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CY15 OPPS Proposed Rule Fact Sheet

Submission of Comments

This document provides an overview of the Medicare proposed rule for the Outpatient Prospective Payment System (OPPS) for calendar year 2015 (CY15). The proposed rule with comment period is available in the July 14, 2014, *Federal Register*.

CMS must receive comments on the proposed rule by, at 5 p.m. EST on September 2, 2014. When commenting, please refer to file code CMS-1613-P.

Because of staff and resource limitations, CMS cannot accept comments by fax.

You may, and CMS encourages you to, submit electronic comments on the regulation to http://www.regulations.gov**.** Follow the instructions under the "submit a comment" tab.

Written comments may be sent regular mail to the following address:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1613-P
P.O. Box 8013
Baltimore, MD 21244-1850

Written comments can also be sent via express/overnight mail to the following address:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1613-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Overview

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule with comment period updating payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments and establishing payments for services furnished in ambulatory surgical centers (ASCs) beginning in calendar year (CY) January 1, 2015. In addition, CMS proposes changes to the data sources used for expansion requests for physician-owned hospitals, changes to the underlying authority for the requirement of an admission order for all hospital inpatient admissions, the requirement of inpatient admission orders only for long-stay and outlier cases, and the establishment of a three-level appeals process for Medicare Advantage (MA) organizations and Part D sponsors that would be applicable to CMS-identified overpayments. The updated rates do not encorporate the impact of the 2 percent sequestration cuts implemented by Congress to reduce the federal deficit.

Payment Impact

The following table shows the estimated impact of this proposed rule on hospitals after all CY15 updates have been made. CMS provides a more comprehensive table on pages 41071- 41072 of the final rule.

CY15 OPPS Update Impact Table

	All Changes (Percentage)
All Hospitals	2.2
Urban Hospitals	2.2
Rural Hospitals	2.5
Teaching Status	
Non-Teaching	2.1
Minor	1.8
Major	2.9

OPPS Payment Updates

Federal Register pages: 40962-40963

Proposed Update: For CY15, CMS payment rates under the OPPS will increase by the proposed outpatient department (OPD) fee schedule increase factor of **2.1 percent** for those hospitals that submit quality data, and **0.1 percent** for those that do not.

Update Summary: The proposed IPPS market basket percentage increase for FY15 is **2.7** percent. Section 1833(t)(3)(F)(i) of the Act reduces that **2.7** percent by the multifactor productivity adjustment (MFP) described in section 1886(b)(3)(B)(xi)(II) of the Act, which is proposed to be **0.4** percent for CY15 (which is also the proposed MFP adjustment for FY15 in the FY15 IPPS proposed rule). The market basket percentage increase is further reduced by an additional **0.2** resulting in the proposed OPD fee schedule increase factor of **2.1** percent, which CMS is proposing to use in the calculation of the CY15 proposed OPPS conversion factor.

CMS proposes to amend 42 CFR 419.32(b)(1)(iv)(B) by adding a new paragraph (*6*) to reflect the requirement in section 1833(t)(3)(F)(i) of the Act that, for CY15, it would reduce the OPD fee schedule increase factor by the MFP adjustment to reflect the requirement in section 1833(t)(3)(G)(iv) of the Act, as required by section 1833(t)(3)(F)(ii), that it reduce the OPD fee schedule market basket update by an additional **0.2** percent for CY15.

Hospitals that fail to meet the Hospital Outpatient Quality Reporting (OQR) requirements are subject to an additional reduction of **2.0** percent from the market basket update that will be used to calculate the OPPS payment rates for their services. As a result, those hospitals failing to meet the Hospital OQR program reporting requirements will receive an OPD fee schedule increase factor of **0.1** percent (which is 2.7 percent, the proposed estimate of the hospital inpatient market basket percentage increase, less the proposed 0.4 percent market basket percentage increase, the 0.2 percent additional adjustment, and finally the 2.0 percent for the Hospital OQR Program reduction.

The table below reflects the CY15 OPPS proposed payment update calculations for hospitals that submit quality data and those that do not.

Impact of Proposed CY15 OPPS Updates

Market Basket Increase	(Minus) MFP Adjustment	(Minus) Additional Reduction	**FY14 Final Payment Increase**
2.7	0.4	0.2	**2.1**

Impact of Proposed CY15 OPPS Updates (No Quality Data)

Market Basket Increase	(Minus) MFP Adjustment	(Minus) Additional Reduction	(Minus) Hospital OQR Reduction	**FY14 Payment Increase**
2.7	0.4	0.2	2.0	**0.1**

Conversion Factor Update
Federal Register pages 40963

Proposed Update: The proposed conversion factor for CY15 is **$74.176**. To set the OPPS conversion factor for CY15, CMS proposes to increase the CY14 conversion factor of $72.672 by **2.1** percent.

Update Summary: To set the OPPS conversion factor for CY15, CMS would increase the CY14 conversion factor of $72.672 by 2.1 percent. In accordance with section 1833(t)(9)(B) of the Act, CMS is proposing to further adjust the conversion factor for CY15 to ensure that any revisions made to the wage index and rural adjustment are made on a budget neutral basis. CMS is proposing to calculate an overall proposed budget neutrality factor of **0.9998** for wage index changes by comparing proposed total estimated payments from its simulation model using the proposed FY15 IPPS wage indexes to those payments using the FY14 IPPS wage indexes, as

adopted on a calendar year basis for the OPPS. CMS proposes to maintain the current rural adjustment policy. Therefore, the proposed budget neutrality factor for the rural adjustment is **1.0000**.

CMS estimates that pass-through spending for drugs, biologicals, and devices for CY15 would equal approximately $15.5 million, which represents 0.03 percent of total projected CY15 OPPS spending. Therefore, the proposed conversion factor would be adjusted by the difference between the 0.02 percent estimate of pass-through spending for CY14 and the 0.03 percent estimate of pass-through spending for CY15, resulting in a proposed adjustment for CY15 of **0.01 percent**. Finally, estimated payments for outliers would remain at **1.0 percent** of total OPPS payments for CY15.

The proposed OPD fee schedule increase factor of 2.1 percent for CY15, the required proposed wage index budget neutrality adjustment of approximately 0.9998, the proposed cancer hospital payment adjustment of 1.0000, and the proposed adjustment of 0.01 percent of projected OPPS spending for the difference in the pass-through spending result in a proposed conversion factor for CY15 of **$74.176**.

Hospitals that fail to meet the reporting requirements of the Hospital OQR Program would continue to be subject to a further reduction of 2.0 percentage points to the OPD fee schedule increase factor. For hospitals that fail to meet the requirements of the Hospital OQR Program, CMS proposes to make all other adjustments previously discussed, but use a reduced OPD fee schedule update factor of 0.1 percent (that is, the proposed OPD fee schedule increase factor of 2.1 percent further reduced by 2.0 percent). This would result in a proposed reduced conversion factor for CY15 of **$72.692** for hospitals that fail to meet the Hospital OQR requirements (a difference of -$1.484 in the conversion factor relative to hospitals that met the requirements).

Hospital Outpatient Outlier Payments
Federal Register pages: 40970-40971

Proposed Update: The fixed-dollar threshold is **$3,100** for FY15. The FY14 fixed dollar threshold is $2,775.

Update Summary: In order to estimate the CY15 hospital outlier payments for this proposed rule, CMS inflated the charges on the CY13 claims using the same inflation factor of 1.1146 that it used to estimate the IPPS fixed-dollar outlier threshold for the FY15 IPPS/LTCH PPS proposed rule. CMS would apply the same (cost-to-charge ratio) CCR inflation adjustment factor that it proposes to apply for the FY15 IPPS outlier calculation to the CCRs used to simulate the proposed CY15 OPPS outlier payments to determine the fixed-dollar threshold.

CMS is concerned that it could systematically overestimate the OPPS hospital outlier threshold if it did not apply a CCR inflation adjustment factor. Therefore, it proposes to apply the same CCR inflation adjustment factor that it is proposing to apply for the FY15 IPPS outlier calculation to the CCRs used to simulate the proposed CY15 OPPS outlier payments to determine the fixed-dollar threshold. Specifically, for CY15, CMS is proposing to apply an adjustment factor of

0.9813 to the CCRs that were in the April 2014 Outpatient Provider-Specific File (OPSF) to trend them forward from CY14 to CY15. To model hospital outlier payments for this proposed rule, CMS applied the overall CCRs from the April 2014 OPSF file after adjustment (using the proposed CCR inflation adjustment factor of **0.9813** to approximate CY15 CCRs) to charges on CY13 claims that were adjusted (using the proposed charge inflation factor of 1.1146 to approximate CY15 charges).

CMS simulated aggregated CY15 hospital outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple threshold constant and assuming that outlier payments would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY15 OPPS payments. CMS estimated that a proposed fixed-dollar threshold of $3,100, combined with the proposed multiple threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments.

CMS is also proposing that 0.47 percent (or 0.0047 percent of total OPPS payments) of the 1.0 percent for outlier payments be allocated to community mental health centers (CMHCs) for partial hospitalization program (PHP) outlier payments. This is the amount of estimated outlier payments that would result from the proposed CMHC outlier threshold as a proportion of total estimated OPPS outlier payments. For CMHCs, CMS is proposing that, if this facility's cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment rate for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate.

Wage Index Changes
Federal Register pages 40963-40966

Proposed Update: For the CY15 OPPS, frontier state hospitals would receive a wage index of 1.00 if the otherwise applicable wage index (including reclassification, rural and imputed floor, and rural floor budget neutrality) is less than 1.00.

The OPPS labor-related share is 60 percent of the national OPPS payment. CMS is not proposing to change its current regulations, which require the use of FY15 IPPS wage indexes for calculating OPPS payments in CY15.

CMS is not reprinting the proposed FY15 IPPS wage indexes referenced in this discussion of the wage index. Readers are referred to the CMS web site for the OPPS at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

Readers will find a link to the proposed FY15 IPPS wage index tables.

Update Summary: CMS confirmed that this labor-related share for outpatient services is appropriate during its regression analysis for the payment adjustment for rural hospitals in the

CY06 OPPS final rule with comment period. Therefore, it proposes to continue this policy for the CY15 OPPS. *Readers are referred to section II.H. of the proposed rule for a description and example of how the wage index for a particular hospital is used to determine payment for a hospital.*

For FY15, frontier state hospitals would receive a wage index of 1.00 if the otherwise applicable wage index (including reclassification, rural and imputed floor, and rural floor budget neutrality) is less than 1.00. Similar to its current policy for HOPDs that are affiliated with multi-campus hospital systems, the HOPD would receive a wage index based on the geographic location of the specific inpatient hospital with which it is associated. Therefore, if the associated hospital is located in a frontier state, the wage index adjustment applicable for the hospital would also apply for the affiliated HOPD.

For CY15, CMS proposes to continue its policy of allowing non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county. CMS refers readers to the CMS web site for the OPPS at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/HospitalOutpatientPPS/index.html.

At this link, readers will find a link to the proposed FY15 IPPS wage index tables.

Adjustment for Rural SCHs and EACHs
Federal Register pages 40968

Proposed Update: CMS is proposing to continue the adjustment of 7.1 percent to the OPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs). This adjustment will apply to all services paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to cost.

Cancer Hospital Payment Adjustment
Federal Register pages 40968-40970

Proposed Update: For CY15, CMS would continue to provide additional payments to cancer hospitals so that their payment to cost ratio (PCR), after the additional payments, is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data. Based on those data, a target PCR of **0.89** would be used to determine the proposed CY15 cancer hospital payment adjustment to be paid at cost report settlement, which is the same as last year.

Update Summary: For CY15, CMS is proposing to continue its policy to provide additional payments to cancer hospitals so that each facility's final PCR is equal to the "target PCR" for the other OPPS hospitals using the most recent submitted or settled cost report data that are available at the time of the development of the proposed rule. To calculate the proposed CY15 target PCR, CMS used the same extract of cost report data from Healthcare Cost Report Information

System (HCRIS), as discussed in section II.A of the proposed rule, used to estimate costs for the CY15 OPPS. CMS included data from Worksheet E, Part B, for each hospital, using data from each hospital's most recent cost report, whether as submitted or settled.

Using this smaller dataset of cost report data, CMS estimated that, on average, the OPPS payments to other hospitals furnishing services under the OPPS are approximately 89 percent of reasonable cost (weighted average PCR of 0.89). Therefore, CMS is proposing that the payment amount associated with the cancer hospital payment adjustment to be determined at cost report settlement would be the additional payment needed to result in a proposed target PCR equal to 0.89 for each cancer hospital. Table 13 of the proposed rule indicates the estimated percentage increase in OPPS payments to each cancer hospital for CY15 due to the cancer hospital payment adjustment policy. The actual amount of the CY15 cancer hospital payment adjustment for each cancer hospital will be determined at cost report settlement and will depend on each hospital's CY15 payments and costs. CMS notes that changes made by section 1833(t)(18) of the Act do not affect the existing statutory provisions that provide for TOPs for cancer hospitals. The TOPs will be assessed as usual after all payments, including the cancer hospital payment adjustment, have been made for a cost reporting period.

CMS is proposing to calculate a CY15 budget neutrality adjustment factor for the cancer hospital payment adjustment by comparing estimated total CY15 payments under section 1833(t) of the Act, including the proposed CY15 cancer hospital payment adjustment, to estimated CY15 total payments using the CY14 final cancer hospital payment adjustment as required under section 1833(t)(18)(B) of the Act. The CY15 estimated payments applying the proposed CY15 cancer hospital payment adjustment are identical to estimated payments applying the CY14 final cancer hospital payment adjustment. Therefore, CMS would apply a budget neutrality adjustment factor of 1.0000 to the conversion factor for the cancer hospital payment adjustment.

Packaging Policy
Federal Register pages: 40937-409378, 40959-40961

Proposed Update: In the rule, CMS is proposing to package the costs of selected HCPCS codes into payment for services reported with other HCPCS codes where it believes that one code reported an item or service that was integral, ancillary, supportive, dependent, or adjunctive to the provision of care that was reported by another HCPCS code. CMS discusses categories and classes of items and services that it proposes to package beginning in CY15.

Background: The OPPS packages payment for multiple interrelated items and services into a single payment to create incentives for hospitals to furnish services most efficiently and to manage their resources with maximum flexibility. CMS's packaging policies support our strategic goal of using larger payment bundles in the OPPS to maximize hospitals' incentives to provide care in the most efficient manner

Update Summary

Comprehensive APCs

In the CY14 OPPS final rule with comment period, CMS discussed the comprehensive APC policy, which it adopted, with modification, but delayed the implementation of, until CY15. CMS also finalized a comprehensive payment policy that bundles or ''packages'' payment for the most costly medical device implantation procedures under the OPPS at the claim level. CMS defined a comprehensive APC (C–APC) as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. Comprehensive APCs were established as a category broadly for OPPS payment, and 29 comprehensive APCs were established to prospectively pay for 167 of the most costly device-dependent services beginning in CY15.

Device-Dependent Codes

Historically, device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. In the CY14 OPPS final rule CMS provided a list of the 39 APCs recognized as device-dependent APCs and identified 29 device-dependent APCs that are converted to comprehensive APCs. Also, in that rule, CMS finalized a policy to define 29 device-dependent APCs as single complete services and to assign them to comprehensive APCs that provide all-inclusive payments for those services, but delayed implementation of this policy until CY15. For CY15, CMS is proposing to no longer implement procedure-to-device and device-to-procedure edits for any APC. Under the proposal, hospitals are still expected to adhere to the guidelines of correct coding and append the correct device code to the claim, when applicable. The proposed CY15 comprehensive APC policy consolidates and restructures the 39 current device-dependent APCs into 26 (of the total 28) comprehensive APCs, which are listed in ***Appendix 1 of this document*** (Table 5 of the proposed rule). As a result of the proposed CY15 comprehensive APC policy, device-dependent APCs would no longer exist in CY15 because these APCs will have all been converted to comprehensive APCs. Also, CMS is proposing to package all of the procedures described by add-on codes that are currently assigned to device-dependent APCs, which will be replaced by comprehensive APCs. The device-dependent add-on codes that are separately paid in CY14 that CMS is proposing to package in CY15 are listed in ***Appendix 2 of this document*** (Table 9 of the proposed rule).

Conditionally Packaged APCs

Under the OPPS, CMS currently pays separately for certain ancillary services. Some of these ancillary services are currently assigned to status indicator "X," which is defined as "ancillary services," but some other ancillary services are currently assigned to status indicators other than "X." This is because the current use of status indicator "X" in the OPPS is incomplete and imprecise. These ancillary services that have been identified are primarily minor diagnostic tests and procedures that are often performed with a primary service, although there are instances where hospitals provide such services alone and without another primary service during the same encounter. Given that the longstanding OPPS policy is to package items and services that are integral, ancillary, supportive, dependent, or adjunctive to a primary service, CMS stated in the CY14 OPPS final rule that it believes that ancillary services should be packaged when they are

performed with another service, but should continue to be separately paid when performed alone. CMS did not finalize the ancillary packaging policy for CY14 because it believed that further evaluation was necessary.

In the CY15 proposed rule, CMS is proposing to conditionally package certain ancillary services when they are integral, ancillary, supportive, dependent, or adjunctive to a primary service. Specifically, it would limit the initial set of APCs that contain conditionally packaged services to those ancillary service APCs with a proposed geometric mean cost of less than or equal to $100 (prior to application of the conditional packaging status indicator). CMS is doing this in response to public comments on the CY14 ancillary service packaging proposal in which commenters expressed concern that certain low volume but relatively costly ancillary services would have been packaged into high volume but relatively inexpensive primary services (for example, a visit).

CMS notes that the proposed $100 geometric mean cost limit for selecting this initial group of conditionally packaged ancillary service APCs is less than the geometric mean cost of APC 0634, which contains the single clinic visit code G0463, which is a single payment rate for clinic visits beginning in CY14, and has a CY15 OPPS proposed rule geometric mean cost of $102.68. Geometric mean costs can change over time. A change in the geometric mean cost of any of the proposed APCs above $100 in future years would not change the conditionally packaged status of services assigned to the APCs selected in 2015 in a future year. CMS will continue to consider these APCs to be conditionally packaged. However, it will review the conditionally packaged status of ancillary services annually. CMS is also proposing to exclude certain services from this packaging policy even though they are assigned to APCs with a geometric mean cost of ≤ $100. Preventive services will continue to be paid separately, and includes the following services listed in Table 10 of the proposed rule.

TABLE 10.—PREVENTIVE SERVICES EXEMPTED FROM THE ANCILLARY SERVICE PACKAGING POLICY

HCPCS Code	Short Descriptor	APC
76977	Us bone density measure	0340
77078	Ct bone density axial	0260
77080	Dxa bone density axial	0261
77081	Dxa bone density/peripheral	0260
G0117	Glaucoma scrn hgh risk direc	0260
G0118	Glaucoma scrn hgh risk direc	0230
G0130	Single energy x-ray study	0230
G0389	Ultrasound exam aaa screen	0265
G0404	Ekg tracing for initial prev	0450
Q0091	Obtaining screen pap smear	0450

CMS is not proposing to package those psychiatry and counseling related services that it sees are similar to a visit and, at this time, does not consider them to be ancillary services. CMS is also not proposing to package certain low-cost drug administration services, as it is examining various alternative payment policies for drug administration services, including the associated drug administration add-on codes. Under the rule, CMS would delete status indicator "X" (ancillary services) because the majority of the services assigned to status indicator "X" are proposed to be assigned to status indicator "Q1" (STV-Packaged Codes). For the services that are currently assigned status indicator "X" that are not proposed to be conditionally packaged under this policy, CMS will assign those services status indicator "S" (Procedure or Service, Not Discounted When Multiple), indicating separate payment and that the services are not subject to the multiple procedure reduction. The APCs that CMS is proposing for conditional packaging as ancillary services in CY15 are listed in ***Appendix 3 of this document*** (Table 11 of the proposed rule).

Pass-through Payments for Devices
Federal Register pages 40989-40990

Update Summary

Proposed CY15 Policy
At the end of CY15, the device category described by HCPCS code C1841 will have been eligible for pass-through payment for more than two years. Therefore, CMS is proposing an expiration date for pass-through payment for HCPCS code C1841 of December 31, 2015. Effective January 1, 2016, HCPCS code C1841 would no longer be eligible for pass-through payment status. In accordance with its established policy, CMS is proposing to package the cost of HCPCS code C1841 after December 31, 2015, into the costs related to the procedures with which it is reported in its claims data. If it creates new device categories for pass-through payment status during the remainder of CY14 or during CY15, CMS will propose future expiration dates in accordance with the statutory requirement that they be eligible for pass-through payments for at least two years, but not more than three years, from the date on which pass-through payment for any medical device described by the category may first be made.

Provisions for Reducing Transitional Pass-through Payments to Offset Costs Packaged into APC Groups
For CY15, CMS proposes to continue its established methodologies for calculating and estimating pass through payments to estimate the portion of each APC payment rate that could reasonably be attributed to, or reflect, the cost of an associated device eligible for pass-through payment, using claims data from the period used for the most recent recalibration of the APC payment rates. Under the proposal, CMS would continue its policy that the pass-through evaluation process and payment methodology for implantable biologicals that are surgically inserted or implanted and that are newly approved for pass-through status beginning on or after January 1, 2010, be the device pass-through process and payment methodology only.

CMS would also continue to calculate and set the device APC offset amounts for each device category eligible for pass-through payment, and also continue its established policy to review

each new device category on a case-by-case basis to determine whether device costs associated with the new category are already packaged into the existing APC structure. If device costs packaged into the existing APC structure are associated with the new category, CMS would deduct the device APC offset amount from the pass-through payment for the device category.

Finally, CMS is proposing to continue to calculate and set any device APC offset amount for any new device pass-through category that includes a newly eligible implantable biological beginning in CY15 using the same methodology it has historically used. CMS is proposing to update the list of all procedural APCs with the final CY15 portions of the APC payment amounts that it determines are associated with the cost of devices on the CMS web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

Proposed Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices

For CY15, CMS is proposing to continue its existing policy of reducing OPPS payment for specified APCs when a hospital furnishes a specified device without cost or with a full or partial credit. Specifically, for CY15, CMS is proposing to continue to reduce the OPPS payment, for the applicable APCs listed in Table 31 **(*See Appendix 4 of this document*)**, by the full or partial credit a provider receives for a replaced device. Under this proposed policy, hospitals would continue to be required to report the amount of the credit in the amount portion for "FD" when the hospital receives a credit for a replaced device, listed in Table 32 of the rule ***(See Appendix 5 of this document)*** that is 50 percent or greater than the cost of the device.

For CY15, CMS is also proposing to continue using the three criteria established in the CY07 OPPS final rule with comment period for determining the APCs to which its proposed CY15 policy would apply. This criteria includes: (1) all procedures assigned to the selected APCs must involve implantable devices that would be reported if device insertion procedures were performed; (2) the required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedure (at least temporarily); and (3) the device offset amount must be significant, which, for purposes of this policy, is defined as exceeding 40 percent of the APC cost. CMS would continue to restrict the devices to which the APC payment adjustment would apply to a specific set of costly devices to ensure that the adjustment would not be triggered by the implantation of an inexpensive device whose cost would not constitute a significant proportion of the total payment rate for an APC. CMS proposes to update the lists of APCs and devices to which the proposed no cost/full credit and partial credit device adjustment policy would apply for CY15, consistent with the three criteria listed, based on the final CY13 claims data available for the CY15 OPPS final rule.

Payments for Hospital Outpatient Visits

Federal Register pages 41008-41009

Proposed Update: For CY15, CMS is proposing to continue the current policy, adopted in CY14, for clinic and ED visits. HCPCS code G0463 for hospital use only will represent any and

all clinic visits under the OPPS, and will continue to be assigned to APC 0634. CMS will continue to use the five separate HCPCS codes to report ED visits.

Update Summary: CMS is proposing to use CY13 claims data to develop the proposed CY15 OPPS payment rates for HCPCS code G0463 based on the total geometric mean cost of the levels one through five CPT E/M codes for clinic visits currently recognized under the OPPS (CPT codes 99201 through 99205 and 99211 through 99215). As established in the CY14 OPPS final rule with comment period, there is no longer a policy to recognize a distinction between new and established patient clinic visits.

At this time, CMS continues to believe that additional study is needed to assess the most suitable payment structure for ED visits. Therefore, CMS is not proposing any change in ED visit coding for CY15, but would continue to use its existing methodology to recognize the existing CPT codes for Type A ED visits, as well as the five HCPCS codes that apply to Type B ED visits, and establish the CY15 proposed OPPS payment rates using its established standard process. CMS intends to further explore the issues related to ED visits, including concerns about excessively costly patients, such as trauma patients. It may propose changes to the coding and APC assignments for ED visits in future rulemaking.

Partial Hospitalization Payments APC Update
Federal Register pages 41009-41012

Proposed Update: For CY15, CMS is proposing to apply its established policies to calculate the four PHP APC per diem payment rates based on geometric mean per diem costs using the most recent claims data for each provider type.

Update Summary:
For CY15, CMS is proposing to apply its established policies to calculate the four PHP APC per diem payment rates based on geometric mean per diem costs using the most recent claims data for each provider type. CMS computed proposed community mental health center (CMHC) partial hospitalization program (PHP) Ambulatory Payment Classification (APC) geometric mean per diem costs for Level I (three services per day) and Level II (four or more services per day) PHP services using only CY13 CMHC claims data, and proposed hospital-based PHP APC geometric mean per diem costs for Level I and Level II PHP services using only CY13 hospital-based PHP claims data. These proposed geometric mean per diem costs are shown on page 14 of this document (Table 44 of the proposed rule).

TABLE 44.—PROPOSED CY 2015 GEOMETRIC MEAN PER DIEM COSTS FOR CMHC AND HOSPITAL-BASED PHP SERVICES, BASED ON CY 2013 CLAIMS DATA

APC	Group Title	Proposed Geometric Mean Per Diem Costs
0172	Level I Partial Hospitalization (3 services) for CMHCs	$97.43
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$114.93
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$177.32
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$190.21

For CY15, the proposed geometric mean per diem costs for days with three services (Level I) is approximately $97 for CMHCs and approximately $177 for hospital-based PHPs. The proposed geometric mean per diem costs for days with four or more services (Level II) is approximately $115 for CMHCs, and approximately $190 for hospital-based PHPs. The CY15 proposed geometric mean per diem costs for CMHCs calculated under the proposed CY15 methodology using CY13 claims data have remained relatively constant when compared to the CY14 final geometric mean per diem costs for CMHCs established in the CY14 OPPS final rule with comment period, with geometric mean per diem costs for Level I CMHC PHP services decreasing from approximately $99 to approximately $97 for CY15, and geometric mean per diem costs for Level II CMHC PHP services increasing from approximately $112 to approximately $115 for CY15.

The CY15 proposed geometric mean per diem costs for hospital-based PHPs calculated under the proposed CY15 methodology using CY13 claims data show more variation when compared to the CY14 final geometric mean per diem costs for hospital-based PHPs with geometric mean per diem costs for Level I hospital-based PHP services decreasing from approximately $191 to approximately $177 for CY15, and geometric mean per diem costs for Level II hospital-based PHP services decreasing from approximately $214 to approximately $190 for CY15. CMS understands that having little variation in the PHP per diem payment amounts from one year to the next allows providers to more easily plan their fiscal needs. However, CMS believes that it is important to base the PHP payment rates on the claims and cost reports submitted by each provider type so these rates accurately reflect the cost information for these providers. CMS also recognizes that several factors may cause a fluctuation in the per diem payment amounts from year to year, and invites public comments on the causes it provides in the proposed rule.

OPPS Payment Status and Comment Indicators
Federal Register pages 41014-41015

The complete list of the proposed CY15 payment status indicators and their definitions is displayed in Addendum D1 on the CMS web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

The proposed CY15 payment status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, on the CMS web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/HospitalOutpatientPPS/index.html.

Update Summary

CY15 Payment Status Indicator Definitions
In the CY14 OPPS final rule with comment period, CMS created a new status indicator "J1" to identify HCPCS codes that are paid under a comprehensive APC. However, because it delayed implementation of the new comprehensive APC policy until CY15, it also delayed the effective date of payment status indicator "J1" to CY15. A claim with payment status indicator "J1" will trigger a comprehensive APC payment for the claim. CMS refer readers to section II.A.2.e. of the proposed rule for a discussion of implementation of the new comprehensive APC policy.

Under the CY15 proposal, CMS would delete payment status indicator "X," and assign ancillary services that are currently assigned payment status indicator "X" to either payment status indicator "Q1" (Packaged APC payment if billed on same date of service as a HCPCS assigned status indicator S, T, V) or "S" (Significant procedure not subject to multiple procedure discounting; Separate APC payment) CMS is also proposing to revise the definition payment status indicator "Q1" by removing payment status indicator "X" from the packaging criteria, so that codes assigned payment status indicator "Q1" would be designated as STV-packaged, rather than STVX-packaged because payment status indicator "X" is proposed for deletion.

In addition, CMS is proposing to clarify the definition of payment status indicator "E" to state that it applies to items, codes, and services:

- For which pricing is not available;
- Not covered by any Medicare outpatient benefit category;
- Statutorily excluded by Medicare; and
- Not reasonable and necessary.

Regarding items "for which pricing is not available," this applies to drugs and biologicals assigned a HCPCS code but with no available pricing information, for example, wholesale acquisition cost. In reviewing the OPPS status indicators and Addendum D1 for CY15, CMS noticed that there are a few drugs or biologicals that are currently assigned payment status indicator "A", indicating payment under a non-OPPS fee schedule. Based on this proposed change to the status indicators for these drugs, for CY15, CMS proposes to remove the phrase

"EPO for ESRD Patients" from the list of examples for status indicator "A." In addition, it is proposing to clarify the definition of payment status indicator "A" by adding the phrase "separately payable" to nonimplantable prosthetic and orthotic devices.

CY15 Comment Indicator Definitions

For the CY15 OPPS, CMS proposes to use the same two comment indicators that are in effect for the CY14 OPPS:

- "CH"—Active HCPCS codes in current and next calendar year; status indicator and/or APC assignment have changed or active HCPCS code that will be discontinued at the end of the current calendar year.

- "NI"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year as compared to current calendar year, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.

CMS is proposing to use the "CH" comment indicator in the proposed rule to indicate HCPCS codes for which the status indicator or APC assignment, or both, are proposed for change in CY15 compared to their assignment as of June 30, 2014. In addition, it is proposing that any existing HCPCS codes with substantial revisions to the code descriptors for CY15 compared to the CY14 descriptors be labeled with comment indicator "NI" in Addendum B to the CY15 OPPS final rule with comment period. Also, any existing HCPCS codes with substantial revisions to the code descriptors for CY15 compared to the CY14 descriptors would be labeled with comment indicator "NI" in Addendum B to the CY15 OPPS final rule with comment period. Only HCPCS codes with comment indicator "NI" in the CY15 OPPS final rule with comment period are subject to comment. In accordance with its usual practice, CMS is proposing that CPT and Level II HCPCS codes that are new for CY15 also would be labeled with comment indicator "NI" in Addendum B to the CY15 OPPS final rule with comment period. CMS believes that the CY14 definitions of the OPPS comment indicators continue to be appropriate for CY15. Therefore, it would continue to use those definitions without modification. The proposed definitions of the OPPS comment indicators are listed in Addendum D2 on the CMS web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service%20Payment/HospitalOutpatientPPS/index.html.

Comprehensive APCs

Federal Register pages 40922, 40940-40941

Proposed Update: In CY14, CMS established comprehensive APCs as a category broadly for OPPS payment and established 29 comprehensive APCs to prospectively pay for 167 of the most costly device-dependent services beginning in CY15. Under this policy, CMS designated each service described by a HCPCS code assigned to a comprehensive APC as the primary service and, with few exceptions, consider all other services reported on a hospital Medicare Part B claim in combination with the primary service to be related to the delivery of the primary service.

Update Summary: Because a comprehensive APC would treat all individually reported codes as representing components of the comprehensive service, CMS's OPPS proposal is to make a single prospective payment based on the cost of all individually reported codes that represent the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. For CY15, CMS proposes to implement, with several modifications, the policy for comprehensive APCs that was finalized in the CY14 OPPS final rule effective January 1, 2015. Under the proposal, CMS would continue to define the services assigned to comprehensive APCs as primary services, and to define a comprehensive APC as a classification for the provision of a primary service and all adjunctive services and supplies provided to support the delivery of the primary service. CMS would continue to consider the entire hospital stay, defined as all services reported on the hospital claim reporting the primary service, to be one comprehensive service for the provision of a primary service into which all other services appearing on the claim would be packaged. This would result in a single Medicare payment and a single beneficiary copayment under the OPPS for the comprehensive service based on all included charges on the claim.

As proposed in the CY14 OPPS proposed rule for CY15, CMS is proposing to no longer implement procedure-to-device edits and device-to-procedure edits for any APC. Under this proposed policy, which was discussed but not finalized in the CY14 OPPS final rule, hospitals are still expected to adhere to the guidelines of correct coding and append the correct device code to the claim, when applicable. The proposed CY15 comprehensive APC policy consolidates and restructures the 39 current device-dependent APCs into 26 (of the total 28) comprehensive APCs, which are listed in Table 5 of the rule. While CMS believes that device-to-procedure edits and procedure-to-device edits are no longer necessary, it is sensitive to the concerns raised by stakeholders in the past about the costs of devices being reported and captured.

CMS wants to make sure it captures the device costs in the new comprehensive APCs for future rate setting. CMS is proposing to create claims processing edits that require ***any*** of the device codes used in the previous device-to-procedure edits to be present on the claim whenever a procedure code assigned to any 1 of the 26 proposed comprehensive APCs listed in Table 5 of the rule is reported on the claim to ensure that device costs are captured by hospitals. CMS would modify the complexity adjustment criteria finalized last year, proposing lower volume and cost threshold criteria for complexity adjustments. Finally, CMS would package all add-on codes furnished as part of a comprehensive service, which is consistent with its general add-on code packaging policy. However, the add-on codes assigned to the CY14 device-dependent APCs would be be evaluated with a primary service for a potential complexity adjustment.

Hospital OQR Program Updates
Federal Register pages 41032-41044

Proposed Update: In this proposed rule, among other updates, CMS proposes to refine the criteria for determining when a measure is "topped-out." CMS is also proposing to add one claims-based quality measure for the CY17 payment determination and subsequent years. In addition, CMS updates several previously adopted measures, exclude one measure from the measure set for the CY16 payment determination, changing it from required to voluntary for the CY17 payment determination and subsequent years, and formalizes a review and corrections period for chart-abstracted measures.

Update Summary:

Removal of OQR Program Measures for CY17 Payment Determination and Subsequent Years
CMS is proposing to remove the following three measures for the CY17 payment determination and subsequent years:

- OP-4: Aspirin at Arrival (NQF # 0286);
- OP-6: Timing of Antibiotic Prophylaxis; and
- OP-7: Prophylactic Antibiotic Selection for Surgical Patients (NQF # 0528)

Based on its analysis of Hospital OQR Program chart-abstracted measure data for January 1, 2013, to June 30, 2013, (Q1-Q2) encounters, the measures meet both: (1) the previously finalized criteria for being "topped-out," that is, measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made, and (2) the two criteria CMS proposes in section XIII.C.2. of the rule for determining "topped-out" status.

Quality Measures for the CY16 Payment Determination and Subsequent Years
In the CY13 OPPS final rule with comment period, CMS finalized a policy that, beginning CY13, when it adopts measures for the Hospital OQR Program, these measures are automatically adopted for all subsequent years' payment determinations, unless it proposes to remove, suspend, or replace the measures.

The final 27 measure set for the Hospital OQR Program for the CY16 payment determination and subsequent years can be found in Appendix 6 of this document.

In the proposal, CMS notes that it corrects some typographical errors, and makes some clarifications pertaining to certain quality measures that were published in the CY14 OPPS final rule.

- Data Submission Requirements for OP-27: Influenza Vaccination Coverage Among Healthcare Personnel (NQF # 0431)
  The Influenza Vaccination Coverage among Healthcare Personnel (HCP)

(NQF # 0431) was finalized for the Hospital OQR Program in the CY14 OPPS final rule with comment period. In the CY15 proposed rule, CMS corrects the previously stated submission deadline of *October 1, 2014*, instead of October 1, 2015; and clarifies that *hospitals should report the influenza vaccination coverage among the HCP (NQF # 0431) measure by CMS certification number, rather than separately reporting for both the inpatient and outpatient setting*.

- *Delayed Data Collection for OP-29 and OP-30*
  In the CY14 OPPS final rule, CMS adopted chart-abstracted measures OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (NQF # 0558), and OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use (NQF # 0659), and proposed that aggregate data would be collected via an online web-based tool (the QualityNet web site) beginning with the CY16 payment determination. CMS finalized that, for the CY16 payment determination, hospitals would be required to submit aggregate-level encounter data between July 1, 2015, and November 1, 2015, for data collected during January 1, 2014 – December 31, 2014. On December 31, 2013, CMS issued guidance stating that it would delay the implementation of OP-29 and OP-30 for 3 months for the CY16 payment determination, changing the encounter period to April 1, 2014 – December 31, 2014. The data submission window for data collected from April 1, 2014 – December 31, 2014 is still July 1, 2015 – November 1, 2015. The data submission and encounter periods for subsequent years remains as previously finalized. Hospitals are to submit web-based data between July 1st and November 1st of the year prior to a payment determination, with respect to the encounter period of January 1st to December 31st of 2 years prior to a payment determination year.

- *OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery*
  In the CY14 OPPS/ASC final rule with comment period, CMS adopted OP-31 Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (NQF # 1536) for the CY16 payment determination and subsequent years. In that rule, CMS also inadvertently misstated that the measure had been field-tested in the HOPD setting, and *clarifies in the CY15 proposed rule that it has not been field-tested in that setting*. CMS notes that in considering and selecting this measure, it took into account other principles or factors which can be found in the CY14 OPPS final rule.

- *Proposed Voluntary Collection of Data for OP-31 for the CY17 Payment Determination and Subsequent Years*
  CMS continues to believe that this measure addresses an area of care that is not adequately addressed in its current measure set and that the measure serves to drive coordination of care. Further, CMS believes that HOPDs should be a partner in care with physicians and other clinicians using their facility, and this measure provides an opportunity to do so. Therefore, it is continuing to include this measure in the Hospital OQR Program measure set, but proposes that hospitals have the option to voluntarily collect and submit OP-31 data for the CY15 encounter period/CY17 payment

determination and subsequent years. CMS will not subject hospitals to a payment reduction with respect to this measure during the period of voluntary reporting.

Proposed New Quality Measure for the CY17 Payment Determination and Subsequent Years
CMS is proposing to adopt one new claims-based measure into the Hospital OQR Program for the CY17 payment determination and subsequent years: *OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy*. CMS expects the measure would promote improvement in patient care over time because transparency in publicly reporting measure scores will make patient unplanned hospital visits (emergency department visits, observation stays, and inpatient admissions) following colonoscopies more visible to providers and patients and encourage providers to incorporate quality improvement activities in order to reduce these visits. Currently, there are no publicly available quality of care reports for providers or facilities that conduct outpatient colonoscopies. Thus, adoption of this measure provides an opportunity to enhance the information available to patients choosing among providers who offer this elective procedure. Although this measure is not NQF-endorsed, it is currently undergoing the endorsement process. Thus, CMS believes the statutory requirement for included measures to have, to the extent feasible and practicable, been set forth by a national consensus-building entity has been met by the measure being proposed for adoption. The measure was also conditionally supported by the Measure Application Partnership.

The proposed and previously finalized measures for FY17 payment determination and subsequent years are listed in Appendix 7 of this document.

II. AMBULATORY SURGICAL CENTERS (ASCs)

Calculation of the ASC Payment Rates
Federal Register pages 41028-41032

Final Update: The FY15 proposed ASC conversion factor is **$43.918**, for ASCs that meet the quality reporting requirements, and **$43.050** for those that do not. The current CY14 conversion factor is $43.471. Total payments to ASCs (including beneficiary costsharing and estimated changes in enrollment, utilization, and case-mix), for CY15 would be approximately **$4.086 billion**, an increase of approximately $243 million compared to estimated CY14 payments.

Update Summary: Consistent with its final ASC payment policy, for the CY15 ASC payment system, CMS is proposing to calculate and apply a budget neutrality adjustment to the ASC conversion factor for supplier level changes in wage index values for the upcoming year, just as the OPPS wage index budget neutrality adjustment is calculated and applied to the OPPS conversion factor. For CY15, CMS calculated this proposed adjustment for the ASC payment system by using the most recent CY13 claims data available and estimating the difference in total payment that would be created by introducing the proposed CY15 ASC wage indexes. CMS calculated the total adjusted payment using the CY14 ASC wage indexes and the total adjusted payment using the proposed CY15 ASC wage indexes (which reflect the new Office of Management and Budget (OMB) delineations and would include any applicable transition period). CMS then used the 50-percent labor related share for both total adjusted payment

calculations, then compared the total adjusted payment calculated with the CY14 ASC wage indexes to the total adjusted payment calculated with the proposed CY15 ASC wage indexes, and applied the resulting ratio of 0.9983 (the proposed CY15 ASC wage index budget neutrality adjustment) to the CY14 ASC conversion factor to calculate the proposed CY15 ASC conversion factor.

For the proposed rule, based on IHS Global Insight's (IGI's) 2014 first quarter forecast with historical data through 2013 fourth quarter, for the 12-month period ending with the midpoint of CY15, the CPI–U update is projected to be 1.7 percent. Also, based on IGI's 2014 first quarter forecast, the MFP adjustment for the period ending with the midpoint of CY15 is projected to be 0.5 percent. CMS is proposing to reduce the CPI–U update of 1.7 percent by the MFP adjustment of 0.5 percent, resulting in an MFP-adjusted CPI–U update factor of 1.2 percent for ASCs meeting the quality reporting requirements. Therefore, CMS would apply a **1.2 percent** MFP adjusted CPI–U update factor to the CY14 ASC conversion factor for ASCs meeting the quality reporting requirements.

For CY15, CMS is also proposing to adjust the CY14 ASC conversion factor ($43.471) by the proposed wage index budget neutrality factor of 0.9983 in addition to the MFP-adjusted update factor of 1.2 percent, which results in a proposed CY15 ASC conversion factor of **$43.918** for ASCs meeting the quality reporting requirements.

The following table displays the CY15 proposed rate update calculations under the ASC payment system.

CPI-U update	(Minus) MFP Adjustment	**MFP-Adjusted CPI-U Update**
1.7%	0.5%	**1.2%**

For ASCs not meeting the quality reporting requirements, CMS is proposing to adjust the CY14 ASC conversion factor ($43.471) by the proposed wage index budget neutrality factor of 0.9983, in addition to the quality reporting/MFP-adjusted update factor of -0.8, which results in a proposed CY15 ASC conversion factor of **$43.050**. Also, for ASCs that do not meet the quality reporting requirements, CMS would reduce the CPI–U update of 1.7 percent by 2.0 percent, and then apply the 0.5 percent MFP reduction, resulting in a **-0.8 percent** quality reporting/MFP adjusted CPI–U update factor. The proposed ASC conversion factor of **$43.050** for ASCs that do not meet the quality reporting requirements is the product of the CY14 conversion factor of $43.471 multiplied by the wage index budget neutrality adjustment of 1.0009 and the quality reporting/MFP-adjusted CPI-U payment update of -0.8 percent. If more recent data are subsequently available (for example, a more recent estimate of the CY15 CPI–U update and MFP adjustment), CMS would use such data, if appropriate, to determine the CY15 ASC update for the final rule with comment period.

The following table displays the CY15 proposed rate update calculations under the ASC payment system for those ASCs not meeting quality reporting requirements.

CPI-U update	Hospital OQR Reduction	(Minus) MFP Adjustment	**MFP-Adjusted CPI-U Update**
1.7 %	2.0%	0.5%	**-0.8 %**

Addenda AA and BB to the proposed rule (which are available via the internet on the CMS web site) display the proposed updated ASC payment rates for CY15 for covered surgical procedures and covered ancillary services, respectively. The payment rates included in these addenda reflect the full ASC payment update and not the reduced payment update used to calculate payment rates for ASCs not meeting the quality reporting requirements under the ambulatory surgical center quality reporting (ASCQR) Program. These addenda contain several types of information related to the proposed CY15 payment rates.

Payment for Covered Ancillary Services
Federal Register pages 41025-41027

Update Summary: For CY15, CMS is proposing to update the ASC payment rates and to make changes to ASC payment indicators as necessary to maintain consistency between the OPPS and ASC payment system regarding the packaged or separately payable status of services, and the proposed CY15 OPPS and ASC payment rates. CMS is also proposing to continue to set the CY15 ASC payment rates for brachytherapy sources and separately payable drugs and biologicals equal to the proposed OPPS payment rates for CY15. The CY15 payment for separately payable covered radiology services would be based on a comparison of the proposed CY15 MPFS nonfacility practice expense relative value unit-based amounts (CMS refers readers to the CY15 MPFS proposed rule) and the proposed CY15 ASC payment rates calculated according to the ASC standard ratesetting methodology, and then set at the lower of the two amounts. Payment for a radiology service would be packaged into the payment for the ASC covered surgical procedure if the radiology service is packaged or conditionally packaged under the OPPS. Also, CMS proposes that, beginning in CY15, certain diagnostic tests within the medicine range of CPT codes for which separate payment is allowed under the OPPS be covered ancillary services when they are integral to an ASC covered surgical procedure. CMS believes that adopting such a payment policy is reasonable and appropriate to ensure access to these tests in ASCs and is consistent with the OPPS.

Finally, CMS has identified one diagnostic test that is within the medicine range of CPT codes, and for which separate payment is allowed under the OPPS: *CPT code 91035 (Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation)*. CMS is proposing to add this code to the list of ASC covered ancillary services, and proposes separate ASC payment as a covered ancillary service for this code beginning in CY15 in cases where the test is integral to an ASC covered surgical procedure. CMS expects the procedure described by CPT code 91035 to be integral to the endoscopic attachment of the electrode to the esophageal mucosa. Most covered ancillary services and their proposed payment indicators are listed in Addendum BB to the proposed rule (which is available on the CMS web site).

Ambulatory Surgical Center Quality Reporting (ASCQR) Program Requirements
Federal Register pages 41044-41052

Proposed Update: CMS proposes to adopt one new quality measure for the CY17 payment determination and subsequent years, exclude one measure that it previously adopted for the CY16 measure set, requiring that it be voluntarily reported for the CY17 payment determination and subsequent years, rather than reported mandatorily. In addition, CMS is proposing to define the data collection timeframes and submission deadlines for one previously adopted measure, discuss the delayed data collection of two measures for the CY16 payment determination, and clarify how it refers to the extraordinary circumstances extensions or exemptions process.

See Appendix 2 of the FY14 OPPS Final Rule Fact Sheet for tables containing CY14 and CY15 Hospital OQR Program Measures.

Update Summary:

ASCQR Program Quality Measures Adopted in Previous Rulemaking
In the CY12 OPPS final rule with comment period, CMS finalized its proposal to implement the ASCQR Program beginning with the CY14 payment determination. In that rule, CMS also adopted five claims-based measures for the CY14 payment determination and subsequent years, two measures with data submission via an online web page for the CY15 payment determination and subsequent years, and one process of care measure for the CY16 payment determination and subsequent years).

In the CY14 OPPS final rule with comment period, CMS adopted three chart-abstracted measures for the CY16 payment determination and subsequent years. The quality measures that CMS has previously adopted are listed below.

ASC PROGRAM MEASURE SET PREVIOUSLY ADOPTED FOR THE CY 2016 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

ASC No.	NQF No.	Measure name
ASC–1	0263	Patient Burn.
ASC–2	0266	Patient Fall.
ASC–3	0267	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant.
ASC–4	0265	Hospital Transfer/Admission.
ASC–5	0264	Prophylactic Intravenous (IV) Antibiotic Timing.
ASC–6	N/A	Safe Surgery Checklist Use.
ASC–7	N/A	ASC Facility Volume Data on Selected ASC Surgical Procedures. Procedure categories and corresponding HCPCS codes are located at: *http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772475754.*
ASC–8	0431	Influenza Vaccination Coverage among Healthcare Personnel.
ASC–9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients.
ASC–10	0659	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use.
ASC–11	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.*

*We are proposing voluntary data collection starting in CY 2017 for this previously adopted measure in section XIV.E.3.c. of this proposed rule.

Proposed Exclusion for ASC–11 for the CY16 Payment Determination

CMS is proposing to exclude *ASC–11 Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery* (NQF #1536) from the CY16 payment determination measure set because it believes that it may be operationally difficult at this time for ASCs to collect and report this measure. CMS will continue to include this measure in the ASCQR Program measure set for the CY17 payment determination, but because of its concerns, it proposes that data collection and submission for this measure be voluntary. As such, ASCs would not be subject to a payment reduction for failing to report this measure during the period of voluntary reporting. For ASCs that choose to submit data, CMS continues to request that they submit it using the means and timelines finalized in the CY14 OPPS final rule.

Proposed New ASCQR Program Quality Measure for the CY17

CMS proposes to adopt one new claims-based measure into the ASCQR Program for the CY17 payment determination and subsequent years: *ASC–12: Facility Seven-Day Risk- Standardized Hospital Visit Rate after Outpatient Colonoscopy*. CMS expects the measure would promote improvement in patient care over time because transparency in publicly reporting measure scores would make patient unplanned hospital visits following colonoscopies more visible to ASCs and patients, and incentivize ASCs to incorporate quality improvement activities in order to reduce these visits. In addition, providing outcome rates to ASCs would make visible to clinicians meaningful quality differences and incentivize improvement. For this measure, which uses ASC Medicare claims data and does not require any additional data submission, such as Quality Data Codes, CMS would use paid Medicare fee-for-service claims from a 12-month period from July 1 of the year 3 years before the payment determination year, to June 30 of the following year. Thus, for the CY17 payment determination for this measure, claims from July 1, 2014, to June 30, 2015, would be used.

If the proposal is finalized, the measure set for the ASCQR Program CY17 payment determination and subsequent years would be as listed below:

PROPOSED ASC PROGRAM MEASURE SET FOR THE CY 2017 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

ASC No.	NQF No.	Measure name
ASC–1	0263	Patient Burn.
ASC–2	0266	Patient Fall.
ASC–3	0267	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant.
ASC–4	0265	Hospital Transfer/Admission.
ASC–5	0264	Prophylactic Intravenous (IV) Antibiotic Timing.
ASC–6	N/A	Safe Surgery Checklist Use.
ASC–7	N/A	ASC Facility Volume Data on Selected ASC Surgical Procedures. Procedure categories and corresponding HCPCS codes are located at: *http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772475754*.
ASC–8	0431	Influenza Vaccination Coverage among Healthcare Personnel.
ASC–9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients.
ASC–10	0659	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use.
ASC–11.	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.*
ASC–12	Pending	Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.**

*We are proposing voluntary data collection for this previously adopted measure in section XIV.E.3.c. of this proposed rule.
**New measure proposed for CY 2017 payment determination and subsequent years.

Collection Periods for Measures for the CY14 and CY15 Payment Determination

In the FY13 IPPS final rule, CMS adopted a policy that claims for services furnished between October 1, 2012, and December 31, 2012, would have to be paid by the administrative contractor by April 30, 2013, to be included in the data used for the CY14 payment determination. For the CY15 payment determination and subsequent years, an ASC must submit complete data on individual claims-based quality measures through a claims-based reporting mechanism by submitting the appropriate quality data codes (QDCs) on the ASC's Medicare claims. The data collection period for such claims-based quality measures is the calendar year 2 years prior to a payment determination year. Only claims for services furnished in each calendar year paid by the administrative contractor by April 30th of the following year of the ending data collection time period would be included in the data used for the payment determination year. Therefore, for example, only claims for services furnished in CY13 (January 1, 2013, through December 31, 2013) paid by the administrative contractor by April 30, 2014, would be included in the data used for the CY15 payment determination.

Data Collection Timeframes for the CY17 Payment Determination and Proposed Submission Deadlines for the CY16 Payment Determination

In the CY12 OPPS final rule, CMS finalized that data collection for the CY16 payment determination would be from October 1, 2014, through, March 31, 2015 (the 2014–2015 influenza season data). CMS is proposing that for the CY17 payment determination and subsequent years, ASCs would collect data from October 1st of the year 2 years prior to the payment determination year to March 31st of the year prior to the payment determination year. In the CY14 OPPS proposed rule, CMS proposed that ASCs would have until August 15, 2015, to submit their 2014–2015 influenza season data (October 1, 2014, through March 31, 2015) to the National Healthcare Safety Network. Due to the concerns expressed by commenters, CMS did not finalize this deadline, but stated that it intended to propose a submission deadline for this measure for the CY16 payment determination in the 2015 OPPS proposed rule. Thus, CMS is proposing that May 15 of the year in which the influenza season ends be the submission deadline for each payment determination year, similar to the Hospital IQR and OQR Programs. For example, for the CY16 payment determination, ASCs would be required to submit their 2014–2015 influenza season data (October 1, 2014, through March 31, 2015) by May 15, 2015. Similarly, for the CY17 payment determination, ASCs would be required to submit their 2015–2016 influenza season data (October 1, 2015, through March 31, 2016) by May 15, 2016.

Delayed Data Collection for OP–29 and OP–30

In the CY14 OPPS final rule, CMS adopted chart abstracted measures *OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients* (NQF #0558) and *OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps--Avoidance of Inappropriate Use* (NQF #0659), and proposed that aggregate data be collected via the QualityNet web site beginning with the CY16 payment determination. On December 31, 2013, CMS issued guidance stating that it would delay the implementation of OP–29 and OP– 30 for 3 months for the CY16 payment determination, changing the encounter period from January 1, 2014–December 31, 2014, to April 1, 2014–December 31, 2014. The data submission window for data collected from April 1, 2014–

December 31, 2014, is still July 1, 2015–November 1, 2015. Hospitals are to submit web based data between July 1st and November 1st of the year prior to a payment determination with respect to the encounter period of January 1st to December 31st of 2 years prior to a payment determination year.

Revision of the Requirements for Physician Certification of Hospital Inpatient Services
Federal Register pages 41056-41058

Proposed Update: In the rule, CMS proposes changes to the underlying authority for the requirement of an admission order for all hospital inpatient admissions and changes to require physician certification for hospital inpatient admissions only for long-stay cases and outlier cases.

Background: In the FY14 IPPS proposed rule, CMS discussed the statutory requirement for certification of hospital inpatient services for payment under Medicare Part A. The certification requirement for inpatient services other than psychiatric inpatient services, found in section 1814(a)(3) of the Act, provides that Medicare Part A payment will only be made for such services ''which are furnished over a period of time, [if] a physician certifies that such services are required to be given on an inpatient basis." In commenting on the proposal, some commenters argued that the statutory reference to services furnished ''over a period of time'' and the then-existing regulation's lack of any specific deadline for physician certifications in nonoutlier cases indicate that no certification is required for short-stay cases. CMS notes that it does not agree with the assertion that the only possible interpretation of the statute is that the requirement for physician certification only applies to long-stay cases, in part, because the statute does not define ''over a period of time.''

In its current regulations, CMS has interpreted the statute's requirement of a physician certification for inpatient hospital services furnished ''over a period of time'' to apply to all inpatient admissions. While this is not the only possible interpretation of the statute, CMS believes that it is a permissible interpretation. CMS also continues to believe that the requirement of an order from a physician or other qualified practitioner in order to trigger an inpatient hospital admission is necessary for all inpatient admissions. As described more fully in the FY14 IPPS final rule, the requirement for a physician order for a hospital inpatient admission has long been clear in the Medicare hospital conditions of participation, and CMS promulgated § 412.3 to make more explicit that admission pursuant to this order is the means whereby a beneficiary becomes a hospital inpatient and, therefore, is required for payment of hospital inpatient services under Medicare Part A.

However, as CMS looks to achieve its policy goals with the minimum administrative requirements necessary, and after considering previous public comments and its experience with existing regulations, CMS believes that, in the majority of cases, the additional benefits (for example, as a program safeguard) of formally requiring a physician certification may not outweigh the associated administrative requirements placed on hospitals. Therefore, while CMS continues to believe that the inpatient admission order is necessary for all inpatient admissions, it is also proposing to require such orders as a condition of payment based upon its general

rulemaking authority under section 1871 of the Act rather than as an element of the physician certification.

Update Summary: As CMS is proposing to rely on a different statutory authority for this regulation, an admission order would no longer be a required component of physician certification of medical necessity. As to the physician certification requirement, CMS maintains that its existing longstanding policy is based upon a permissible interpretation of section 1814(a)(3) of the Act pursuant to that provision's express delegation of authority to the agency to determine the circumstances under which such certification should be required. Nonetheless, CMS proposes to change its interpretation of section 1814(a)(3) of the Act to require a physician certification only for long-stay cases and outlier cases. CMS believes that, in most cases, the admission order, medical record, and progress notes will contain sufficient information to support the medical necessity of an inpatient admission without a separate requirement of an additional, formal, physician certification. However, it believes that evidence of additional review and documentation by a treating physician beyond the admission order is necessary to substantiate the continued medical necessity of long or costly inpatient stays.

Specifically, CMS proposes to revise paragraph (a) of § 424.13 to specify that ''Medicare Part A pays for inpatient hospital services (other than inpatient psychiatric facility services) for cases that are 20 inpatient days or more, or are outlier cases under subpart F of Part 412 of this chapter, only if a physician certifies or recertifies the following:

1. The reasons for either:
    a. Continued hospitalization of the patient for medical treatment or medically required diagnostic study; or
    b. Special or unusual services for cost outlier cases (under the prospective payment system set forth in subpart F of part 412 of this chapter).
2. The estimated time the patient will need to remain in the hospital.
3. The plans for post-hospital care, if appropriate.

CMS would also revise paragraph (b) of § 424.13 to specify that certifications for long-stay cases must be furnished no later than 20 days into the hospital stay. CMS is not proposing changes to the certification requirements for inpatient psychiatric hospital services. Also, as discussed more fully in the FY14 IPPS final rule, there also are inherent differences in the operation of and beneficiary admission to Inpatient Rehabilitation Facility (IRFs). Therefore, CMS also is not proposing any changes to the admission requirements for IRFs.

CMS-Identified Overpayments Associated With Payment Data Submitted by Medicare Advantage (MA) Organizations and Medicare Part D Sponsors

Federal Register, pages 41058-41063

Background: Medicare Part C and Part D payments to Medicare Advantage (MA) organizations and Part D sponsors are determined, in part, using data submitted to CMS by the MA organizations and Part D sponsors. These ''payment data'' include diagnosis data that are used by CMS to risk adjust Part C and Part D payments, prescription drug event data that are used by

CMS to cost reconcile various Part D subsidies, as well as other types of data. Through its review and oversight of payment data submitted by MA organizations and Part D sponsors, CMS identified situations where MA organizations and/or Part D sponsors have submitted payment data to CMS that should not have been submitted--either because the data are inaccurate or inconsistent with Part C and Part D requirements which CMS refers to as ''erroneous payment data.''

If a MA organization or Part D sponsor submits erroneous payment data to CMS, these entities can address errors by submitting corrected data to the CMS payment systems. CMS's approach thus far to these kinds of situations has been to request that MA organizations and Part D sponsors make these kinds of data corrections voluntarily. However, in instances in which the MA organization or Part D sponsor fails to make the requested data correction, the payment amount calculated for the plan may also be incorrect. As a result, CMS has concluded that it needs to establish a formal process that allows it to recoup overpayments that result from the submission of erroneous payment data. CMS notes that the proposed new process is not intended to replace established recovery and appeals processes, such as the Risk Adjustment Data Validation audit dispute and appeal process, or the Part D payment appeals process. It would not constitute a change to the existing Part C or Part D payment methodologies. Rather, CMS merely proposes to adopt a procedural mechanism for recouping overpayments that it will use in those limited circumstances when an MA organization or Part D sponsor fails to correct erroneous payment data.

Update Summary: Under the proposal, CMS would establish regulations relating to MA organizations, and Part D sponsors that would specify the procedural mechanism used by CMS to recoup overpayments associated with errors identified by CMS in payment data submitted by MA organizations and Part D sponsors. CMS also proposes to create a process whereby an MA organization or Part D sponsor can appeal the finding that payment data are erroneous.

Proposed Definitions of ''Payment Data'' and ''Applicable Reconciliation Date''
CMS is proposing to define ''payment data'' to mean data controlled and submitted to CMS by an MA organization or a Part D sponsor that is used for payment purposes. The MA organization or Part D sponsor is responsible for the accuracy of such data. For MA organizations under Part C, CMS is proposing that the ''applicable reconciliation date'' occurs on the date of the annual final risk adjustment data submission deadline. By proposing that the applicable reconciliation date occurs on the risk adjustment data submission deadline, CMS intends to signal that the normal payment process for the year has been concluded. For Part D sponsors, the ''applicable reconciliation date'' would be the later of either: the annual deadline for submitting PDE data for the annual Part D payment reconciliations, or the annual deadline for submitting DIR data.

Request for Corrections of Payment Data
Under the proposal, if CMS identifies an error in payment data submitted by an MA organization or Part D sponsor that would result in an overpayment, CMS would be able to request that the organization make corrections to the applicable payment data. CMS would make the request through a data correction notice that would contain or make reference to the specific payment data that it identifies as erroneous, the reason why the payment data are believed to be erroneous,

and the timeframe in which the MA organization or Part D sponsor must make corrections to the data. CMS may identify payment data that need to be corrected through a variety of different mechanisms, including, but not limited to, CMS analyses of payment data, CMS audits, or communications with the MA organization or Part D sponsor. CMS would request corrections to erroneous payment data only if the erroneous data affects payments for one or more of the 6 most recently completed payment years. The timeframes for correcting payment data would be the same as the current practice for correcting payment data, and would be explained in additional procedural rules and subregulatory guidance, as necessary.

Proposed Payment Offset

If the MA organization or Part D sponsor submits corrected payment data in response to CMS's request, CMS' systems will conduct a payment reconciliation process, and determine the associated payment adjustment based on the corrected data using established payment procedures. However, if the MA organization or Part D sponsor fails to correct the erroneous payment data, CMS would conduct a payment offset from plan payments. CMS would determine the overpayment offset amount by applying a payment calculation algorithm to simulate the payment calculations currently applied by CMS to produce the routine Part C and Part D payments. The payment calculation algorithm would apply the Part C or Part D payment rules for the applicable year to calculate what the correct payment should have been using corrected payment data. The actual process for calculating the overpayment will be different for Part C and Part D due to the different payment rules for the two programs. In the proposal, CMS provides examples of how the offset amount would be calculated for Part C and Part D relative to two different types of payment data errors.

Payment Offset Notification and Appeals Process

CMS would provide a payment offset notice to the MA organization or Part D sponsor, that would provide the dollar amount to be offset against a plan's monthly prospective payments, an explanation of how the erroneous data were identified, and the calculation of the payment offset amount. The notice would also explain that, in the event the MA organization or Part D sponsor disagrees with the payment offset, it may request an appeal within 30 days of the issuance of the payment offset notice. CMS proposes an appeals process for MA organizations and Part D sponsors with three levels of review, including reconsideration request, which must be filed within 30 days from the date that the payment offset notice was issued, an informal hearing request, which must be made in writing and filed within 30 days of the date of CMS' reconsideration decision, or an Administrator's review of the hearing officer's decision, which may be requested within 30 days of issuance.

More Information

The proposed rule is available in the July 14, 2014, *Federal Register*. Additional information regarding the OPPS is available on the CMS web site.

Appendix 1: *Proposed CY15 comprehensive APCs*

TABLE 5—PROPOSED APCS THAT WOULD REQUIRE A DEVICE CODE TO BE REPORTED ON A CLAIM WHEN A PROCEDURE ASSIGNED TO ONE OF THESE APCS IS REPORTED

APC	APC Title
0039.	Level III Neurostimulator.
0061	Level II Neurostimulator.

APC	APC Title
0083	Level I Endovascular.
0084	Level I EP.
0085	Level II EP.
0086	Level III EP.
0089	Level III Pacemaker.
0090	Level II Pacemaker.
0107	Level I ICD.
0108	Level II ICD.
0202	Level V Female Reproductive.
0227	Implantation of Drug Infusion.
0229	Level II Endovascular.
0259	Level VII ENT Procedures.
0293	Level IV Intraocular.
0318	Level IV Neurostimulator.
0319	Level III Endovascular.
0384	GI Procedures with Stents.
0385	Level I Urogenital.
0386	Level II Urogenital.
0425	Level V Musculoskeletal.
0427	Level II Tube/Catheter.
0622	Level II Vascular Access.
0648	Level IV Breast Surgery.
0652	Insertion of IP/PI. Cath.
0655	Level IV Pacemaker.

Appendix 2: Add-on Codes for Device-dependent APCs to be Packaged in CY15

TABLE 9—ADD-ON CODES ASSIGNED TO DEVICE-DEPENDENT APCS FOR CY 2014 THAT ARE PROPOSED TO BE PACKAGED IN CY 2015

CY 2014 Add-on code	Short descriptor	CY 2014 APC
19297	Place breast cath for rad	0648
33225	L ventric pacing lead add-on	0655
37222	Iliac revasc add-on	0083
37223	Iliac revasc w/stent add-on	0083
37232	Tib/per revasc add-on	0083
37233	Tib/per revasc w/ather add-on	0229
37234	Revsc opn/prq tib/pero stent	0083
37235	Tib/per revasc stnt & ather	0083
37237	Open/perq place stent ea add	0083
37239	Open/perq place stent ea add	0083
49435	Insert subq exten to ip cath	0427
92921	Prq cardiac angio addl art	0083
92925	Prq card angio/athrect addl	0082
92929	Prq card stent w/angio addl	0104
92934	Prq card stent/ath/angio	0104
92938	Prq revasc byp graft addl	0104
92944	Prq card revasc chronic addl	0104
92998	Pul art balloon repr precut	0083
C9601	Perc drug-el cor stent bran	0656
C9603	Perc d-e cor stent ather br	0656
C9605	Perc d-e cor revasc t cabg b	0656
C9608	Perc d-e cor revasc chro add	0656

Appendix 3: CY15 APCs for Conditional Packaging as Ancillary Services

TABLE 11—APCS FOR PROPOSED CONDITIONALLY PACKAGED ANCILLARY SERVICES FOR CY 2015

APC	Proposed CY 2015 OPPS geometric mean cost	Proposed CY 2015 OPPS SI	Group title
0012	$76.29	Q1	Level I Debridement & Destruction.
0060	20.64	Q1	Manipulation Therapy.
0077	52.08	Q1	Level I Pulmonary Treatment.
0099	81.27	Q1	Electrocardiograms/Cardiography.
0215	104.63	Q1	Level I Nerve and Muscle Services.
0230	55.00	Q1	Level I Eye Tests & Treatments.
0260	62.43	Q1	Level I Plain Film Including Bone Density Measurement.
0261	99.85	Q1	Level II Plain Film Including Bone Density Measurement.
0265	96.51	Q1	Level I Diagnostic and Screening Ultrasound.
0340	64.78	Q1	Level II Minor Procedures.

TABLE 11—APCS FOR PROPOSED CONDITIONALLY PACKAGED ANCILLARY SERVICES FOR CY 2015—Continued

APC	Proposed CY 2015 OPPS geometric mean cost	Proposed CY 2015 OPPS SI	Group title
0342	56.99	Q1	Level I Pathology.
0345	78.83	Q1	Level I Transfusion Laboratory Procedures.
0364	42.69	Q1	Level I Audiometry.
0365	123.21	Q1	Level II Audiometry.
0367	166.31	Q1	Level I Pulmonary Tests.
0420	130.93	Q1	Level III Minor Procedures.
0433	190.21	Q1	Level II Pathology.
0450	29.91	Q1	Level I Minor Procedures.
0624	83.61	Q1	Phlebotomy and Minor Vascular Access Device Procedures.
0690	37.25	Q1	Level I Electronic Analysis of Devices.
0698	106.17	Q1	Level II Eye Tests & Treatments.

Appendix 4: CY15 Proposed No Cost/Full Credit/Partial Credit Device APCs

TABLE 31—PROPOSED APCS TO WHICH THE PROPOSED NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE PAYMENT ADJUSTMENT POLICY WOULD APPLY IN CY 2015

Proposed CY 2015 APC	Proposed CY 2015 APC title
0039	Level III Neurostimulator & Related Procedures.
0061	Level II Neurostimulator & Related Procedures.
0064	Level III Treatment Fracture/Dislocation.
0089	Level III Pacemaker and Similar Procedures.
0090	Level II Pacemaker and Similar Procedures.
0107	Level I ICD and Similar Procedures.
0108	Level II ICD and Similar Procedures.
0227	Implantation of Drug Infusion Device.
0229	Level II Endovascular Procedures.
0259	Level VII ENT Procedures.
0293	Level IV Intraocular Procedures.
0318	Level IV Neurostimulator & Related Procedures.
0319	Level III Endovascular Procedures.
0351	Level V Intraocular Procedures.
0385	Level I Urogenital Procedures.
0386	Level II Urogenital Procedures.
0425	Level V Musculoskeletal Procedures Except Hand and Foot.
0434	Cardiac Defect Repair.
0655	Level IV Pacemaker and Similar Procedures.

Appendix 5: CY15 Proposed Replaced Device for which No Cost/Full Credit/Partial Credit Applies

TABLE 32—PROPOSED DEVICES TO WHICH THE PROPOSED NO COST/ FULL CREDIT AND PARTIAL CREDIT DEVICE PAYMENT ADJUSTMENT POLICY WOULD APPLY IN CY 2015

Proposed CY 2015 device HCPCS code	Proposed CY 2015 short descriptor
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1728	Cath, brachytx seed adm.
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.
C1772	Infusion pump, programmable.
C1776	Joint device (implantable).
C1777	Lead, AICD, endo single coil.
C1778	Lead, neurostimulator.
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.
C1786	Pmkr, single, rate-resp.
C1789	Prosthesis, breast, imp.
C1813	Prosthesis, penile, inflatab.
C1815	Pros, urinary sph, imp.
C1818	Integrated keratoprosthesis.
C1820	Generator, neuro rechg bat sys.
C1840	Lens, intraocular (telescopic).
C1881	Dialysis access system.
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.
C1895	Lead, AICD, endo dual coil.
C1896	Lead, AICD, non sing/dual.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1899	Lead, pmkr/AICD combination.
C1900	Lead coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.
C2622	Prosthesis, penile, non-inf.
C2626	Infusion pump, non-prog, temp.
C2631	Rep dev, urinary, w/o sling.

Appendix 6 – Final CY16 and Subsequent Years Hospital OQR Program Measures

HOSPITAL OQR PROGRAM MEASURE SET PREVIOUSLY ADOPTED FOR THE CY 2016 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

NQF No.	Measure name
N/A	OP–1: Median Time to Fibrinolysis.
0288	OP–2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival****.
0290	OP–3: Median Time to Transfer to Another Facility for Acute Coronary Intervention.
0286	OP–4: Aspirin at Arrival**.
0289	OP–5: Median Time to ECG.
N/A	OP–6: Timing of Prophylactic Antibiotics**.
0528	OP–7: Prophylactic Antibiotic Selection for Surgical Patients**.
0514	OP–8: MRI Lumbar Spine for Low Back Pain.
N/A	OP–9: Mammography Follow-up Rates.
N/A	OP–10: Abdomen CT—Use of Contrast Material.
0513	OP–11: Thorax CT—Use of Contrast Material.
N/A	OP–12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data.
0669	OP–13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery.
N/A	OP–14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT).
N/A	OP–15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache.
N/A	OP–17: Tracking Clinical Results between Visits.
0496	OP–18: Median Time from ED Arrival to ED Departure for Discharged ED Patients.
N/A	OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional.

HOSPITAL OQR PROGRAM MEASURE SET PREVIOUSLY ADOPTED FOR THE CY 2016 PAYMENT DETERMINATION AND SUBSEQUENT YEARS—Continued

NQF No.	Measure name
0662	OP–21: Median Time to Pain Management for Long Bone Fracture.
N/A	OP–22: ED—Left Without Being Seen****.
0661	OP–23: ED—Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of Arrival.
N/A	OP–25: Safe Surgery Checklist Use.
N/A	OP–26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures*.
0431	OP–27: Influenza Vaccination Coverage among Healthcare Personnel.
0658	OP–29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients.
0659	OP–30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use.
1536	OP–31: Cataracts—Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery***.

*OP–26: Procedure categories and corresponding HCPCS codes are located at: *http://qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228889963089&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D1r_OP26MIF_v+6+0b.pdf&blobcol=urldata&blobtable=MungoBlobs.*

**Measures we are proposing for removal beginning with the CY 2017 payment determination in section XIII.C.3. of this proposed rule.

***Measure we are proposing for voluntary data collection in section XIII.D.3.b. of this proposed rule.

****Name has been updated to correspond with NQF-endorsed name.

Appendix 7: Proposed and Previously Finalized Measures for CY17

PROPOSED HOSPITAL OQR PROGRAM MEASURE SET FOR THE CY 2017 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

NQF No.	Measure name
N/A	OP–1: Median Time to Fibrinolysis.
0288	OP–2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival.****
0290	OP–3: Median Time to Transfer to Another Facility for Acute Coronary Intervention.
0289	OP–5: Median Time to ECG.
0514	OP–8: MRI Lumbar Spine for Low Back Pain.
N/A	OP–9: Mammography Follow-up Rates.
N/A	OP–10: Abdomen CT—Use of Contrast Material.
0513	OP–11: Thorax CT—Use of Contrast Material.
N/A	OP–12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data.
0669	OP–13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery.
N/A	OP–14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT).
N/A	OP–15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache.
N/A	OP–17: Tracking Clinical Results between Visits.
0496	OP–18: Median Time from ED Arrival to ED Departure for Discharged ED Patients.
N/A	OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional.
0662	OP–21: Median Time to Pain Management for Long Bone Fracture.
N/A	OP–22: ED—Left Without Being Seen.****

PROPOSED HOSPITAL OQR PROGRAM MEASURE SET FOR THE CY 2017 PAYMENT DETERMINATION AND SUBSEQUENT YEARS—Continued

NQF No.	Measure name
0661	OP–23: ED—Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of Arrival.
N/A	OP–25: Safe Surgery Checklist Use.
N/A	OP–26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures.*
0431	OP–27: Influenza Vaccination Coverage among Healthcare Personnel.
0658	OP–29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients.
0659	OP–30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use.
1536	OP–31: Cataracts—Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.**
N/A	OP–32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.***

*OP–26: Procedure categories and corresponding HCPCS codes are located at: *http://qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228889963089&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D1r_OP26MIF_v+6+0b.pdf&blobcol=urldata&blobtable=Mungo Blobs.*

** Measure we are proposing for voluntary data collection in section XIII.D.3.b. of this proposed rule.

*** New measure proposed for the CY 2017 payment determination and subsequent years.

**** Name has been updated to correspond with NQF-endorsed name.