CMS Issues 2017 Final 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 Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital

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Comment Deadline

CMS is accepting comments on the final rule through December 31, 2016 at Regulations.gov. The final rule goes into effect January 1, 2017.

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Overview

On November 1, 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 final rule. CMS is accepting public comments on the final rule through December 31, 2016 and the final rule goes into effect January 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.)

Final OPPS and ASC Payment Updates

For 2017, CMS is updating OPPS rates by 1.65 percent. After considering all other policy changes proposed under the OPPS, including estimated spending for pass-through payments, CMS estimates a 1.7 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 2.2 percent. The MFP adjustment is projected to be 0.3 percent, resulting in an MFP-adjusted CPI-U update factor of 1.9 percent.

Final OPPS Ambulatory Payment Classifications (APCs)

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. Many spine procedures in the hospital outpatient setting are assigned to

one of the following musculoskeletal APCs:

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	Comprehensive APC?
5111	Level 1 Musculoskeletal Procedures	T	2.6633	$199.75	No
5112	Level 2 Musculoskeletal Procedures	J1	16.2251	$1,216.90	Yes
5113	Level 3 Musculoskeletal Procedures	J1	32.4970	$2,437.31	Yes
5114	Level 4 Musculoskeletal Procedures	J1	69.5906	$5,219.36	Yes
5115	Level 5 Musculoskeletal Procedures	J1	127.4276	$9,557.20	Yes
5116	Level 6 Musculoskeletal Procedures	J1	195.9697	$14,697.92	Yes

(Note: Status Indicator "T" indicates a paid service under the OPPS with separate APC payment. Status indicator "J1" indicates that hospital Part B services are paid through a Comprehensive APC (C-APC). Under a C-APC, CMS packages payment for adjunctive and secondary items, services, and procedures into the most costly primary procedure under the OPPS at the claim level. CMS only makes one payment to the facility for the primary procedure and considers all other items and services reported on the hospital outpatient claim as being integral, ancillary, supportive, dependent, adjunctive, and therefore packaged into the primary service.)

New Spine Code Assignments

CMS is finalizing the assignment of new surgical spine CPT codes going into effect 01/01/17 under the OPPS and ASC Payment Systems:

CPT Code	Descriptor	Final OPPS APC Assignment	Final OPPS Status Indicator	Final ASC Payment Indicator
22867	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 ($14,697.92)	J1 - Hospital Part B services paid through a comprehensive APC	J8 - Device-intensive procedure; paid at adjusted rate ($10,541.98)
22868	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

22869	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 ($14,697.92)	J1 - Hospital Part B services paid through a comprehensive APC	J8 - Device-intensive procedure; paid at adjusted rate ($10,541.98)
22870	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
22853	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.	N1- Packaged service/item; no separate payment made
22854	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.	N1- Packaged service/item; no separate payment made
22859	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.	N1- Packaged service/item; no separate payment made

62380	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 ($5,219.36)	J1 - Hospital Part B services paid through a comprehensive APC	J8 - Device-intensive procedure; paid at adjusted rate ($3,631.80)

Removal of Spine Codes from the Inpatient-Only List

Removal of a code from the inpatient-only list does not mean that all procedures described by the code or even a majority of procedures must or should be performed in the outpatient setting. Removal of a procedure from the inpatient-only list means that the procedure is no longer precluded from being paid under the OPPS if it is performed in the outpatient setting. CMS is removing the following spine codes from the inpatient-only list:

- CPT Code 22585 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure))
- CPT Code 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 Code 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 Code 22845 (Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure));
- 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))

Since these are add-on codes, CMS is packaging them with their associated procedure and assigning 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

Adding codes to list of ASC covered surgical procedures does not mean that all procedures described by the code or even a majority of procedures must or should be performed in the ASC setting; it simply means that the procedure is no longer precluded from being paid under the ASC payment system if it is performed in the ASC setting. CMS is adding the following spine codes to the list of ASC Covered Surgical Procedures:

CPT Code	Long Descriptor	Final 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
22585	(Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; each additional interspace (List separately in addition to code for primary 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
22853	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 (List separately in addition to code for primary procedure)	N1
22854	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 (List separately in addition to code for primary procedure)	N1
22859	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 (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.)

Device-Intensive Procedure Policies

CMS is finalizing 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 is finalizing its proposal to change the device-intensive calculation methodology from calculating the device offset amount at the APC level and instead will calculate the device offset amount at the HCPCS code level so that device-intensive status is assigned to all device-intensive procedures that exceed the 40 percent threshold.

- New Payment Policy for Low Volume Device-Intensive Procedures: CMS is also finalizing a proposal 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.

EHR Incentive Program: 90-Day EHR Reporting Period in 2016 and 2017

CMS is finalizing a 90-day electronic health record (EHR) reporting period in 2016 and 2017 for all returning eligible physicians that have previously demonstrated meaningful use in the Medicare and Medicaid EHR Incentive Programs. The EHR reporting period will be any continuous 90-day period between January 1st and December 31st in 2016 and 2017.

Next Steps

CMS is accepting comments on the final rule through December 31, 2016. Comments should be submitted here using the "Comment Now!" button on the right side of the page. The final rule goes into effect January 1, 2017.