Briefings on APCs

CMS implementing site-neutral payment policies in 2017

CMS made certain concessions from its proposed site-neutral payment policies required by Section 603 of the Bipartisan Budget Act, but it is still moving forward with implementation January 1, 2017, according to the 2017 OPPS final rule.

In the final rule, released November 1, CMS finalized its proposed policy to pay off-campus, provider-based hospital outpatient departments (PBD) that began billing after November 2, 2015, at non-OPPS rates for all items and services provided, as these facilities are considered non-excepted. The good news is that these providers will continue to be able to bill on UB-04 claim forms instead of the CMS-1500 as originally proposed by CMS, says **Jugna Shah, MPH,** president and founder of Nimitt Consulting, Inc.

The final rule references payment occurring under the MPFS for non-excepted items and services, but those MPFS rates are different from the ones used for freestanding physician offices, says Shah. The actual payment rates for non-excepted providers are approximately 50% of the OPPS rates. CMS plans to apply OPPS payment policies (e.g., drug packaging, conditional packaging, comprehensive APCs) to the non-excepted PBDs, but will not apply them to other providers traditionally paid under the MPFS.

“What CMS is implementing is a mixed bag of payment rates and payment policies, and providers will need to keep track of these,” says Shah.

Non-excepted providers will be required to append new HCPCS modifier -PN (non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital) on each UB-04 claim line to receive payment. This finalized policy replaces CMS’ complicated and unsatisfying proposal to pay hospitals for these services through employed or contracted physicians who reassign their billing to their facility. Excepted providers will continue to bill as they have been, continuing to report modifier -PO for off-campus PBDs billing under the OPPS prior to November 2, 2015.

“The agency did not finalize its policy to limit expansion of services for excepted PBDs based on proposed APC clinical families, which is a huge win for providers,” says Shah. “But providers will want to monitor this, since CMS remains very concerned about expansion of services in excepted off-campus PBDs.”

As long as a facility remains excepted, it can continue to bill through the OPPS for all appropriate services, including new services or service lines, but CMS says it intends to monitor this and propose changes based on provider feedback and data.

Despite adding some flexibility for excepted PBDs that must change location due to an emergency, CMS continued to take a hard stance on relocation issues, says Shah.

In the proposed rule, CMS did not allow for any relocated PBD to maintain its exception and continue to bill under the OPPS, but in the final rule, CMS agreed with commenters that in “extraordinary circumstances” requiring relocation, facilities could maintain excepted status by requesting it from CMS regional offices.

Additionally, in some instances, CMS is asking providers to use different CPT®/HCPCS codes to report their services, such as radiation therapy services, depending on whether the PBD is excepted or non-excepted. This is likely to cause confusion and operational burden for providers, says Shah.

C-APCs expanded

Since implementing comprehensive APCs (C-APC) in 2015 to package payment for adjunctive items and services into higher-cost primary procedures at the claim level, CMS has continued to revise the policy and add procedures.

With 37 C-APCs already created, the agency has finalized 25 new C-APCs for 2017 (see Table 1 on p. X). However, the number of CPT codes grouped to these procedures has grown dramatically as a result of the new C-APCs.

“A whopping 1,877 CPT codes are grouped into these newly finalized C-APCs,” says **Valerie Rinkle, MPA,** lead regulatory specialist and instructor for HCPro, a division of BLR, in Middleton, Massachusetts. “As a result of this increase, the number of code combinations that qualify for a C-APC complexity adjustment have significantly increased from 66 in 2016 to 312 in the 2017 final rule.”

The complexity adjustment is applied when a primary procedure assigned to a C-APC is reported with other specified procedures also assigned to C-APCs or with a specified packaged add-on code. When the facility reports one of these combinations, CMS will increase the payable APC to the next higher APC in the clinical group, similar to DRGs on the inpatient side.

While the agency finalized all proposed C-APCs, CMS listened to commenter concerns regarding C-APC 5244 (Level 4 Blood Product Exchange and Related Services), creating a new revenue code and raising the payment rate for the services.

“This is a huge win for providers,” says Shah. “CMS agreed to use only correctly coded claims to set the rate for the C-APC, which means the payment rate went from a proposed rate of about $15,300 to $27,752.”

CMS was persuaded by commenters, as well as presentations made during the summer Hospital Outpatient Payment Panel meeting, to make this change, according to the final rule.

In order to receive payment for the C-APC, which includes CPT code 38240 (hematopoietic progenitor cell; allogeneic transplantation per donor), providers must use CMS’ new revenue code.

“CMS will create this code edit beginning in 2017, which means claims submitted with CPT must also have revenue code 0815 [Allogeneic Stem Cell Acquisition Services], otherwise the claim will be returned to the provider,” says Shah.

CMS also finalized the use of new standard cost center 77 (Allogeneic Stem Cell Acquisition), to be added to Worksheet A and applicable worksheets, with the standard cost center code 07700.

For more information on C-APCs, including a list of C-APCs active for 2017 and associated complexity adjustments, see Addendum J of the final rule.

APC restructuring

Each year, CMS looks at APCs and considers consolidation based on changes in clinical and resource homogeneity. For 2017, the agency revisited APCs it revised just last year. After restructuring the imaging APCs for 2016, CMS is once again consolidating them, reducing them to six APCs from 17 (see Table 2 on p. X). All of the new imaging APCs have been assigned status indicator S (significant procedure; not discounted when multiple).

The agency increased the number of new technology APCs as well, finalizing a proposal to add three new APCs for 2017. The new technology APCs are now:

- 1901, New Technology - Level 49 ($100,001–$120,000)
- 1902, New Technology - Level 49 ($100,001–$120,000)
- 1903, New Technology - Level 50 ($120,001–$140,000)
- 1904, New Technology - Level 50 ($120,001–$140,000)
- 1905, New Technology - Level 51 ($140,001–$160,000)
- 1906, New Technology - Level 51 ($140,001–$160,000)

APCs 1901, 1903, and 1905 have been assigned status indicator S, while APCs 1902, 1904, and 1906 have been assigned status indicator T (significant procedure subject to multiple procedure discounting).

Device payment policy changes

CMS finalized numerous changes to its device-intensive procedure policies, which apply to APCs with a device offset of more than 40%.

The agency finalized its proposal to define device-intensive procedures at the HCPCS code level rather than the APC level. As C-APCs containing multiple procedures have proliferated, CMS deemed the APC level to be too broad. CMS also finalized a policy to define device offsets at the HCPCS level, rather than the APC level, and noted that the majority of commenters supported this new methodology.

Another policy was finalized to deal with payments for new HCPCS codes describing procedures requiring implantation of a device that does not have claims data associated with it. CMS finalized its proposal to apply device-intensive status with a default device offset of 41% in such cases. However, the agency also notes that in certain rare instances, it may temporarily assign a higher offset, if warranted.

As a result of the change to definitions at the HCPCS level, CMS also finalized changes to claims processing edits related to devices. For 2017 and subsequent years, CMS will apply 2016 device coding requirements to device-intensive procedures newly defined at the HCPCS level. Any device code, when reported on a claim with a device-intensive procedure, will satisfy the edit, according to CMS.

CMS stated that a number of commenters asked the agency to reinstate specific device-to-procedure and procedure-to-device edits. While it is not doing that, CMS is introducing a generic HCPCS code to report when a device does not have a specific HCPCS C code.

Effective January 1, providers may report C1889 (implantable/insertable device for device-intensive procedure, not otherwise classified) for devices implanted or inserted during a device-intensive procedure when a specific C code is not available.

CMS finalized a policy to use the implantable device cost-to-charge ratio (CCR) to calculate pass-through device payment for facilities that file cost reports designating that cost center.

Payment rates

CMS is issuing a 1.65% net increase in OPPS payments for 2017 over the current conversion factor. This includes a market basket increase of 2.7%, with reductions of 0.3% and 0.75% due to multifactor productivity and provisions of the Affordable Care Act, respectively.

These numbers do not take into account the 2% reduction in payments for all Medicare fee-for-service claims as a result of sequestration, which has been in place since April 2013. The sequestration reduction will continue until Congress acts.

CMS will continue to reimburse separately payable drugs at average sales price plus 6% and raised the packaging threshold for drugs to $110. The agency did not implement any provisions from its ambitious proposed Part B drug payment model released earlier in the year.