedures in the APC be based on the median cost instead of the geometric mean cost. CMS believes that this approach will mitigate significant year-to-year payment rate fluctuations while preserving accurate claims-data-based payment rates for low volume device-intensive procedures.

Hospital Value-Based Purchasing Pain Measures

CMS proposes to remove the current pain management questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care survey beginning in 2018 in response to stakeholder feedback that pain management questions should not be used in a program where there is a link between scoring well in the program and higher payments. CMS is developing alternative questions for the Pain Management dimension to address these concerns.

Next Steps

CMS is accepting comments on the proposed rule through September 6, 2016. Comments should be submitted at the following link: https://www.regulations.gov/document?D=CMS-2016-0115-0002 using the "Comment Now!" button on the right side of the page. A final rule is expected to be released in early November 2016.