healthcare financial management association

CY15 OPPS Final Rule Fact Sheet

Submission of Comments

This document provides an overview of the Medicare final rule for the Outpatient Prospective Payment System (OPPS) for calendar year 2015 (CY15). The final rule with comment period is available in the Nov. 10, 2014, *Federal Register*.

CMS must receive comments on the proposed rule by, 5 p.m. EST on Dec. 30, 2014. When commenting, please refer to file code CMS–1613–FC.

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–FC, P.O. Box 8013
Baltimore, MD 21244–1850
Written comments can also be sent via express/overnight mail to the following address ONLY:

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

Overview

The Centers for Medicare & Medicaid Services (CMS) released a final 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 finalizes 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 will 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 the final rule on hospitals after all CY15 updates have been made. CMS provides a more comprehensive table on pages 67020-67022 of the final rule.

CY15 OPPS Update Impact Table

	All Changes (Percentage)
All Hospitals	2.3
Urban Hospitals	2.3
Rural Hospitals	1.9
Teaching Status	
Non-Teaching	2.0
Minor	2.0
Major	3.1

OPPS Payment Updates

Federal Register pages: 66776, 67018, 66825-66826

Final Update: For CY15, payment rates under the OPPS will increase by the final outpatient department (OPD) fee schedule increase factor of **2.2 percent** for those hospitals that submit quality data, and **0.2 percent** for those that do not.

Update Summary: The final IPPS market basket percentage increase for FY15 is **2.9** percent. Section 1833(t)(3)(F)(i) of the Act reduces that **2.9** percent by the multifactor productivity adjustment (MFP) described in section 1886(b)(3)(B)(xi)(II) of the Act, which is **0.5** percent for CY15 (which is also the MFP adjustment for FY15 in the FY15 IPPS/LTCH PPS final rule). The market basket percentage increase is further reduced by an additional **0.2** resulting in the proposed OPD fee schedule increase factor of **2.2** percent, which CMS is using in the calculation of the CY15 OPPS conversion factor.

The table below reflects the CY15 OPPS final 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**
2.9	0.5	0.2	**2.2**

Impact of Proposed CY15 OPPS Updates (No Quality Data) %

Market Basket Increase	(Minus) MFP Adjustment	(Minus) Additional Reduction	(Minus) Hospital OQR Reduction	**FY14 Final Payment Increase**
2.9	0.5	0.2	2.0	**0.2**

Conversion Factor Update
Federal Register pages 66824-66826

Final Update: The final conversion factor for CY15 is **$74.144**. To set the OPPS conversion factor for CY15, CMS will increase the CY14 conversion factor of $72.672 by **2.2** percent.

Update Summary: CMS uses a conversion factor of **$74.144** in the calculation of the national unadjusted payment rates for those items and services for which payment rates are calculated using geometric mean costs, that is the OPD fee schedule increase factor of 2.2 percent for CY15, the required wage index budget neutrality adjustment of approximately **0.9996**, the cancer hospital payment adjustment of **1.0000**, and the adjustment of -0.13 percent of projected OPPS spending for the difference in the pass-through spending, resulting in a conversion factor for CY15 of **$74.144**.

CMS estimates that pass-through spending for drugs, biologicals, and devices for CY15 will equal approximately $82.8 million, which represents 0.15 percent of total projected CY15 OPPS spending. Therefore, the conversion factor is also adjusted by the difference between the 0.02 percent estimate of pass-through spending for CY14 and the 0.15 percent estimate of pass-through spending for CY15, resulting in an adjustment for CY15 of -0.13 percent. Finally, estimated payments for outliers remain at 1.0 percent of total OPPS payments for CY15.

For hospitals that fail to meet the requirements of the Hospital OQR Program, CMS will use a reduced conversion factor of **$72.661** in the calculation of payments for hospitals that fail to meet the Hospital OQR Program requirements (a difference of -$1.483 in the conversion factor relative to hospitals that met the requirements).

Hospital Outpatient Outlier Payments
Federal Register pages: 66832-66834

Final Update: The CY15 outlier payment fixed-dollar threshold will be **$2,775**.

Update Summary: In order to determine the CY15 hospital outlier payments for this final rule, CMS used updated data. For CY15, CMS has applied the overall cost-to-charge ratios (CCRs) from the July 2014 Outpatient Provider-Specific File after adjustment (using the CCR inflation adjustment factor of **0.9821** to approximate CY15 CCRs) to charges on CY13 claims that were adjusted (using the charge inflation factor of 1.1044 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 will continue to be made at 50 percent of the amount by which the cost of furnishing the service will 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 estimates that a fixed-dollar threshold of **$2,775**, combined with the multiple threshold of 1.75 times the APC payment rate, will allocate 1.0 percent of aggregated total OPPS payments to outlier payments.

For community mental health centers (CMHCs), if a CMHC'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 will 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 66826-66828

Final Update: For the CY15 OPPS, frontier state hospitals will 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 changing its current regulations, which requires the use of FY15 IPPS wage indexes for calculating OPPS payments in CY15.

CMS is not reprinting the 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 final 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, in the CY15 OPPS/ASC proposed rule, it proposed to continue this policy for the CY15 OPPS. *It referred readers 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 will 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 hospital outpatient departments (HOPDs) that are affiliated with multi-campus hospital systems, the HOPD will 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 will also apply for the affiliated HOPD.

For CY15, CMS will 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. Because non-IPPS hospitals cannot reclassify, they will be eligible for the out-migration wage adjustment if they are located in a section 505 out-migration county. This is the same out-migration adjustment policy that would apply if the hospital were paid under the IPPS. CMS refers readers to Table 4J from the FY15 IPPS/LTCH PPS final rule, published on its web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

The table identifies counties eligible for the outmigration adjustment and IPPS hospitals that will receive the adjustment for FY15.

Adjustment for Rural SCHs and EACHs
Federal Register pages 66830-66831

Final Update: CMS will continue the adjustment of a 7.1 percent payment adjustment that is done in a budget-neutral manner for certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs), for all services and procedures 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 costs.

Cancer Hospital Payment Adjustment
Federal Register pages 66825, 66831- 66832

Final Update: For CY15, CMS will 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** will 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. That is, the payment adjustments will be the additional payments needed to result in a PCR equal to 0.89 for each cancer hospital.

Update Summary: CMS finalizes its proposal to establish the target PCR equal to 0.89 for each cancer hospital. For the final rule with comment period, CMS re-ran its calculations to determine the target PCR using the latest available cost data and has determined that 0.89 is still the correct target PCR. CMS limited the dataset to the hospitals with CY13 claims data that it used to model the impact of the final CY15 APC relative payment weights. The cost report data for the hospitals in this dataset were from cost report periods with fiscal year ends ranging from 2011 to 2013. Using this smaller dataset of cost report data, we 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 finalizing that the payment amount associated with the cancer hospital payment adjustment to be determined at cost report settlement will be the additional payment needed to result in a target PCR equal to 0.89 for each cancer hospital. Table 14 of the 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 that the changes made by section 1833(t)(18) of the Act do not affect the existing statutory provisions that provide for Transitional Outpatient Payments (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.

Packaging Policy
Federal Register pages: 66817- 66822

Final Update: CMS will 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 proposed 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 its 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 CY14, CMS established comprehensive ambulatory payment classifications (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.

Because a comprehensive APC would treat all individually reported codes as representing components of the comprehensive service, CMS will 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 will implement, with several modifications, the policy for comprehensive APCs that was finalized in the CY14 OPPS final rule effective Jan. 1, 2015. Under the final rule, CMS will 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 will 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 results 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.

CMS will no longer implement procedure-to-device edits and device-to-procedure edits for any APC. Under this final 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 final CY15 comprehensive APC policy is discussed in section II.A.2.e. of the final rule. As a result of the final CY15 comprehensive APC policy, only three of the current 39 device-dependent APCs will remain in the CY15 OPPS because all other device-dependent APCs are being converted to comprehensive APCs. All of the remaining device-dependent APCs were either deleted due to the consolidation and restructuring of these APCs or they were converted to comprehensive APCs.

CMS will also 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 of the current device-dependent APCs, (that remain after the consolidation and restructuring of these APCs) found in ***Appendix 1*** of this document, is reported on the claim to ensure that device costs are captured by hospitals. CMS will monitor the claims data to ensure that hospitals continue reporting appropriate device codes on the claims for the formerly device-dependent APCs. CMS notes that while it proposed to make all 26 of the APCs listed in Table 5 comprehensive APCs for CY15, in section II.A.2.e. of the final rule it is not finalizing its proposal to recognize APCs 0427, 0622, and 0652 as comprehensive APCs. While APCs 0427, 0622, and 0652 will not be recognized as comprehensive APCs for CY15, its finalized device edit policy will apply to these three APCs, as they are formerly device dependent APCs. Also, the term ‘‘device dependent APC’’ will no longer be employed beginning in CY15.

CMS will refer to APCs with a device offset of more than 40 percent as ‘‘device intensive’’ APCs. Device-intensive APCs will be subject to the no cost/full credit and partial credit device policy. For a discussion of device-intensive APCs and the no cost/full credit and partial credit device policy, please refer to section IV.B. of the final rule. For a discussion of ASC procedures

designated as device-intensive, CMS refers readers to section XII.C.1.c. of the final rule.

Complexity adjustments

CMS will use complexity adjustments to provide increased payment for certain comprehensive services. CMS will apply a complexity adjustment by promoting qualifying ''J1'' service code combinations or code combinations of ''J1'' services and certain add-on codes (as described in the rule) from the originating C–APC (the C–APC to which the designated primary service is first assigned) to a higher paying C–APC in the same clinical family of C–APCs, if reassignment is clinically appropriate and the reassignment would not create a violation of the 2-times rule in the receiving APC (the higher paying C–APC in the same clinical family of C–APCs).

CMS is establishing a new complexity adjustment criteria:

- Frequency of 25 or more claims reporting the HCPCS code combination (the frequency threshold); and
- Violation of the ''2-times'' rule (the cost threshold).

The 25 C-APCs are as follows (Table 7 of the final rule):

TABLE 7—CY 2015 C–APCS

Clinical family*	C–APC	APC title	CY 2015 payment
AICDP	0090	Level II Pacemaker/Similar Procedures	$6,542.78
AICDP	0089	Level III Pacemaker/Similar Procedures	9,489.74
AICDP	0655	Level IV Pacemaker/Similar Procedures	16,400.98
AICDP	0107	Level I ICD and Similar Procedures	22,907.64
AICDP	0108	Level II ICD and Similar Procedures	30,806.39
BREAS	0648	Level IV Breast and Skin Surgery	7,461.40
ENTXX	0259	Level VII ENT Procedures	29,706.85
EPHYS	0084	Level I Electrophysiologic Procedures	872.92
EPHYS	0085	Level II Electrophysiologic Procedures	4,633.33
EPHYS	0086	Level III Electrophysiologic Procedures	14,356.62
EYEXX	0293	Level IV Intraocular Procedures	8,446.54
EYEXX	0351	Level V Intraocular Procedures	23,075.30
GIXXX	0384	GI Procedures with Stents	3,173.83
NSTIM	0061	Level II Neurostim./Related Procedures	5,288.58
NSTIM	0039	Level III Neurostim./Related Procedures	17,099.35
NSTIM	0318	Level IV Neurostim./Related Procedures	26,152.16
ORTHO	0425	Level V Musculoskeletal Procedures	10,220.00
PUMPS	0227	Implantation of Drug Infusion Device	15,566
RADTX	0067	Single Session Cranial SRS	9,765
UROGN	0202	Level V Gynecologic Procedures	3,977
UROGN	0385	Level I Urogenital Procedures	6,822
UROGN	0386	Level II Urogenital Procedures	13,967
VASCX	0083	Level I Endovascular Procedures	4,537
VASCX	0229	Level II Endovascular Procedures	9,624
VASCX	0319	Level III Endovascular Procedures	14,840

*Clinical Family Descriptor Key:
AICDP = Automatic Implantable Cardiac Defibrillators, Pacemakers, and Related Devices.
BREAS = Breast Surgery.
ENTXX = ENT Procedures.
EPHYS = Cardiac Electrophysiology.
EYEXX = Ophthalmic Surgery.
GIXXX = Gastrointestinal Procedures.
NSTIM = Neurostimulators.
ORTHO = Orthopedic Surgery.
PUMPS = Implantable Drug Delivery Systems.
RADTX = Radiation Oncology.
UROGN = Urogenital Procedures.
VASCX = Vascular Procedures.

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 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 assigned to these 29 APCs beginning in CY15.

Device-Dependent APCs

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. CMS will no longer implement specific procedure-to-device and device-to-procedure edits for any APC. CMS will also 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 of the current device-dependent APCs (that remain after the consolidation and restructuring of these APCs) listed in Table 5 of the final rule is reported on the claim to ensure that device costs are captured by hospitals. Hospitals are still expected to adhere to the guidelines of correct coding and append the correct device code to the claim, when applicable.

CMS will monitor the claims data to ensure that hospitals continue reporting appropriate device codes on the claims for the formerly device-dependent APCs. CMS notes that while it proposed to make all 26 of the APCs listed in Table 5 ***(Appendix 1** of this document)* comprehensive APCs for CY15, in section II.A.2.e. of the final rule, it is not finalizing its proposal to recognize APCs 0427, 0622, and 0652 as C–APCs. While these APCs will not be recognized as comprehensive APCs for CY15, CMS’s finalized device edit policy will apply to them, as these 3 APCs are formerly device-dependent APCs. The term ‘‘device-dependent APC’’ will no longer be employed beginning in CY15. CMS will refer to APCs with a device offset of more than 40 percent as ‘‘device-intensive’’ APCs. Device-intensive APCs will be subject to the no cost/full credit and partial credit device policy.

CMS is finalizing its proposal 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, as listed in Table 9 of the CY15 OPPS proposed rule, and included in ***Appendix 2** of this document* (Table 10 of the final rule). The current device-dependent add-on codes that are separately paid in CY14 that will be packaged in CY15 are included in Table 8 (***Appendix 3*** of this document) under section II.A.2.e. of the final rule, which addresses the comprehensive APC policy.

Ancillary Services

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.

CMS will conditionally package certain ancillary services when they are integral, ancillary, supportive, dependent, or adjunctive to a primary service. Specifically, it will 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 $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 had a CY15 OPPS proposed rule geometric mean cost of approximately $103. This $100 geometric mean cost limit is part of the methodology of selecting the initial set of conditionally packaged ancillary service APCs under this packaging policy.

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 will also 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 11 of the final rule.

TABLE 11—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 did not propose 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, nor did it propose 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.

CMS is finalizing its ancillary services packaging policy as proposed, including deletion of status indicator ''X.'' It is also adopting as final its proposed revision of the regulations at 42 CFR 419.2(b)(7) to replace the phrase ''incidental services such as venipuncture'' with ''ancillary services'' to more accurately reflect the final packaging policy for CY15. The APCs that CMS is conditionally packaging as ancillary services in CY15 are listed in Table 12 of the final rule (***Appendix 4*** of this document). The HCPCS codes that it is conditionally packaging as ancillary services for CY15 are displayed in Addendum B to the final rule with comment period (which is available on the CMS web site).

Pass-through Payments for Devices
Federal Register pages 66870-66873

Update Summary

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 will expire HCPCS code C1841 device category from pass-through payment status after Dec. 31, 2015. CMS is also finalizing its proposal to package the costs for devices described by HCPCS code C1841 into the costs of the procedure with which the device is reported in the hospital claims data used in the development of the OPPS relative payment weights that will be used to establish the ASC payment rates for CY16. With the expiration of HCPCS code C1841 device category from pass-through payment status at the end of CY15, there are no other currently active categories for which CMS will expire pass-through status in CY15. If CMS creates new device categories for pass-through payment status during the remainder of CY14 or during CY15, CMS will propose future expiration dates.

Provisions for Reducing Transitional Pass-through Payments to Offset Costs Packaged into APC Groups
For CY15, CMS will 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. CMS will 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 Jan. 1, 2010, be the device pass-through process and payment methodology only.

CMS will 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 will deduct the device APC offset amount from the pass-through payment for the device category.

Finally, CMS will 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. Additionally, CMS is updating, on its web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*, 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 so that this information is available for use by the public in developing potential CY15 device pass-through payment applications and by it in reviewing those applications.

Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices
For CY15, CMS continues 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. CMS examined the offset amounts calculated from the CY15 final rule with comment period data and the clinical characteristics of the final CY15 APCs to determine which APCs meet the criteria for CY15. Table 26 of the final rule (***Appendix 5** of this document*) lists the APCs to which the payment adjustment policy for no cost/full credit and partial credit devices will apply in CY15. Table 27 of the final rule ***(Appendix 6** of this document)* lists the devices to which the payment adjustment policy for no cost/full credit and partial credit devices will apply in CY15.

For CY15, CMS will also continue using the three criteria established in the CY07 OPPS final rule with comment period for determining the APCs to which its CY15 policy will apply. These criteria include: (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. Based on the final CY13 claims data available for this CY15 OPPS final rule with comment period, CMS updated the lists of APCs and devices to which the no cost/full credit and partial credit device adjustment policy will apply for CY15, consistent with the three criteria.

OPPS Payments for Hospital Outpatient Visits
Federal Register pages 66898-66899

Final Update: For CY15, CMS will 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.

Update Summary: CMS is finalizing its CY15 proposal, without modification, to continue to use HCPCS code G0463 (for hospital use only) to represent any and all clinic visits under the OPPS for CY15. In addition, for CY15 CMS will continue to assign HCPCS code G0463 to APC 0634, and to use CY13 claims data to develop the 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. CMS will 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 to establish the CY15 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. CMS may propose changes to the coding and APC assignments for ED visits in the future rulemaking.

Partial Hospitalization Payments APC Update
Federal Register pages 66900-66908

Final Update: For CY15, CMS will apply its established policies to calculate the four partial hospitalization program (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:
CMS computed final community mental health center (CMHC) PHP 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 final geometric mean per diem costs are shown below (Tables 39 and 40 of the final rule).

TABLE 39—CY 2015 GEOMETRIC MEAN PER DIEM COSTS FOR CMHC PHP SERVICES

APC	Group title	Geometric mean per diem costs
0172	Level I Partial Hospitalization (3 services) for CMHCs	$100.15
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	118.54

TABLE 40—CY 2015 GEOMETRIC MEAN PER DIEM COSTS FOR HOSPITAL-BASED PHP SERVICES

APC	Group title	Geometric mean per diem costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$185.87
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	203.01

OPPS Payment Status and Comment Indicators
Federal Register pages 66914-66915

The complete list of the CY15 payment status indicators and their definitions is displayed in Addendum D1 to the final rule with comment period, which is available on the CMS web site at: *http://www.cms.gov/Medicare/Medicare-Feefor-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 refers readers to section II.A.2.e. of this final rule with comment period for a discussion of implementation of the new comprehensive APC policy.

Under the CY15 final rule, CMS will 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 will also 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" will be deleted.

In addition, CMS will 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 final change to the status indicators for these drugs, for CY15, CMS will remove the phrase "EPO for ESRD Patients" from the list of examples for status indicator "A." In addition, it will 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 will 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 will use the "CH" comment indicator to indicate HCPCS codes for which the status indicator or APC assignment, or both, are finalized for change in CY15 compared to their assignment as of June 30, 2014. Only HCPCS codes with comment indicator ''NI'' the final rule with comment period are subject to comment. HCPCS codes that do not appear with comment indicator ''NI'' in the final rule will not be open to public comment, unless CMS specifically requests additional comments elsewhere in the final rule. The definitions of the OPPS comment indicators for CY15 are listed in Addendum D2 of the rule with comment period, which is available on the CMS web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

Hospital OQR Program Updates

Federal Register pages 66940-66948

Final Update: CMS will refine the criteria for determining when a measure is "topped-out." Specifically, CMS is finalizing a policy that a measure under the Hospital Outpatient Quality Reporting (OQR) Program is ''topped-out'' when it meets both of the following criteria: (1) Statistically indistinguishable performance at the 75th and 90th percentiles; and (2) a truncated coefficient of variation less than or equal to 0.10. To identify if a measure has statistically indistinguishable performance at the 75th and 90th percentiles, CMS will determine whether the difference between the 75th and 90th percentiles for a measure is within two times the standard error of the full dataset.

CMS is finalizing its proposal to add one claims-based quality measure, ***OP–32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy***, for the Hospital OQR Program for the CY18 payment determination and subsequent years, instead of the CY17 payment determination and subsequent years as proposed. Because this measure is claims-based, it will not require additional burden from data reporting or other action on the part of the hospitals. Therefore, CMS does not anticipate that this measure will cause any additional facilities to fail to meet requirements of the Hospital OQR Program for the CY18 payment determination and subsequent years.

Update Summary:

Removal of OQR Program Measures for CY17 Payment Determination and Subsequent Years
CMS is finalizing its proposal to remove the following measures from the Hospital OQR Program as proposed:

- 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 we finalized in section XIII.C.2. of the final rule with comment period for determining ''topped-out'' status.

However, it is not finalizing its proposal to remove measure OP–4: Aspirin at Arrival (NQF # 0286); and is retaining that measure in the Hospital OQR Program. Hospitals are to report data on OP–4 as previously required. CMS refer readers to the CY08, CY13, and CY14 OPPS final rule for more information about OP–4 and the data submission requirements.

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 7 of this document.

In the CY15 OPPS proposed rule, CMS corrected some typographical errors, and made 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. CMS corrects the previously stated submission deadline of *Oct. 1, 2014*, instead of Oct. 1, 2015. In addition, CMS clarified that the data to be submitted are more specifically referred to as ''Healthcare Personnel (HCP) Influenza Vaccination summary reporting data'', instead of ''HAI measure collection data'', and clarified 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. ***(Note: this wording was pulled directly from the rule.)***CMS finalized that, for the CY16 payment determination, hospitals would be required to submit aggregate-level encounter data between July 1, 2015, and Nov. 1, 2015, for data collected during Jan. 1, 2014 – Dec. 31, 2014. On Dec. 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 – Dec. 31, 2014.

  The data submission window for data collected from April 1, 2014 – Dec. 31, 2014 is still July 1, 2015 – Nov. 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 Nov. 1st of the year prior to a payment determination, with respect to the encounter period of Jan. 1st to Dec. 31st of 2 years prior to a payment determination year. CMS believes that this 3-month period is sufficient to allow hospitals to put the necessary mechanisms in place to collect these data

- *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 final 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.

- *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 finalized that hospitals have the option to voluntarily collect and submit OP-31 data for the CY15 encounter period/CY17 payment determination and subsequent years. For hospitals that choose to submit data, CMS requests that they submit it using the means and timelines finalized in the CY14 OPPS/ASC final rule with comment period. CMS will not subject hospitals to a payment

reduction with respect to this measure during the period of voluntary reporting. However, data submitted voluntarily will be publicly reported.

- *New Quality Measure for the CY18 Payment Determination and Subsequent Years*
  CMS will adopt one new claims-based measure into the Hospital OQR Program for the CY18 payment determination and subsequent years, instead of the 2017 payment determination as proposed: *OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy*. CMS expects that 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.

  CMS is committed to filling the performance gaps in colonoscopy performed in the outpatient setting. Therefore, it believes this measure is appropriate for the outpatient setting. However, in response to comments, to allow sufficient time to conduct further analysis of this measure, CMS is finalizing this measure beginning with the CY18 payment determination. CMS plans to perform a dry run of the measure in 2015. Because this measure is claims-based, it will not require additional burden from data reporting or other action on the part of the hospitals. Therefore, CMS does not anticipate that this measure will cause any additional facilities to fail to meet requirements the Hospital OQR Program for the CY18 payment determination and subsequent years.

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

Revision of the Requirements for Physician Certification of Hospital Inpatient Services
Federal Register pages 66997- 66999

Final Update: CMS will change 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. As indicated in its response to these public comments in that final rule, 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 previous 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.

Update Summary: CMS finalized the policy included in the CY15 OPPS proposed rule, which limits the requirement for physician certification to long-stay (20 days or longer) and outlier cases. Since CMS proposed 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 will 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 finalized its proposal to 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 believes that this change will reduce administrative burden in general, and in particular will reduce the administrative burden associated with the majority of cases involving an admission order issued by a practitioner qualified to issue the order, but who did not meet the statutory definition of a physician and therefore could not certify the case. CMS is also adding the word ‘‘Continued’’ at the beginning of paragraph (a)(1)(i), which it inadvertently omitted when it set out the regulation text in the proposed rule.

CMS did not propose 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 did not propose any changes to the admission requirements for IRFs.

II. AMBULATORY SURGICAL CENTERS (ASCs)

Calculation of the ASC Payment Rates

Federal Register pages 66935-66940

Final Update: The FY15 final ASC conversion factor is **$44.071**, for ASCs that meet the quality reporting requirements, and **$43.202** for those that do not. The current CY14 conversion factor is $43.471. Total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY15 will be approximately **$4.147** billion, an increase of approximately $236 million compared to estimated CY14 Medicare payments.

Update Summary: CMS will apply its established methodology for determining the final CY15 ASC conversion factor. Using more complete CY13 data for the final rule with comment period than were available for the proposed rule, CMS calculated a wage index budget neutrality adjustment of 0.9998. CMS is also applying its established methodology for determining the final CY15 ASC conversion factor. Using more complete CY13 data for the final rule with

comment period than were available for the proposed rule, CMS calculated a wage index budget neutrality adjustment of 0.9998. Based on IHS Global Insight's (IGI's) 2014 third quarter forecast, the CPI–U for the 12- month period ending with the midpoint of CY15 is now projected to be **1.9** percent, while the MFP adjustment (as discussed and finalized in the CY12 MPFS final rule with comment period is **0.5** percent, resulting in an MFP-adjusted CPI–U update factor of **1.4** percent for ASCs that meet the quality reporting requirements.

The final ASC conversion factor of **$44.071**, for ASCs that 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 0.9998 and the MFP-adjusted CPI–U payment update of 1.4 percent.

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

CPI-U update	(Minus) MFP Adjustment	**MFP-Adjusted CPI-U Update**
1.9	0.5%	**1.4%**

For ASCs that do not meet the quality reporting requirements, CMS is reducing the CPI–U update of 1.9 percent by 2.0 percent, and then applying the 0.5 percent MFP reduction, resulting in a **-0.6** percent quality reporting/MFP-adjusted CPI–U update factor. The final ASC conversion factor of **$43.202** 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 0.9998 and the quality reporting/MFP-adjusted CPI–U payment update of -0.6 percent.

The following table displays the CY15 final 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**
1.9	2.0%	0.5%	**-0.6**

Addenda AA and BB to the final rule (which are available on the CMS web site) display the final updated CY15 ASC payment rates 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 ASCQR Program. These addenda contain several types of information related to the CY15 payment rates.

Payment for Covered Ancillary Services
Federal Register pages 66932-66934

Update Summary: CMS will expand the scope of ASC-covered ancillary services to include certain diagnostic tests for which separate payment is allowed under the OPPS when provided integral to covered ASC surgical procedures; to pay for these diagnostic tests at the lower of the Medicare Physician Fee Schedule (MPFS) non-facility practice expense (PE) RVU based (or technical component) amount or the rate calculated according to the ASC standard ratesetting methodology; and to revise §§ 416.164(a)(11) and (b)(5) as well as § 416.171(b)(1) to reflect these finalized policies. CMS is also revising the regulation text at § 416.171(d) to reflect that payment for these tests will be at the lower of the MPFS non-facility PE RVU-based amount or the rate calculated according to the ASC standard ratesetting methodology, as discussed above and in the CY15 OPPS proposed rule.

For those covered ancillary services where the payment rate is the lower of the final rates under the ASC standard ratesetting methodology and the MPFS final rates, the final payment indicators and rates set forth in the final rule are based on a comparison using the MPFS rates effective January 1, 2015. These payment rates and indicators do not include the effect of the negative update to the MPFS payment rates effective April 1, 2015, under current law. Updates to these rates and payment indicators effective April l, 2015, will be included in the April 2015 quarterly ASC addenda posted on the CMS web site. For a discussion of the MPFS rates, CMS refers readers to the CY15 MPFS final rule with comment period.

In the CY15 OPPS proposed rule, CMS 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 will add this code to the list of ASC covered ancillary services, and will 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 payment indicators are listed in Addendum BB to the final rule (which is available on the CMS web site).

Ambulatory Surgical Center Quality Reporting (ASCQR) Program
Federal Register pages 66981- 67016

Final Update: CMS will adopt the *ASC–12: Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy* measure for the ASCQR Program. However, to allow ASCs sufficient time to review their measure data from the dry run and utilize the confidential facility reports with patient-level associated hospital event information, it is finalizing the adoption of this measure for the CY18 payment determination and subsequent years, instead of the CY17 payment determination and subsequent years as proposed. The finalized measure set for the ASCQR Program CY17 payment determination and subsequent years, is listed in ***Appendix* 8** of this document. CMS plans to perform a dry run of the measure in 2015. Also,

with national implementation of a dry run of this measure, it will also review the appropriate cutoff volume for facilities, if necessary, in reporting the measure score.

CMS is also finalizing its proposal to adopt May 15 of the year in which the influenza season ends as the data submission deadline for the ASC–8 (Influenza Vaccination Coverage Among Healthcare Personnel) measure for each payment determination year, beginning with the CY16 payment determination. CMS is also finalizing that for the CY17 payment determination and subsequent years, ASCs will collect data from October 1 of the year 2 years prior to the payment determination year to March 31 of the year prior to the payment determination year.

In the CY15 OPPS proposed rule, CMS did not propose any substantive changes to its extraordinary circumstances extension or waiver process under the Hospital Outpatient Quality Reporting Program. However, in the future, it will refer to the process as the Extraordinary Circumstances Extensions or Exemptions process. CMS notes that it is in the process of revising the Extraordinary Circumstances/Disaster Extension or Waiver Request form (CMS–10432), approved under OMB control number 0938–1171. It is updating the forms and instructions so that a hospital or facility may apply for an extension for all applicable quality reporting programs at one time.

In the CY14 OPPS final rule, CMS adopted ASC–9: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (NQF #0658) and ASC–10: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps--Avoidance of Inappropriate Use (NQF #0659). For the CY16 payment determination, ASCs would be required to submit aggregate-level encounter data from Jan. 1, 2014, to Dec. 31, 2014, using CMS's web-based tool during the data submission window of Jan. 1, 2015, to Aug. 15, 2015. On Dec. 31, 2013, CMS issued guidance stating that it would delay the implementation of ASC–9 and ASC–10 for 3 months for the CY16 payment determination, with a resulting encounter period of April 1, 2014, to Dec. 31, 2014, instead of Jan. 1, 2014, to Dec. 31, 2014. The data submission timeframe and the encounter period for subsequent years remain as previously finalized.

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

Exclusion for ASC–11 for the CY16 Payment Determination

CMS will remove ASC–11 *Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery* (NQF #1536) from the ASCQR Program measure set from the CY16 payment determination measure set. CMS is also finalizing its proposal to allow voluntary data collection and reporting of this measure for the CY17 payment determination and subsequent years. ASCs will be able to begin reporting with Jan. 1, 2015, services. For ASCs that choose to submit data, CMS requests that they submit such data using the means and timelines finalized in the CY14 OPPS final rule.

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 Oct. 1, 2012, and Dec. 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 will be included in the data used for the payment determination year. Therefore, for example, only claims for services furnished in CY13 (Jan. 1, 2013, through Dec. 31, 2013) paid by the administrative contractor by April 30, 2014, will 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 will be from Oct. 1, 2014, through, March 31, 2015 (the 2014–2015 influenza season data). CMS finalizes its proposal without modification to adopt May 15 of the year in which the influenza season ends as the data submission deadline for the ASC–8 measure (Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431), for each payment determination year, beginning with the CY16 payment determination. CMS also finalizes its proposal without modification that, for the CY17 payment determination and subsequent years, ASCs will collect data from Oct. 1 of the year 2 years prior to the payment determination year to March 31 of the year prior to the payment determination year.

Revisions to the CY16 Payment Determination Estimates

In the CY14 OPPS final rule, CMS finalized the adoption of three new measures for the CY16 payment determination and subsequent years: ASC–9: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (NQF #0658); ASC–10: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use (NQF # 0659); and ASC–11: Cataracts—Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery (NQF #1536). In that final rule CMS estimated that each participating ASC would spend 35 minutes per case to collect and submit the data for these measures, resulting in a total estimated burden for ASCs with a single case per ASC of 3,067 hours CMS also stated that it expected ASCs would vary greatly as to the number of cases per ASC due to ASC specialization.

CMS has delayed reporting for ASC–9 and ASC–10 for the CY16 payment determination by one quarter. Therefore, it estimates a 25-percent reduction in cases and burden for these measures for the CY16 payment determination. As CMS stated in the CY15 OPPS proposed rule and the final rule, it delayed reporting of ASC–11 by 1 year. CMS is also finalizing its proposal to exclude ASC–11 from the CY16 payment determination measure set. As a result, it does not believe there would be any burden associated with this measure for the CY16 payment determination.

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

Federal Register, pages 66999-67011

Final Update: CMS will establish a process for recovering identified overpayments associated with erroneous payment data submitted by Medicare Advantage (MA) organizations and Part D sponsors.

Background: Medicare Part C and Part D payments to 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, calculated using that erroneous payment data, 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 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 does not constitute a change to the existing Part C or Part D payment methodologies. Rather, CMS merely adopted 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 after notice and request to do so.

Update Summary

Definitions of ''Payment Data'' and ''Applicable Reconciliation Date''
CMS is finalizing the regulatory definition of ''payment data", proposed as, the *mean data controlled and submitted to CMS by an MA organization or a Part D sponsor that is used for payment purposes*, with a modification to remove the reference to ''controlled.'' The MA organization or Part D sponsor is responsible for the accuracy of such data. CMS is also adding a definition of ''erroneous payment data'' in the final regulation text at §§ 422.330(a) and 423.352(a).

Request for Corrections of Payment Data

CMS is finalizing proposed §§ 422.330(b), 423.352(b), §§ 422.330(c) and 423.352(c) with modifications. CMS is moving the language regarding the 6-year look-back period from proposed §§ 422.330(b) and 423.352(b) to §§ 422.330(c)(1) and 423.352(c)(1) in order to indicate that if the MA organization or Part D sponsor fails to correct payment data, CMS will conduct a payment offset if the payment error affects payments for any of the 6 most recently completed payment years and the payment error for a particular payment year is identified after the applicable reconciliation date for that payment year.

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 will conduct a payment offset from plan payments. CMS will 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 will 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. CMS provides examples of how the offset amount will be calculated for Part C and Part D relative to two different types of payment data errors.

Payment Offset Notification and Appeals Process

CMS will provide a payment offset notice to the MA organization or Part D sponsor, that will 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 will 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. There will be 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. CMS will provide written notice of the time and place of the hearing 30 days before the scheduled date.

Nonrecurring Policy Changes: Collecting Data on Services Furnished in Off-Campus Provider-Based Departments of Hospitals

Federal Register pages 66910-66914

In the CY15 OPPS proposed rule CMS stated that it continues to seek a better understanding of how the growing trend toward hospital acquisition of physicians' offices and subsequent treatment of those locations as off-campus provider based departments (PBDs) of hospitals affects payments under the MPFS and the OPPS, as well as beneficiary cost sharing obligations. In order to understand how this trend is affecting Medicare, CMS needs information on the

extent to which this shift is occurring. To that end, during the CY14 OPPS rulemaking cycle, CMS sought public comment regarding the best method for collecting information and data that would allow it to analyze the frequency, type, and payment for physicians' and outpatient hospital services furnished in off-campus PBDs of hospitals.

Based on its analysis of the public comments received, CMS proposed for the CY15 OPPS ASC proposed rule that the most efficient and equitable means of gathering this important information across two different payment systems would be to create a HCPCS modifier to be reported with every code for physicians' services and outpatient hospital services furnished in an off-campus PBD of a hospital on both the CMS–1500 claim form for physicians' services and the UB–04 form (CMS Form 1450) for hospital outpatient services.

CMS finalizes its proposal to create a HCPCS modifier that is to be reported with every code for outpatient hospital services furnished in an off-campus PBD of a hospital. This code will not be required to be reported for remote locations of a hospital defined at 42 CFR 412.65, satellite facilities of a hospital defined at 42 CFR 412.22(h), or for services furnished in an emergency department. CMS defines ''campus'' as the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus. In response to inquiries about when to report the modifier for these services CMS clarified that the location where the service is actually furnished would dictate the use of the modifier, regardless of where the order for services initiated. CMS also expects the modifier and the place of service code for off-campus PBDs to be reported in locations in which the hospital expends resources to furnish the service in an off-campus PBD setting.

Reporting of this new modifier will be voluntary for 1 year (CY15), with reporting required beginning on Jan. 1, 2016. CMS notes that additional instruction and provider education will be forthcoming in subregulatory guidance.

More Information
The final rule is available in the, *Federal Register*. Additional information regarding the OPPS is available on the CMS web site.

Appendix 1: *Final CY15 Comprehensive APCs*

TABLE 5—APCS THAT WILL 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.
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/Pl. Cath.
0655	Level IV Pacemaker.

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

TABLE 10—ADD-ON CODES ASSIGNED TO DEVICE-DEPENDENT APCS FOR CY 2014 THAT ARE PACKAGED IN CY 2015

CY 2015 add-on code	Short descriptor
19297	Place breast cath for rad.
33225	L ventric pacing lead add-on.
37222	Iliac revasc add-on.
37223	Iliac revasc w/stent add-on.
37232	Tib/per revasc add-on.
37233	Tibper revasc w/ather add-on.
37234	Revsc opn/prq tib/pero stent.
37235	Tib/per revasc stnt & ather.
37237	Open/perq place stent ea add.
37239	Open/perq place stent ea add.
49435	Insert subq exten to ip cath.
92921	Prq cardiac angio addl art.
92925	Prq card angio/athrect addl.
92929	Prq card stent w/angio addl.
92934	Prq card stent/ath/angio.
92938	Prq revasc byp graft addl.
92944	Prq card revasc chronic addl.
92998	Pul art balloon repr precut.
C9601	Perc drug-el cor stent bran.
C9603	Perc d-e cor stent ather br.
C9605	Perc d-e cor revasc t cabg b.
C9608	Perc d-e cor revasc chro add.

Appendix 3: Device-dependent Add-on Codes Separately Paid in CY14 that to be Packaged in CY15

TABLE 8—CY 2015 PACKAGED CPT ADD–ON CODES THAT ARE EVALUATED FOR A COMPLEXITY ADJUSTMENT

CY 2015 CPT/ HCPCS add-on code	CY 2015 short descriptor
19297	Place breast cath for rad.
33225	L ventric pacing lead add-on.
37222	Iliac revasc add-on.
37223	Iliac revasc w/stent add-on.
37232	Tib/per revasc add-on.
37233	Tibper revasc w/ather add-on.
37234	Revsc opn/prq tib/pero stent.
37235	Tib/per revasc stnt & ather.
37237	Open/perq place stent ea add.
37239	Open/perq place stent ea add.
92921	Prq cardiac angio addl art.
92925	Prq card angio/athrect addl.
92929	Prq card stent w/angio addl.
92934	Prq card stent/ath/angio.
92938	Prq revasc byp graft addl.
92944	Prq card revasc chronic addl.
92998	Pul art balloon repr precut.
C9601	Perc drug-el cor stent bran.
C9603	Perc d-e cor stent ather br.
C9605	Perc d-e cor revasc t cabg b.
C9608	Perc d-e cor revasc chro add.

Appendix 4: CY15 APCs for Conditional Packaging as Ancillary Services

TABLE 12—APCS FOR CONDITIONALLY PACKAGED ANCILLARY SERVICES FOR CY 2015

APC	CY 2015 OPPS Geometric mean cost (with application of Q1 status indicator)	Final CY 2015 OPPS SI	Group title
0012	$102.18	Q1	Level I Debridement & Destruction.
0060	20.57	Q1	Manipulation Therapy.
0077	170.77	Q1	Level I Pulmonary Treatment.
0099	81.40	Q1	Electrocardiograms/Cardiography.
0215	98.52	Q1	Level I Nerve and Muscle Services.
0230	54.01	Q1	Level I Eye Tests & Treatments.
0260	61.59	Q1	Level I Plain Film Including Bone Density Measurement.
0261	98.56	Q1	Level II Plain Film Including Bone Density Measurement.
0265	95.12	Q1	Level I Diagnostic and Screening Ultrasound.
0340	54.33	Q1	Level II Minor Procedures.
0342	56.31	Q1	Level I Pathology.
0345	78.91	Q1	Level I Transfusion Laboratory Procedures.
0364	44.94	Q1	Level I Audiometry.
0365	122.36	Q1	Level II Audiometry.
0367	167.31	Q1	Level I Pulmonary Tests.
0420	136.66	Q1	Level III Minor Procedures.
0433	190.55	Q1	Level II Pathology.
0450	30.33	Q1	Level I Minor Procedures.
0624	81.76	Q1	Phlebotomy and Minor Vascular Access Device Procedures.
0690	36.47	Q1	Level I Electronic Analysis of Devices.
0698	104.61	Q1	Level II Eye Tests & Treatments.

Appendix 5: CY15 Final No Cost/Full Credit/Partial Credit Device APCs

TABLE 26—APCS TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE PAYMENT ADJUSTMENT POLICY WILL APPLY IN CY 2015

CY 2015 APC	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.
0655	Level IV Pacemaker and Similar Procedures.

Appendix 6: CY15 Final Replaced Device for which No Cost/Full Credit/Partial Credit Applies

TABLE 27—DEVICES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE PAYMENT ADJUSTMENT POLICY WILL APPLY IN CY 2015

CY 2015 Device HCPCS code	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 7– 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 #	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**
528	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
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 removed beginning with the CY 2017 payment determination, as set forth in section XIII.D.3.b. of this final rule with comment period.

***Measure collected voluntarily, as set forth in section XIII.D.3.b. of this final rule with comment period.

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

Appendix 8: Finalized Measure Set For the ASCQR Program CY 2017 Payment Determination and Subsequent Years

FINALIZED 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.*

* Measure voluntarily collected starting as set forth in section XIV.E.3.c. of this final rule with comment period.