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CY16 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 2016 (CY16). The proposed rule with comment period is available in the July 8, 2015, *Federal Register*.

Comments on the proposed rule are due by **Aug. 31, 2015**.

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-1633-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-1633-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 that would revise the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for calendar year 2016 (CY16). In the proposed rule, CMS describes the proposed changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system. The proposal would also update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program. Further, the proposed rule includes certain proposals relating to the hospital inpatient prospective payment system (IPPS), including the two-midnight rule under the short inpatient hospital stay policy, the related -0.2 percent payment adjustment, and a proposed transition for Medicare-dependent, small rural hospitals located in all-urban states. Additionally, the agency proposes to apply a 2 percent reduction to the CY16 conversion factor to redress the inflation in OPPS payment rates resulting from excess packaged payment under the OPPS for laboratory tests from its final CY14 laboratory packaging policy.

Comments on the proposed rule are due on Aug. 31, 2015**.**

Payment Impact

The following table shows the estimated impact of the proposed rule on hospitals after all CY16 updates have been made. CMS provides a more comprehensive table on pages 39362-39363 (Table 65) of the proposed rule.

CY16 OPPS Update Impact Table

	All Changes (Percentage)
All Hospitals	-0.2
Urban Hospitals	-0.2
Rural Hospitals	-0.3
Teaching Status	
Non-Teaching	-0.2
Minor	-0.1
Major	-0.3

OPPS Payment Updates

Federal Register pages: 39205, 39238

Proposed Update: For CY16, the proposed conversion factor is **$73.929.** CMS calculated this factor using the CY15 conversion factor of $74.173 and applied the market basket increase of **2.7** percent, which was adjusted for:

- -0.6 percent Affordable Care Act (ACA) multifactor productivity
- -0.2 percent required by the ACA
- -2 percent CMS estimation error related to lab packaging (explained in this document)

Hospitals that fail to meet the OQR reporting requirements will see the market basket update reduced by an additional 2 percent.

Update Summary: The proposed IPPS market basket percentage increase for FY16 is **2.7** percent. The market basket increase is reduced by the multifactor productivity adjustment (MFP), which is proposed to be **0.6 percent** for CY16. The market basket percentage increase is further reduced by an additional **0.2**, as required by the Affordable Care Act, resulting in the proposed outpatient department (OPD) fee schedule increase factor of **1.9** percent, which would be used in the calculation of the CY16 proposed OPPS conversion factor.

Hospital Outpatient Outlier Payments
Federal Register pages: 39246-39247

Proposed Update: The fixed-dollar threshold would be **$ 3,650** for FY16. The FY15 fixed dollar threshold is $**2,775**.

Wage Index Changes
Federal Register pages 39240- 39242

Proposed Update: For the CY16 OPPS, CMS is proposing to implement this provision in the same manner it has since CY11. Under this policy, 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 reprinting the proposed FY16 IPPS wage indexes referenced in the discussion of the wage index. CMS refers readers to the OPPS area of its website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

Readers will also find a link to the proposed FY16 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, CMS proposes to continue this policy for the CY16 OPPS. It refers readers to section II.H. of the proposed rule for a description and an example of how the wage index for a particular hospital is used to determine payment for the hospital.

For CY16, frontier state hospitals would receive a wage index of 1.00. Because the hospital outpatient department (HOPD) receives a wage index based on the geographic location of the specific inpatient hospital with which it is associated, the frontier state wage index adjustment applicable for the inpatient hospital also would apply for any associated HOPD. CMS would use the proposed FY16 hospital IPPS post-reclassified wage index for urban and rural areas as the

wage index for the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount for CY16.

For CY16, CMS proposes to continue its policy of allowing non-IPPS hospitals paid under the OPPS to qualify for the outmigration adjustment, if they are located in a section 505 out-migration county. The new Table 2 from the FY16 IPPS/Long-term care hospital (LTCH) PPS proposed rule is on the CMS web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html, and identifies counties eligible for the outmigration adjustment and IPPS hospitals that would receive the adjustment for FY16.

For CY15, CMS finalized a one-year blended wage index for all hospitals that experienced any decrease in their actual payment wage index exclusively due to the implementation of the new Office of Management and Budget (OMB) delineations. This one-year 50 percent transition blend is applied to hospitals paid under the OPPS, but not under the IPPS, and, therefore, does not apply for the CY16 OPPS wage index, because it expires at the end of CY15.

Adjustment for Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs)
Federal Register pages 39244

Proposed Update: For the CY16 OPPS, CMS proposes to continue its policy of a 7.1 percent budget neutral payment adjustment that is done in a budget neutral manner for rural SCHs, including 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 39206, 39238, 39244-39246

Proposed Update: CMS proposes to continue adjusting payments to each of the 11 exempt cancer hospitals so their payment-to-cost ratio equals the weighted average of other OPPS hospitals (.90). The adjustment is budget neutral based on the most recently filed cost report data.

Packaging Policy
Federal Register pages: 39233-39236

Proposed Update: For CY16, CMS is proposing to expand the set of conditionally packaged ancillary services to include three new Ambulatory Payment Classifications (APCs).

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. The 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. As CMS continues to develop larger payment groups that more broadly reflect services provided in an encounter or episode of care, CMS has expanded the

OPPS packaging policies. In order to further advance the OPPS towards a more prospective system, it continues to examine the payment for items and services provided under the OPPS to determine which services can be packaged.

Ancillary Services

In the CY15 OPPS final rule, CMS conditionally packaged payment for ancillary services assigned to APCs, with a geometric mean cost of less than or equal to $100 (prior to application of the conditional packaging status indicator). CMS implemented 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). An increase in the geometric mean cost of any of those packaged APCs to above $100 in future years does not change the conditionally packaged status of services assigned to the APCs selected in CY15 in a future year. When CMS finalized this policy, it stated that it would continue to consider services in these APCs to be conditionally packaged and would review the conditionally packaged status of ancillary services annually.

Packaging Policies

For CY16, CMS is proposing to not limit its examination to ancillary service APCs with a geometric mean cost of $100 or less, as there are some ancillary services that are assigned to APCs with a geometric mean cost above $100, but for which conditional packaging is appropriate, given the context in which the service is performed. Under CMS's proposal to evaluate categories of ancillary services by considering the clinical similarity of such categories of services to the currently conditionally packaged ancillary services that have already been determined to be integral, ancillary, supportive, dependent, or adjunctive to a primary service, it identified services in certain APCs that meet these criteria and did not apply the $100 geometric mean cost threshold that it applied for CY15.

For CY16, CMS would expand the set of conditionally packaged ancillary services to include services in the three APCs listed in the table below (Table 8 of the proposed rule).

TABLE 8—PROPOSED APCS FOR CONDITIONALLY PACKAGED ANCILLARY SERVICES FOR CY 2016

Proposed renumbered CY 2016 APC*	Proposed CY 2016 APC title	Proposed CY 2016 OPPS status indicator	Proposed CY 2016 payment rate
5734	Level 4 Minor Procedures	Q1	$119.58
5673	Level 3 Pathology	Q2	229.13
5674	Level 4 Pathology	Q2	459.96

*Addendum Q to this proposed rule (which is available via the Internet on the CMS Web site) contains a crosswalk of the existing APC numbers to the proposed APC renumbers for CY 2016.

Ancillary services in the APCs in Table 8 are typically furnished with a higher paying, separately payable primary procedure. However, to avoid packaging a subset of high-cost pathology services into lower cost and nonprimary services frequently billed with some of the services assigned to Level 3 and Level 4 pathology APCs, CMS is proposing to package Level 3 and 4 pathology services only when they are billed with a surgical service. For the Level 3 and 4 pathology APCs listed in the table, the assigned status indicator would be ''Q2'' (''T

packaging''). The Healthcare Common Procedure Coding System (HCPCS) codes that would be conditionally packaged as ancillary services for CY16 are displayed in Addendum B to the proposed rule (which is available on the CMS website). Additionally, CMS is proposing to continue to exclude certain services from this ancillary services packaging policy, including preventive services, certain psychiatric and counseling-related services, and certain low-cost drug administration services, which are separately payable under the OPPS. The preventable services that would continue to be exempted from the ancillary service packaging policy for CY16 are listed in Table 9 of the proposed rule.

APC Restructuring

For the CY16 update, as a part of its continued review of the structure of the APCs, CMS proposes to restructure the following ***nine APC clinical families*** based on the same principles used for restructuring the ophthalmology and gynecology APCs for CY15:

- Airway Endoscopy Procedures
- Diagnostic Tests and Related Services
- Excision/Biopsy and Incision and Drainage Procedures
- Gastrointestinal (GI) Procedures
- Imaging Services
- Orthopedic Procedures
- Skin Procedures
- Urology and Related Services Procedures
- Vascular Procedures (Excluding Endovascular Procedures)

CMS based the restructuring of the APCs for these clinical families on the following principles:

- Improved clinical homogeneity
- Improved resource homogeneity
- Reduced resource overlap in APCs within a clinical family
- Greater simplicity and improved understanding of the structure of the APCs

Tables 19 through 36 contain the current CY15 APCs and the proposed CY16 APCs that would result from the proposed consolidation and restructuring of the groupings for the nine APC clinical categories. In conjunction with this proposed restructuring, CMS is also proposing to renumber several families of APCs to provide consecutive APC numbers for consecutive APC levels within a clinical family for improved identification and ease of understanding the APC groupings.

Expiration of Transitional Pass-Through Payments

Under OPPS, a category of devices is eligible for transitional pass-through payments for at least two years, but not more than three years. There currently are four device categories eligible for pass-through payment:

- HCPCS code C1841 (Retinal prosthesis, includes all internal and external components), established effective Oct. 1, 2013

- HCPCS code C2624 (Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components), established effective Jan, 1, 2015
- HCPCS code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser), established effective April 1, 2015
- HCPCS code C2613 (Lung biopsy plug with delivery system), established effective July 1, 2015

The pass-through payment status of the device category for **HCPCS code C1841** will end on Dec. 31, 2015. Therefore, in accordance with its established policy, beginning with CY16, CMS is proposing to package the costs of HCPCS code C1841 devices into the costs related to the procedures with which the device is reported in the hospital claims data. If CMS creates any new device categories for pass-through payment status during the remainder of CY15 or during CY16, it will propose future expiration dates.

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

For CY16 and subsequent years, CMS proposes 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. Under this proposed policy, hospitals would continue to be required to report on the claim the amount of the credit in the amount portion for value code ‘‘FD’’ when the hospital receives a credit for a replaced device that is 50 percent or greater than the cost of the device.

For CY16 and subsequent years, CMS also is 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 CY16 policy would apply. The criteria include:

- All procedures assigned to the selected APCs must involve implantable devices that would be reported if device insertion procedures were performed.
- 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).
- The device offset amount must be significant, which, for purposes of this policy, is defined as exceeding 40 percent of the APC cost.

CMS examined the offset amounts calculated from the CY16 proposed rule claims data and the clinical characteristics of the proposed CY16 APCs to determine which APCs meet the criteria for CY16. This full list of device-intensive APCs to which CMS is proposing that the payment adjustment policy for no cost/full credit and partial credit devices would apply in CY16 is included in ***Appendix 1*** (Table 38 of the proposed rule).

Payments for Hospital Outpatient Visits
Federal Register pages 39287-39290

Proposed Update:
For CY16, CMS is proposing to continue the current policy, adopted in CY14, for clinic and emergency department (ED) visits. HCPCS code G0463 (for hospital use only) will represent any and all clinic visits under the OPPS. As part of its broader initiative to restructure APCs across the OPPS in order to collectively group services that are clinically similar and have similar resource costs within the same APC, CMS would reassign HCPCS code G0463 from existing APC 0634 to proposed renumbered APC 5012 (Level 2 Examinations and Related Services), formerly APC 0632.

Update Summary:
At this time, as stated in the CY14 OPPS final rule, CMS continues to believe that additional study is needed to assess the most suitable payment structure for ED visits. Therefore, for CY16, CMS is not proposing any change in ED visit coding. Rather, as it did for CY15 and prior years, for CY16, CMS proposes to continue to use the existing methodology to recognize the existing five 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 proposed CY16 OPPS payment rates using its established standard process. CMS may propose changes to the coding and APC assignments for ED visits in future rulemaking.

Critical Care Service Payments
For CY16 and subsequent years, CMS is proposing to continue its policy (that has been in place since CY11) to recognize the existing CPT codes for critical care services and to establish a payment rate based on historical claims data. CMS is also proposing to continue to implement claims processing edits that conditionally package payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment.

Proposed Payment for Chronic Care Management Services
In the CY15 OPPS final rule with comment period, CMS assigned CPT code 99490 to APC 0631 (Level 1 Examinations and Related Services), with a payable status indicator of ‘‘V,’’ under general physician supervision. In the proposed rule, for CY16 and subsequent years, CMS is proposing to renumber APC 0631 as **APC 5011**. The current code descriptor for CPT code 99490 is ‘‘Chronic Care Management Services (CCM). In reviewing the questions from hospitals on billing of CCM services, CMS identified several issues that it believes need to be clarified. Therefore, for CY16 and subsequent years, CMS proposes additional requirements for hospitals to bill and receive OPPS payment for CPT code 99490. One requirement is that a hospital would only be able to bill CPT code 99490 for CCM services when they are furnished to a patient who has been either admitted to the hospital as an inpatient or has been a registered outpatient of the hospital within the last 12 months, and for whom the hospital furnished therapeutic services. Thus, the adopted relationship requirement would be an explicit condition for billing and payment of CCM services under the OPPS. Also, for CY16 and subsequent years, hospitals furnishing and billing services described by CPT code 99490 under the OPPS would be required to have documented in the hospital’s medical record, the patient’s agreement to have the

services provided, or, alternatively, to have the patient's agreement to have the CCM services provided documented in a beneficiary's medical record that can be accessed by the hospital. Additionally, hospitals furnishing and billing for CCM services described would be required to document in the hospital or beneficiary medical record that all elements of the CCM services were explained and offered to the beneficiary, including a notation of the beneficiary's decision to accept or decline the services.

CMS proposes to require a hospital that bills and receives OPPS payment for their clinical staff furnishing CCM services described by CPT code 99490 under the direction of a physician or other appropriate nonphysician practitioner to provide:

- Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record.
- Access to care management services 24 hours a day/seven days a week (providing the beneficiary with a means to make timely contact with health care providers to address his or her urgent chronic care needs).
- Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.
- Care management for chronic conditions, including systematic assessment of the beneficiary's medical, functional, and psychosocial needs.
- Documentation of the creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment or reassessment and an inventory of resources and supports (a comprehensive care plan for all health issues).
- A written or electronic copy of the care plan provided to the beneficiary, the provisions of which are document in the electronic medical record using certified information technology.
- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an ED visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities.
- Coordination with home- and community-based clinical service providers required to support the patient's psychosocial needs and functional deficits.
- Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non face-to-face consultation methods.

Partial Hospitalization Payments APC Update
Federal Register pages 39290-39299

Proposed Update: For CY16, CMS is proposing to continue to 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 and cost data for each provider type.

Update Summary:
The relative payment weights for the OPPS payment rates for PHP services provided by community mental health centers (CMHCs) are based solely on CMHC data and relative payment weights for hospital-based PHP services to be based exclusively on hospital data. CMS would compute proposed CMHC PHP APC geometric mean per diem costs for Level 1 (three services per day) and Level 2 (four or more services per day) PHP services using only CY14 CMHC claims data and the most recent cost data. CMS would compute proposed hospital-based PHP APC geometric mean per diem costs for Level 1 and Level 2 PHP services using only CY14 hospital-based PHP claims data and the most recent cost data.

OPPS Payment Status and Comment Indicators
Federal Register pages 39302-39303

Proposed Update: For CY16, CMS is proposing to create two new status indicators:

- ''J2''- to identify certain combinations of services that it is proposing to pay through new proposed C–APC 8011 (Comprehensive Observation Services)
- ''Q4''- to identify conditionally packaged laboratory tests

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

The proposed CY16 payment status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, to the proposed rule, which are available on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

Comment Indicator Definitions
For CY16, CMS proposes to use three comment indicators. Two comment indicators, ''CH'' and ''NI,'' in effect in CY15 and would continue in CY16. Under the proposal, a new comment indicator, "NP", would be created that would be used to identify a new code for the next calendar year or an existing code with substantial revision to its code descriptor in the next calendar year as compared to current calendar year, proposed APC assignment; and that would indicate that comments will be accepted on the proposed APC assignment for the new code. CMS would use the ''CH'' comment indicator in the CY16 OPPS proposed rule to indicate HCPCS codes for which the status indicator or APC assignment, or both, are proposed for change in CY16 compared to their assignment as of June 30, 2015. CMS believes that using the ''CH'' indicator in the proposed rule will facilitate the public's review of the changes that it is proposes for CY16. Use of the comment indicator ''CH'' in association with a composite APC indicates that the configuration of the composite APC would be changed in the CY16 OPPS final rule with comment period.

For CY16, CMS proposes that any existing HCPCS codes with substantial revisions to the code descriptors for CY16 compared to the CY15 descriptors would be labeled with comment indicator ‘‘NI’’ in Addendum B to the CY16 OPPS final rule with comment period. However, in order to receive the comment indicator ‘‘NI,’’ the CY16 revision to the code descriptor (compared to the CY15 descriptor) must be significant such that the new code descriptor describes a new service or procedure for which the OPPS treatment may change. CMS would use comment indicator ‘‘NI’’ to indicate that these HCPCS codes will be open for comment as part of the CY16 OPPS final rule with comment period.

The proposed definitions of the OPPS comment indicators for CY16 are listed in Addendum D2 to the proposed rule, which is available on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/HospitalOutpatientPPS/index.html

Comprehensive APCs
Federal Register pages 39222-39228

Proposed Update: For CY16, CMS proposes to continue to implement the Comprehensive Ambulatory Payment Classification (C–APC) payment policy methodology made effective in CY15.

Update Summary: In the CY14 OPPS final rule, CMS finalized a comprehensive payment policy that packages payment for adjunctive and secondary items, services, and procedures into the most costly primary procedure under the OPPS at the claim level. This policy was finalized in CY14, but the effective date was delayed until Jan. 1, 2015, to allow additional time for further analysis, opportunity for public comment, and systems preparation. In the CY15 final rule, CMS established C–APCs as a category broadly for OPPS payment and implemented 25 C–APCs, beginning in CY15. Under this policy, a HCPCS code assigned to a C–APC is designated as the primary service (identified by a new OPPS status indicator ‘‘J1’’).

For CY16, CMS is not proposing extensive changes to the already established methodology used for C–APCs. However, under the proposal, CMS would continue to define the services assigned to C–APCs as primary services and to define a C–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 also continue to follow the C–APC payment policy methodology of including all covered hospital outpatient department services on a hospital outpatient claim reporting a primary service that is assigned to status indicator ‘‘J1,’’ excluding services that are not covered OPD services or that cannot by statute be paid under the OPPS. After its annual review of the OPPS, CMS is proposing **nine additional C– APCs** to be paid under the existing C–APC payment policy, beginning in CY16.

Among these is a proposed new comprehensive observation services APC (C-APC 8011), which would replace the current composite extended assessment and management APC 8009. With the proposed establishment of C–APC 8011 to capture qualifying extended assessment and management encounters currently paid using composite APC 8009, CMS would delete APC 8009.

CMS would make a C–APC payment through the proposed new C–APC 8011 for claims that meet the following criteria:

- The claims do not contain a HCPCS code to which CMS has assigned status indicator ‘‘T’’ that is reported with a date of service on the same day or one day earlier than the date of service associated with HCPCS code G0378.
- The claims contain eight or more units of services described by HCPCS code G0378 (Observation services, per hour).
- The claims contain one of the following codes: HCPCS code G0379 on the same date of service as G0378, CPT code 99285 or HCPCS code G0384, CPT code 99291, or HCPCS code G0463 provided on the same date of service or one day before the date of service for HCPCS code G0378.
- The claims do not contain a HCPCS code to which CMS has assigned status indicator ‘‘J1.’’

In CY16, CMS would pay for all qualifying extended assessment and management encounters through this new C–APC and assign the services within this APC to proposed new status indicator ‘‘J2.’’ CMS also proposes to create new C-APCs for ear, nose, and throat procedures, intraocular procedures, gynecologic procedures, laparoscopy, musculoskeletal procedures, urology and related procedures, and ancillary outpatient procedures when a patient expires. All C–APCs, including those effective in CY16 and those being proposed for CY16, are displayed in ***Appendix 2*** (Table 6 of the proposed rule), with the proposed new C–APCs denoted with an asterisk. Addendum J of the rule, available on the CMS website, contains all of the data related to the C–APC payment policy methodology, including the list of proposed complexity adjustments.

CMS is proposing to continue to define the services assigned to C–APCs as primary services and to define 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. 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. In CY15, CMS established C–APCs as a category broadly for OPPS payment and implemented 25 C–APCs. It also excluded preventive services from the C–APC payment policy. A list of these services can be found in ***Appendix 3*** (Table 5 of the proposed rule), which also includes any new preventive services added for CY16.

Hospital OQR Program Updates
Federal Register pages 39325- 39340

Proposed Update: For the Hospital OQR Program, CMS is making proposals that include changes for the CY17, CY18, and CY19 payment determination and subsequent years.

Update Summary:

Quality Measure for Removal for CY17 Payment Determination and Subsequent Years

CMS is proposing to remove one measure from the Hospital OQR Program quality measure set beginning with the CY17 payment determination and subsequent years:

- **OP–15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache**

The measure does not align with current clinical guidelines or practice.

New Quality Measures for the CY18 Payment Determination and Subsequent Years

CMS is also proposing to adopt the following new measure for the CY18 Hospital OQR Program:

- **OP–33: External Beam Radiotherapy (EBRT) for Bone Metastases (NQF #1822)** This chart-abstracted measure is National Quality Forum (NQF)-endorsed and was supported by the Measure Application Partnership (MAP) for inclusion in the OQR. OP-33 assesses the percentage of patients with painful bone metastases with no previous radiation to the same site who receive (EBRT using certain "fractionation," or dosing, schedules. CMS believes that this measure will reduce the rate of EBRT services overuse, support its commitment to promoting patient safety, and support the NQF priority of making care safer. CMS proposes that hospitals submit OP-33 data using its web-based tool on the QualityNet website. In the proposed rule, CMS indicates its hope that reporting the measure will encourage hospitals to deliver no more radiation therapy to bone metastasis patients than is necessary.

The proposed and previously finalized measures for the CY18 payment determination and subsequent years are listed in ***Appendix 4***.

New Quality Measures for the CY19 Payment Determination and Subsequent Years

To address concerns associated with care when patients are transferred EDs to other facilities, CMS proposes to adopt the following new web-based quality measure for the Hospital OQR Program, effective with the CY19 payment determination and subsequent years:

- **OP–34: Emergency Department Transfer Communication (EDTC) (NQF #0291)** CMS believes hospitals will require approximately three to six months to familiarize themselves with the implementation protocol and tools related to the EDTC measure and to make associated improvements prior to the first reporting deadline. The EDTC measure captures the percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative and clinical information was communicated to the receiving facility in an appropriate time frame. This measure is designed to prevent gaps in care transitions caused by inadequate or insufficient information that lead to avoidable adverse events. The measure consists of seven subcomponents, comprised of a total of 27 elements. CMS is proposing to use a scoring methodology by which the facility score is reported as the percentage (0–100 percent) of all cases with a perfect score of seven. The measure has been rigorously peer

reviewed and extensively tested with field tests from 2004 to 2014, across 16 states in 249 hospitals. CMS proposes that hospitals submit OP-34 data using its web-based tool on the QualityNet website.

The list of numerator elements for the measure is included in ***Appendix 5*** of this document

In the rule, CMS provides illustrations of two cases in which all patient data elements were recorded and transferred to the receiving facility, and when patient data elements failed to be recorded and/or transferred to the receiving facility.

The proposed and previously finalized measures for the CY19 payment determination and subsequent years are listed in ***Appendix 6***.

Hospital OQR Program Measures and Topics for Future Consideration
For future payment determinations, CMS is considering expanding the Hospital OQR measure areas and creating measures in new areas. Specifically, CMS is exploring electronic clinical quality measures and whether, in future rulemaking, it would propose that hospitals have the option to voluntarily submit data for OP–18: Median Time from ED Arrival to ED Departure for Discharged ED Patients electronically, beginning with the CY19 payment determination. Hospitals would otherwise still be required to submit data for this measure through chart abstraction.

Requirements Regarding Participation Status
CMS proposes to make one change to the requirements regarding participation in the Hospital OQR Program, beginning with the CY17 payment determination. Currently, a participating hospital may withdraw from the Hospital OQR Program any time from Jan. 1 to Nov. 1 of the year prior to the affected annual payment update. Under the proposal, beginning in CY17, hospitals could submit a withdrawal up to and including Aug. 31 of the year prior to the affected annual payment update. The proposed change to the withdrawal deadline is consistent with the ASCQR Program withdrawal deadline.

Form, Manner, and Timing of Data Submitted for the Hospital OQR Program
The chart-abstracted data upon which CMS bases Annual Percentage Update (APU) determinations on is quarter three of the two years prior to the payment determination through quarter two of the year prior to the payment determination. APU determinations are applied to payments beginning in January of the following year, providing less than two months between the time the data on which it bases APU determinations is submitted for validation and the beginning of the payments that are affected by this data. This timeline creates compressed processing issues for CMS, and a short window of time for hospitals to review their APU determination decisions. To ease this burden for both CMS and hospitals, CMS is proposing to change the timeframe on which it bases APU determinations for the Hospital OQR Program to patient encounter quarter two of the two years prior to the payment determination, through patient encounter quarter one of the year prior to the payment determination, beginning with CY18 and for subsequent years. Since the deadline for hospitals to submit chart-abstracted data for quarter one is Aug. 1, this change will give both CMS and hospitals additional time to review

the APU determinations before they are implemented in January. To ease the transition to the newly proposed timeframe for CY18 payments and subsequent years, CMS would use only three quarters of data for determining the CY17 payments. **CMS notes, however, that data submission deadlines will not be changing.** The data submission quarters are outlined in ***Appendix 7***.

Proposed Data Submission Requirements for Measure Data Submitted via Web-based Tool
There are many web-based quality measures previously finalized and retained in the Hospital OQR Program that require data to be submitted via a web-based tool (QualityNet website or Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) website). CMS is proposing to make one change to the data submission requirements for measures submitted via this tool, beginning with the CY17 payment determination. This proposal does not affect OP–27: Influenza Vaccination Coverage Among Healthcare Personnel, which is submitted via the CDC NHSN website. To be consistent with the data submission deadlines proposed by the ASCQR Program (explained in section XIV.D.8. of the proposed rule) and align with the submission deadline for OP–27, hospitals would have to report web-based measures by May 15 of the year prior to the payment determination with respect to the encounter period of Jan. 1 to Dec. 31 of two years prior to the payment determination year. For example, for the CY17 payment determination, the data submission window would be Jan. 1, 2016, through May 15, 2016.

Hospital OQR Program Reconsideration and Appeals Procedures for the CY18
Currently, a hospital must submit a reconsideration request to CMS via the QualityNet website no later than the first business day of the month of February of the affected payment year. CMS is proposing that, beginning with the CY18 payment determination, hospitals must submit a reconsideration request to CMS via the QualityNet website by no later than the first business day on or after March 17 of the affected payment year. Again, CMS is proposing this new reconsideration submission deadline to be consistent with the proposed ASCQR Program reconsideration submission deadline. CMS is also proposing to change the reconsideration request deadline from the first business day of the month of February of the affected payment year to the first business day on or after March 17 of the affected payment year. These procedure changes would be effective for the CY18 OQR program.

II. AMBULATORY SURGICAL CENTERS (ASCs)
Federal Register pages 39302-39325

Calculation of the ASC Payment Rates
Federal Register pages 39322-39324

Proposed Update: Most ASC payment rates are calculated by multiplying the ASC conversion factor by the ASC relative payment weight. The FY16 proposed ASC conversion factor is **$44.605** for ASCs that meet the quality reporting requirements and **$43.723** for those that do not. CMS estimates that proposed total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) for CY16 would be approximately **$4.293 billion**, an increase of approximately $186 million compared to estimated CY15 Medicare payments.

Update Summary: Consistent with its final FY15 ASC payment policy, for the CY16 ASC payment system and subsequent years, 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 CY16, CMS calculated this proposed adjustment for the ASC payment system by using the most recent CY14 claims data available and estimating the difference in total payment that would be created by introducing the proposed CY16 ASC wage indexes. CMS calculated the total adjusted payment using the CY15 ASC wage indexes (which reflect the new OMB delineations and include any applicable transition period) and the total adjusted payment using the proposed CY16 ASC wage indexes (which would fully reflect the new OMB delineations). CMS then used the 50-percent labor-related share for both total adjusted payment calculations, then compared the total adjusted payment calculated with the CY15 ASC wage indexes to the total adjusted payment calculated with the proposed CY16 ASC wage indexes, and applied the resulting ratio of 1.0014 (the proposed CY16 ASC wage index budget neutrality adjustment) to the CY15 ASC conversion factor to calculate the proposed CY16 ASC conversion factor.

Quality Reporting

For the proposed rule, based on IHS Global Insight's (IGI's) 2015 first quarter forecast with historical data through 2014 fourth quarter, for the 12-month period ending with the midpoint of CY16, the Consumer Price Index for All Urban Consumers (CPI–U) update is projected to be **1.7** percent. Also, based on IGI's 2015 first quarter forecast, the MFP adjustment for the period ending with the midpoint of CY16 is projected to be 0.6 percent. CMS is proposing to reduce the CPI–U update of 1.7 percent by the MFP adjustment of 0.6 percent, resulting in an MFP adjusted CPI–U update factor of **1.1** percent for ASCs meeting the quality reporting requirements. Therefore, CMS would apply a **1.1** percent MFP-adjusted CPI–U update factor to the CY15 ASC conversion factor for ASCs meeting the quality reporting requirements.

For CY16, CMS is also proposing to adjust the CY15 ASC conversion factor ($44.058) by the proposed wage index budget neutrality factor of 1.0014 in addition to the MFP-adjusted CPI–U update factor of 1.1 percent discussed above, which results in a proposed CY16 ASC conversion factor of **$44.605** for ASCs meeting the quality reporting requirements.
The following table displays the CY16 proposed rate update calculations under the ASC payment system.

Quality Reporting

CPI-U update	(Minus) MFP Adjustment	**MFP-Adjusted CPI-U Update**
1.7	0.6%	**1.1%**

No Quality Reporting

CMS is proposing to apply a **0.9** percent quality reporting/MFP adjusted CPI–U update factor to the CY15 ASC conversion factor for ASCs not meeting the quality reporting requirements. CMS is proposing to adjust the CY15 ASC conversion factor ($44.058) by the proposed wage index

budget neutrality factor of 1.0014, in addition to the quality reporting/MFP-adjusted CPI–U update factor of -0.9 percent, which results in a proposed CY16 ASC conversion factor of **$43.723**. For ASCs that do not meet the quality reporting requirements, CMS would reduce the CPI–U update of 1.7 percent by the 2.0 percent additional OQR reduction, and then apply the 0.6 percent MFP reduction, resulting in a **-0.9** percent quality reporting/MFP adjusted CPI–U update factor to the CY15 ASC conversion factor for ASCs not meeting the quality reporting requirements. CMS also proposed that, if more recent data are subsequently available (for example, a more recent estimate of the CY16 CPI–U update and MFP adjustment), it would use this data, if appropriate, to determine the CY16 ASC update for the OPPS final rule.

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

No Quality Reporting

CPI-U update	(Minus) Hospital OQR Reduction	(Minus) MFP Adjustment	**MFP-Adjusted CPI-U Update**
1.7%	2.0%	0.6%	**-0.9 %**

Addenda AA and BB to the proposed rule (which are available on the CMS website) display the proposed updated ASC payment rates for CY16 for covered surgical procedures and covered ancillary services, respectively. The proposed 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 proposed CY16 payment rates.

ASC-covered Surgical Procedures

Surgical procedures in an ASC are procedures that are separately paid under the OPPS, that would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure, or an ‘‘overnight stay.’’ Payment for ancillary items and services that are not paid separately under the ASC payment system is packaged into the ASC payment for the covered surgical procedure. CMS updates the lists of, and payment rates for, covered surgical procedures and ancillary services in ASCs in conjunction with the annual proposed and final rules updating the OPPS and ASC payment system. CMS conducted a review of HCPCS codes currently paid under the OPPS, but not included on the ASC list of covered surgical procedures, to determine if changes in technology or medical practice affected the clinical appropriateness of these procedures for the ASC setting. Based on this review, CMS is proposing to update the list of ASC covered surgical procedures by adding 11 procedures to the list for CY16, which are listed in the table below.

TABLE 63—PROPOSED ADDITIONS TO THE LIST OF ASC COVERED SURGICAL PROCEDURES FOR CY 2016

Proposed CY 2016 HCPCS code	Proposed CY 2016 long descriptor	Proposed CY 2016 ASC payment indicator
0171T	Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level.	J8
0172T	Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; each additional level.	N1
57120	Colpocleisis (Le Fort type)	J8
57310	Closure of urethrovaginal fistula	J8
58260	Vaginal hysterectomy, for uterus 250 g or less	J8
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	J8
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g	J8
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	J8
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g	J8
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	J8
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	J8

Surgical Procedures Designated as Office-based

Office-based procedures are those that are included on the ASC list of covered surgical procedures that it determines are performed more than 50 percent of the time in physicians' offices. Each year, CMS identifies covered surgical procedures as either temporarily, permanently, or non-office-based, after taking into account updated volume and utilization data. CMS's review of the CY14 volume and utilization data resulted in its identification of two covered surgical procedures that it believes meet the criteria for designation as office-based. These two CPT codes are listed in the table below.

TABLE 59—ASC COVERED SURGICAL PROCEDURES NEWLY PROPOSED AS PERMANENTLY OFFICE-BASED FOR CY 2016

Proposed CY 2016 CPT code	Proposed CY 2016 long descriptor	CY 2015 ASC payment indicator	Proposed CY 2016 ASC payment indicator *
43197	Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).	G2	P3
43198	Esophagoscopy, flexible, transnasal; with biopsy, single or multiple	G2	P3

* Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. Current law specifies a 0.5 percent update to the MPFS payment rates for CY 2016. For a discussion of the MPFS rates, we refer readers to the CY 2016 MPFS proposed rule.

Payment for Covered Ancillary Services

Federal Register pages 39316- 39320

Update Summary: For CY16 and subsequent years, 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 systems regarding the packaged or separately payable status of services, and the proposed CY16 OPPS and ASC payment rates and subsequent year payment rates. CMS is also proposing to continue to set the CY16 ASC payment rates and subsequent year payment rates for brachytherapy sources and separately payable drugs and biologicals equal to the proposed OPPS payment rates for CY16. The CY16 payment for separately payable covered radiology services would be based on a comparison of the proposed CY16 MPFS nonfacility practice expense relative value unit-based amounts (CMS refers readers to the CY16 MPFS proposed rule) and the CY16 ASC payment rates calculated according to the ASC standard ratesetting methodology, and then set at the lower of the two amounts. CMS is proposing to continue the methodologies for paying for covered ancillary services established for

CY15. Most of these covered ancillary services and their proposed payment are listed in Addendum BB to the proposed rule, available on the CMS website.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program Requirements
Federal Register pages 39340-39347

Proposed Update: CMS proposes to codify many of the existing administrative policies regarding the ASCQR Program. Its statutory authority for the ASCQR Program would be codified in new proposed 42 CFR 416.300(a).

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, preventive service measure submitted via an on-line web-based tool (to CDC's NHSN) 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 in the following table.

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.

In the CY15 OPPS final rule, CMS excluded one of these measures, **ASC–11: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (NQF #1536)**, from the CY16 payment determination measure set, and allowed for voluntary data collection and reporting for the CY17 payment determination and subsequent years. Also, in that rule, CMS adopted one additional claims-based measure for the CY18 payment determination and subsequent years. Most of the quality measures adopted for use by the ASCQR Program are NQF endorsed, although such endorsement is not a requirement for

adopting a measure. Two measures previously adopted for the ASCQR Program that are not currently NQF endorsed and were not endorsed when adopted for the program, include:

- ASC–6: Safe Surgery Checklist Use
- ASC–7: ASC Facility Volume Data on Selected ASC Surgical Procedures

ASC–12: Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (NQF #2539) was not NQF-endorsed at the time it was adopted for the ASCQR Program, but now is NQF-endorsed. Recently, NQF removed its endorsement from ASC–5: Prophylactic Intravenous (IV) Antibiotic Timing (formerly NQF #0264). However, CMS continues to believe that ASC–5 is appropriate for measurement of the quality of care furnished by ASCs and should be retained by the ASCQR Program. CMS will continue to evaluate the appropriateness of this measure for the ASCQR Program as it does other measures.

The previously finalized measure set for the ASCQR Program CY17 payment determination and subsequent years is listed in the following table.

ASCQR Program Measure Set Previously Finalized 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	All-Cause Hospital Transfer/Admission.*
ASC–5	N/A	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.**

*This measure was previously titled "Hospital Transfer/Admission." According to the NQF Web site, the title was changed to better reflect what is being measured. We have updated the title of this measure to align it with the NQF update to the title.
**Measure voluntarily collected effective beginning with the CY 2017 payment determination as set forth in section XIV.E.3.c. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66984 through 66985).

CMS is not proposing to adopt any additional measures for the ASCQR Program for the CY18 payment determination and subsequent years in the proposed rule. The previously finalized measure set for the CY18 ASCQR Program is listed in the following table.

ASCQR PROGRAM MEASURE SET PREVIOUSLY FINALIZED FOR THE CY 2018 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	All-Cause Hospital Transfer/Admission.*
ASC–5	N/A	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	2539	Facility Seven-Day Risk—Standardized Hospital Visit Rate after Outpatient Colonoscopy.***

*This measure was previously titled "Hospital Transfer/Admission." According to the NQF Web site, the title was changed to better reflect what is being measured. We have updated the title of this measure to align it with the NQF update to the title.

**Measure voluntarily collected effective beginning with the CY 2017 payment determination as set forth in section XIV.E.3.c. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66984 through 66985).

***New measure finalized for the CY 2018 payment determination and subsequent years in the CY 2015 OPPS/ASC final rule with comment period (79 FR 66970 through 66979).

ASCQR Program Measures for Future Consideration

In this proposed rule, CMS is inviting public comment on the following two measures developed by the ASC Quality Collaboration for inclusion in the ASCQR Program in the future:

1. ***Normothermia Outcome***: This measure assesses the percentage of patients having surgical procedures under general or neuroaxial anesthesia of 60 minutes or more in duration who have a normal body temperature within 15 minutes of arrival in the post-anesthesia care unit. CMS suggests that perioperative hypothermia increases the risk of adverse events, and the measure would assess an aspect of ASC safety. This measure is of interest to the ASCQR Program because many surgical procedures performed at ASCs involve anesthesia.

2. ***Unplanned Anterior Vitrectomy***: This measure assesses the percentage of cataract surgery patients who have an unplanned anterior "vitrectomy," or the removal of the clear gel present in the anterior chamber of the eye. CMS suggests that, while unplanned victrectomy rates are low, it can result in poor surgical outcomes. This measure is of interest to the ASCQR Program because cataract surgery is a procedure commonly performed at ASCs.

Both measures have received conditional support from the MAP, pending the completion of reliability testing and NQF endorsement. CMS is inviting public comment on the possible inclusion of these measures in the ASCQR Program measure set in the future.

Public Reporting of ASCQR Program Data

The data that an ASC submits for the ASCQR Program is publicly available on a CMS website after it has had an opportunity to review the data to be made public. These data are displayed at the CMS Certification Number level. To allow for identification of individual facility information, beginning with any public reporting that occurs on or after Jan. 1, 2016, CMS is

proposing to display the data by the National Provider Identifier (NPI) when data are submitted by the NPI. CMS believes identifying data by the NPI would enable consumers to make more informed decisions about their care because the public would be able to distinguish between ASCs. CMS is also proposing, beginning with any public reporting that occurs on or after Jan. 1, 2016, to display data by the CMS Certification Number (CCN) when data are submitted by the CCN. When data are submitted by the CCN, all NPIs associated with the CCN would be assigned the CCN's value because CMS would not be able to parse the data by the NPI.

Requirements for Data Submitted Via Online Data Submission Tool

In the CY14 OPPS, CMS finalized the data collection time period for quality measures for which data are submitted via an online data submission tool as services furnished during the calendar year two years prior to the payment determination year. CMS also finalized its policy that these data will be submitted during the time period of Jan. 1 to Aug. 15 in the year prior to the affected payment determination year. Under the proposal, May 15 would be the submission deadline for all data submitted via a CMS web-based tool in the ASCQR Program for the CY17 payment determination and subsequent years. Thus, data collected for a quality measure for which data are submitted via a CMS online data submission tool must be submitted between Jan. 1 and May 15 in the year prior to the payment determination year for the CY17 payment determination and subsequent years. CMS is proposing this change because it believes that aligning all web-based tool data submission deadlines with the end date of May 15 would allow for earlier public reporting of measure data and reduce the administrative burden for ASCs.

Claims-Based Measure Data Requirements for the ASC–12

Unlike the other claims-based measures adopted for the ASCQR Program, this claims-based measure does not require any additional data submission, such as quality data codes (QDCs). CMS is proposing to align its policy regarding the paid claims to be included in the calculation for claims-based measures not using QDCs with its policy regarding the paid claims to be included for the claims-based measures using QDCs. Beginning with the CY18 payment determination, CMS would use claims for services furnished in each calendar year that have been paid by the Medicare Administrative Contractor (MAC) by April 30 of the following year of the ending data collection time period to be included in the data used for the payment determination.

Exclusion of Indian Health Service Hospital Outpatient Departments

CMS has considered Indian health service (IHS) hospital outpatient departments to be ASCs for purposes of the ASCQR Program due to their payment under the ASC payment system. Under the rule, CMS is now proposing that these facilities not be considered ASCs for purposes of the ASCQR Program, beginning with the CY17 payment determination. These facilities would not be required to meet ASCQR Program requirements and would not receive any payment reduction under the ASCQR Program. Because IHS hospital outpatient departments are required to meet the conditions of participation for hospitals, they should be included in the hospitals' ongoing, hospital-wide, data driven quality assessment and performance improvement programs, which CMS believes ensures that they engage in quality improvement efforts outside of participation in CMS's quality reporting programs.

ASCQR Program Reconsideration Procedures

For those ASCs that submit a reconsideration request, the reconsideration determination is the final ASCQR Program payment determination. For ASCs that do not submit a timely reconsideration request, the CMS determination is the final payment determination. There is no appeal of any final ASCQR Program payment determination. In the proposed rule, CMS would make one change to these requirements. Under the current reconsideration procedures, ASCs are required to submit reconsideration requests by March 17 of the affected payment determination year. In some payment years, March 17 may fall outside of the business week. Therefore, CMS proposes that, beginning with the CY17 payment determination, ASCs must submit a reconsideration request to CMS by no later than the first business day on or after March 17 of the affected payment year.

Short Inpatient Hospital Stays

Federal Register pages 39348-39353

Proposed Update: CMS is proposing several changes to its short stay policy, including altering it so that certain hospital inpatient services that do not cross two midnights may be appropriate for payment under Medicare Part A.

Background: In the FY14 IPPS final rule, CMS discussed its longstanding policy on how Medicare contractors review inpatient hospital and critical access hospital admissions for payment purposes. In that final rule, CMS discussed previously existing Medicare policy stating that when a beneficiary receives a minor surgical procedure or other treatment in the hospital that is expected to keep him or her for only a few hours (less than 24 hours), the services generally should be billed as outpatient hospital services, regardless of the hour the beneficiary comes to the hospital, whether he or she uses a bed, and whether he or she remains in the hospital past midnight. This instruction provided a benchmark to ensure that all beneficiaries received consistent application of their Medicare Part A benefit to whatever clinical services were medically necessary. However, due to persistently large improper payment rates in short-stay hospital inpatient claims, requests to provide additional guidance regarding the proper billing of those services, and concerns about increasingly long stays of Medicare beneficiaries as outpatients due to hospital uncertainties about payment, CMS modified and clarified its general rule in the regulations with respect to Medicare payment for inpatient hospital admissions.

CMS provided guidance for payment purposes that specified that, generally, a hospital inpatient admission is considered reasonable and necessary if a physician or other qualified practitioner (collectively, ‘‘physician’’) orders such admission based on the expectation that the beneficiary’s length of stay will exceed two midnights, or if the beneficiary requires a procedure specified as inpatient only. Not only did CMS finalize that services designated under the OPPS as inpatient only procedures would continue to be appropriate for inpatient hospital admission and payment under Medicare Part A, it also finalized a benchmark providing that surgical procedures, diagnostic tests, and other treatments would be generally considered appropriate for inpatient hospital admission and payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least two midnights and admits the patient to the hospital based upon that expectation. Conversely, when a beneficiary enters a hospital for these services, and

the physician expects to keep the beneficiary in the hospital for only a limited period of time that does not cross two midnights, the services would be generally inappropriate for payment under Medicare Part A, regardless of the hour that the beneficiary came to the hospital, or whether the beneficiary used a bed.

CMS continues to believe that use of the two-midnight benchmark gives appropriate consideration to the medical judgment of physicians and also furthers the goal of clearly identifying when an inpatient admission is appropriate for payment under Medicare Part A. CMS also acknowledges that certain procedures may have intrinsic risks, recovery impacts, or complexities that would cause them to be appropriate for inpatient coverage under Medicare Part A regardless of the length of hospital time the admitting physician expects a particular patient to require. In January 2014, CMS identified medically necessary, newly initiated mechanical ventilation (excluding anticipated intubations related to minor surgical procedures or other treatment) as the first such rare and unusual exception to the two-midnight benchmark.

As part of its efforts to provide education to stakeholders on the two-midnight rule, CMS has hosted numerous ''Open Door Forums," conducted national provider calls, and posted frequently asked questions on its website, in addition to ''probe and educate'' reviews of inpatient claims. In response to industry feedback, including suggestions to limit the Recovery Audit Program, on Dec. 30, 2014, CMS announced a number of changes to the program, to be effective with the next Recovery Audit Program contract awards.

Update Summary:
Under the existing rare and unusual policy, CMS has identified one exception, prolonged mechanical ventilation, to date. Upon further consideration and based on feedback from stakeholders, CMS believes there may be other patient specific circumstances where certain cases may be appropriate for Part A payment, absent an expected stay of at least two midnights. Under the proposed rule, CMS would modify its existing ''rare and unusual'' exceptions policy to allow for Medicare Part A payment on a case-by case basis for inpatient admissions that do not satisfy the two-midnight benchmark, if the documentation in the medical record supports the admitting physician's determination that the patient requires inpatient care despite an expected length of stay less than two midnights. For payment purposes, several factors, among others, would be relevant to determining whether an inpatient admission where the patient stay is expected to be less than two midnights is nonetheless appropriate for Part A payment. These factors include:

- The severity of the signs and symptoms exhibited by the patient.
- The medical predictability of something adverse happening to the patient.
- The need for diagnostic studies that appropriately are outpatient services (that is, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more).

CMS notes that these cases will be prioritized for medical review. As under the current policy, under the proposed revised policy, the medical reviewer's clinical judgment would involve the synthesis of all submitted medical record information to make a medical review determination on

whether the clinical requirements in the relevant policy have been met. CMS invites public comment on whether specific medical review criteria should be adopted for inpatient hospital admissions that are not expected to span at least two midnights and, if so, what those criteria should be. CMS is not proposing any changes for hospital stays that are expected to be greater than two midnights, nor is it proposing to change the two-midnight presumption.

Currently, the MACs perform ‘‘probe and educate’’ audits under the two-midnight rule. Regardless of whether CMS finalizes the policy proposals outlined in the rule, it has announced that, no later than Oct. 1, 2015, it is changing the medical review strategy and plans to have Quality Improvement Organization (QIO) contractors conduct the reviews of short inpatient stays rather than the MACs. QIOs will now refer hospitals with high denial rates to the Recovery Audit Contactors for further payment audit. CMS has not defined what a “high” denial rate is. CMS notes that it will adopt this new medical review strategy regardless of whether the two-midnight rule remains unchanged or is modified. In addition to the formal medical review process, CMS intends to continuously monitor and evaluate the proposed changes to the two-midnight payment policy and medical review strategy, and also monitor applicable data for signs of systematic gaming of this policy.

Several stakeholder groups have examined short-stay payment policies, but there is no consensus on what a short-stay payment policy should be. In Chapter 7 of its June Report to Congress, MedPAC recently recommended repealing the two-midnight rule in its entirety, but has not recommended a short-stay payment policy. CMS has requested public comment on three different occasions on issues pertaining to the two-midnight rule. The public comment process has not produced any consensus on a recommended payment policy proposal to address this issue. CMS continues to be open to considering potential payment policy options that have the potential to address this issue.

Transition for Medicare-Dependent, Small Rural Hospitals (MDHs)
Federal Register, pages 39353-39354

Proposed Update: CMS proposes to allow Medicare-Dependent, Small Rural Hospitals **(**MDHs) a three-year transition period to phase out its MDH payments.

Background: Section 1885(d)(5)(G) of the Act provides special payment protections under the IPPS to MDHs. MDHs are paid for their hospital inpatient services based on the higher of the federal rate, or a blended rate based, in part, on the federal rate and the MDH’s hospital specific rate. Although the MDH program was to be in effect through the end of FY11 only, the program has since been extended several times. Most recently, section 205 of the Medicare Access and CHIP Reauthorization Act of 2015, enacted April 16, 2015, provides for an extension of the program through FY17.

Update Summary:

Implementation of New OMB Delineations and Urban to Rural Reclassification
On Feb. 28, 2013, the OMB issued OMB Bulletin No. 13–01, which established revised delineations for Metropolitan Statistical Areas (MSAs), Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas, based on 2010 decennial Census data. In the FY15 IPPS final rule, CMS adopted the new OMB labor market area delineations, beginning in FY15. Consequently, there were 105 counties that were previously located in rural areas that became urban areas under the new OMB delineations. This transition from rural to urban under the new OMB delineations required MDHs in those counties to apply for rural status in order to retain their MDH classifications and avoid losing the special payment protections provided to them. In order to be approved for a rural reclassification, a hospital located in an urban area must meet one of the following four criteria:

1. Is located in a rural census tract of an MSA;
2. Is located in an area designated by any state law or regulation as a rural area or is designated by such state as a rural hospital;
3. Would qualify as a rural referral center or a sole community hospital if the hospital were located in a rural area; or
4. Meets such other criteria as the HHS Secretary may specify.

A hospital may not reclassify from urban to rural under section 1886(d)(8)(E) of the Act in an all-urban state, which, as of Oct. 1, 2014, included New Jersey, Delaware, and Rhode Island. MDHs that shifted from rural to urban under the new OMB delineations may apply for rural reclassification under §412.103. In a situation where a hospital could not reclassify to a rural area under §412.103 because it is now located in an all-urban state, the hospital would lose its MDH status and would be paid for hospital inpatient services at the federal rate, which may be substantially lower than its hospital-specific rate. Given that the MDH program was recently extended to expire Oct. 1, 2017, CMS believes it would be appropriate to provide a prospective payment rate transition period for MDHs that cannot retain such status due to their location in a newly redesignated urban area located in an all-urban state and, therefore, lack a rural area within their state into which they could reclassify.

CMS is proposing that, effective Jan. 1, 2016, payments to hospitals that lost their MDH status because they are no longer in a rural area due to the adoption of the new OMB delineations and are now located in all-urban states would transition from payments based, in part, on the hospital-specific rate, to payments based entirely on the federal rate. Currently, an MDH receives the higher of the federal rate or the federal rate payment plus 75 percent of the amount by which the federal rate payment is exceeded by its hospital-specific rate payment. For discharges occurring on or after Jan. 1, 2016, and before Oct. 1, 2016, a former MDH in an all-urban state would receive the federal rate plus two-thirds of 75 percent of the amount by which the federal rate payment is exceeded by its hospital-specific rate payment. Also, for FY18, for discharges occurring on or after Oct. 1, 2018, CMS is proposing that these former MDHs would be paid solely based on the federal rate.

CMS notes that allowing a gradual transition for such hospitals from payments based, in part, on the hospital-specific rate to payments based solely on the federal rate would minimize the negative impact of its adoption of the new OMB delineations, which caused certain rural hospitals to lose their MDH status.

More Information

The proposed rule was published in the *July 8, 2015*, *Federal Register*. Additional information regarding the OPPS is available on the CMS website.

Appendix 1: CY16 Proposed Device Intensive APCs

TABLE 38—PROPOSED CY 2016 DEVICE-INTENSIVE APCS

Proposed re-numbered CY 2016 APC *	Proposed CY 2016 APC title
0039	Level III Neurostimulator & Related Procedures.
0061	Level II Neurostimulator & Related Procedures.
0089	Level III Pacemaker & Similar Procedures.
0090	Level II Pacemaker & Similar Procedures.
0105	Level I Pacemaker & Similar Procedures.
0107	Level I ICD & Similar Procedures.
0108	Level II ICD & Similar Procedures.
0227	Implantation of Drug Infusion Device.
0229	Level II Endovascular Procedures.
0259	Level VI ENT Procedures.
0293	Level III Intraocular Procedures.
0318	Level IV Neurostimulator & Related Procedures.
0319	Level III Endovascular Procedures.
0351	Level IV Intraocular Procedures.
0386	Level VII Urology & Related Procedures.
0425	Level IV Musculoskeletal Procedures.
0655	Level IV Pacemaker & Similar Procedures.
1564	New Technology—Level 27.
1593	New Technology—Level 46.

* Addendum Q to this proposed rule (which is available via the Internet on the CMS web site) provides a crosswalk of the existing APC numbers to the proposed APC renumbers.

Appendix 2: CY16 Proposed C-APCs

Note: the proposed new C–APCs denoted with an asterisk

TABLE 6—PROPOSED CY 2016 C–APCS

Proposed CY 2016 C–APC+	Proposed CY 2016 APC descriptor	Clinical family	New C–APC
5222	Level 2 Pacemaker and Similar Procedures	AICDP	
5223	Level 3 Pacemaker and Similar Procedures	AICDP	
5224	Level 4 Pacemaker and Similar Procedures	AICDP	
5231	Level 1 ICD and Similar Procedures	AICDP	
5232	Level 2 ICD and Similar Procedures	AICDP	
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	BREAS	
5165	Level 5 ENT Procedures	ENTXX	*
5166	Level 6 ENT Procedures	ENTXX	
5211	Level 1 Electrophysiologic Procedures	EPHYS	
5212	Level 2 Electrophysiologic Procedures	EPHYS	
5213	Level 3 Electrophysiologic Procedures	EPHYS	

TABLE 6—PROPOSED CY 2016 C–APCS—Continued

Proposed CY 2016 C–APC+	Proposed CY 2016 APC descriptor	Clinical family	New C–APC
5492	Level 2 Intraocular Procedures	EYEXX	*
5493	Level 3 Intraocular Procedures	EYEXX	
5494	Level 4 Intraocular Procedures	EYEXX	
5331	Complex GI Procedures	GIXXX	
5415	Level 5 Gynecologic Procedures	GYNXX	
5416	Level 6 Gynecologic Procedures	GYNXX	*
5361	Level 1 Laparoscopy	LAPXX	*
5362	Level 2 Laparoscopy	LAPXX	*
5462	Level 2 Neurostimulator and Related Procedures	NSTIM	
5463	Level 3 Neurostimulator and Related Procedures	NSTIM	
5464	Level 4 Neurostimulator and Related Procedures	NSTIM	
5123	Level 3 Musculoskeletal Procedures	ORTHO	*
5124	Level 4 Musculoskeletal Procedures	ORTHO	
5471	Implantation of Drug Infusion Device	PUMPS	
5631	Single Session Cranial Stereotactic Radiosurgery	RADTX	
5375	Level 5 Urology and Related Services	UROXX	*
5376	Level 6 Urology and Related Services	UROXX	
5377	Level 7 Urology and Related Services	UROXX	
5191	Level 1 Endovascular Procedures	VASCX	
5192	Level 2 Endovascular Procedures	VASCX	
5193	Level 3 Endovascular Procedures	VASCX	
5881	Ancillary Outpatient Services When Patient Expires	N/A	*
8011	Comprehensive Observation Services	N/A	*

+ We refer readers to section III.D. of this proposed rule for a discussion of the proposed overall restructuring and renumbering of APCs and to Addendum Q to this proposed rule (which is available via the Internet on the CMS Web site) for a complete crosswalk of the existing APC numbers to the proposed new APC numbers.

* Proposed New C–APC for CY 2016.

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
GYNXX = Gynecologic Procedures
LAPXX = Laparoscopic Procedures
NSTIM = Neurostimulators
ORTHO = Orthopedic Surgery
PUMPS = Implantable Drug Delivery Systems
RADTX = Radiation Oncology
UROXX = Urologic Procedures
VASCX = Vascular Procedures

Appendix 3: C-APC Payment Policy Excluded Services

TABLE 5—COMPREHENSIVE APC PAYMENT POLICY EXCLUSIONS FOR CY 2016

Ambulance services;
Brachytherapy;
Diagnostic and mammography screenings;
Physical therapy, speech-language pathology and occupational therapy services—Therapy services reported on a separate facility claim for recurring services;
Pass-through drugs, biologicals, and devices;
Preventive services defined in 42 CFR410.2:

- Annual wellness visits providing personalized prevention plan services
- Initial preventive physical examinations
- Pneumococcal, influenza, and hepatitis B vaccines and administrations
- Mammography Screenings
- Pap smear screenings and pelvic examination screenings
- Low Dose Computed Tomography
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetes outpatient self-management training services
- Bone mass measurements
- Glaucoma screenings
- Medical nutrition therapy services
- Cardiovascular screening blood tests
- Diabetes screening tests
- Ultrasound screenings for abdominal aortic aneurysm
- Additional preventive services (as defined in section 1861(ddd)(1) of the Act);

Self-administered drugs (SADs)—Drugs that are usually self-administered and do not function as supplies in the provision of the comprehensive service;
Services assigned to OPPS status indicator "F" (certain CRNA services, Hepatitis B vaccines and corneal tissue acquisition);
Services assigned to OPPS status indicator "L" (influenza and pneumococcal pneumonia vaccines); and
Certain Part B inpatient services—Ancillary Part B inpatient services payable under Part B when the primary "J1" service for the claim is not a payable Medicare Part B inpatient service (for example, exhausted Medicare Part A benefits, beneficiaries with Part B only).

Appendix 4: Proposed and Previously Finalized CY18 OQR Measures

PROPOSED HOSPITAL OQR PROGRAM MEASURE SET FOR THE CY 2018 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.
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–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.**
2539	OP–32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.
1822	OP–33: External Beam Radiotherapy for Bone Metastases.***

*OP–26: Procedure categories and corresponding HCPCS codes are located at: *https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1196289981244.*

Appendix 5: OP-34 Numerator Elements

NUMERATOR ELEMENTS FOR OP–34: EMERGENCY DEPARTMENT TRANSFER COMMUNICATION
(EDTC) Measure (NQF #0291)

Administrative communication (EDTC-Subsection 1)	
	Nurse to nurse communication. Physician to physician communication.
Patient information (EDTC-Subsection 2)	
	Name.

NUMERATOR ELEMENTS FOR OP–34: EMERGENCY DEPARTMENT TRANSFER COMMUNICATION—Continued
(EDTC) Measure (NQF #0291)

	Address. Age. Gender. Significant others contact information. Insurance.
Vital signs (EDTC-Subsection 3)	
	Pulse. Respiratory rate. Blood pressure. Oxygen saturation. Temperature. Glasgow score or other neuro assessment for trauma, cognitively altered or neuro patients only.
Medication information (EDTC-Subsection 4)	
	Medications administered in ED. Allergies. Home medications.
Physician or practitioner generated information (EDTC-Subsection 5)	
	History and physical. Reason for transfer and/or plan of care.
Nurse generated information (EDTC-Subsection 6)	
	Assessments/interventions/response. Sensory Status (formerly Impairments). Catheters. Immobilizations. Respiratory support. Oral limitations.
Procedures and tests (EDTC-Subsection 7)	
	Tests and procedures done. Tests and procedure results sent.

Appendix 6:- Proposed and Previously Finalized CY19 OQR Measures

PROPOSED HOSPITAL OQR PROGRAM MEASURE SET FOR THE CY 2019 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.
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–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.**
2539	OP–32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.
1822	OP–33: External Beam Radiotherapy for Bone Metastases.***
0291	OP–34: Emergency Department Transfer Communication Measure.****

*OP–26: Procedure categories and corresponding HCPCS codes are located at: *https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1196289981244.*

**Measure voluntarily collected as set forth in section XIII.D.3.b. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66946 through 66947).

***New measure proposed for the CY 2018 payment determination and subsequent years.

****New measure proposed for the CY 2019 payment determination and subsequent years.

Appendix 7: Proposed Updates for APU Determination

APU DETERMINATION TRANSITION

[CY 2016 Payment Determination (Current State)]

Patient encounter quarter	Clinical data submission deadline
Q3 2014 (July 1–Sept. 30) ...	2/1/2015
Q4 2014 (Oct. 1–Dec. 31)	5/1/2015
Q1 2015 (Jan. 1–March 31)	8/1/2015
Q2 2015 (April 1–June 30) ...	11/1/2015

[Proposed CY 2017 Payment Determination (Future State—Transition Period)]

Patient encounter quarter	Clinical data submission deadline
Q3 2015 (July 1–Sept. 30).	2/1/2016
Q4 2015 (Oct. 1–Dec. 31).	5/1/2016
Q1 2016 (Jan. 1–March 31).	8/1/2016

[Proposed CY 2018 Payment Determination and Subsequent Years (Future State)]

Patient encounter quarter	Clinical data submission deadline
Q2 2016 (April 1–June 30).	11/1/2016
Q3 2016 (July 1–Sept. 30).	2/1/2017
Q4 2016 (Oct. 1–Dec. 31).	5/1/2017
Q1 2017 (Jan. 1–March 31).	8/1/2017