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CY16 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 2016 (CY16). The final rule with comment period is available in the Nov. 13, 2016, *Federal Register*.

Comments on the final rule are due by Dec. 29, 2015.

Because of staff and resource limitations, the Centers for Medicare & Services (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–FC
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–FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Overview

CMS released a final rule with comment period revising the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for CY16 to implement certain applicable statutory requirements and changes. In this final rule, CMS describes the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and the ASC payment system. The final rule also updates and refines the requirements for the Hospital Outpatient Quality Reporting (OQR) Program, as well as the ASC Quality Reporting (ASCQR) Program. Further, the rule also includes certain finalized policies relating to the hospital inpatient prospective payment system (IPPS), including changes to the two-midnight rule under the short inpatient hospital stay policy; and a payment transition for hospitals that lost their status as a Medicare-dependent, small rural hospital (MDH), because they are no longer in a rural area due to the implementation of the new Office of Management and Budget (OMB) delineations in FY15 and have not reclassified from urban to rural before Jan. 1, 2016. The rule finalizes certain 2015 proposals and addresses public comments received, relating to the changes in the Medicare regulations governing provider administrative appeals and judicial review relating to appropriate claims in provider cost reports.

The final rule is effective Jan. 1, 2016, and comments are due Dec. 29, 2015**.**

Payment Impact

The following table shows the impact of the final rule on hospitals after all CY16 updates have been made. CMS provides a more comprehensive table on pages 70588-70589 (Table 70) of the final rule.

CY16 OPPS Update Impact Table

	All Changes (Percentage)
All Hospitals	-0.4
Urban Hospitals	-0.4
Rural Hospitals	-0.6
Teaching Status	
Non-Teaching	-0.7
Minor	-0.5
Major	0.1

OPPS Payment Updates

Federal Register pages: 70351-70357

Final Update: For CY16, the conversion factor is:

- **$73.725** for organizations that submit outpatient quality data.
- **$72.251** for organizations that do not submit outpatient quality data

CMS is decreasing the payment rates under the OPPS by an outpatient department (OPD) fee schedule increase factor of **-0.3** percent, as reflected by the adjustments in the following table.

Adjustment	Percentage
Market Basket Update	2.4%
Multifactor Productivity Adjustment	-0.5%
Affordable Care Act (ACA) Adjustment	-0.2%
Lab Packing Estimation Error Adjustment	-2.0%
Final OPPS Payment Rate Update	**-0.3%**

Short Inpatient Hospital Stays

Federal Register pages 70538-70549

Final Update:

Under the final rule, CMS will revise its previous ‘‘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 hospital care despite an expected length of stay that is less than two midnights. For payment purposes, several factors, among others, will be relevant to determine 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 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. Although CMS reviewers will take into consideration the physician’s decision to admit a beneficiary, the admission must be reasonable and necessary, and supported by clear documentation in the patient’s medical record in order to be covered under Medicare Part A. CMS did not make any changes pertaining to hospital stays that are expected to be greater than two midnights, nor did it change the two-midnight presumption.

Announcement Regarding Change in Medical Review Responsibilities

Currently, the Medicare Administrative Contractors (MACs) perform ‘‘probe and educate’’ audits under the two-midnight rule. CMS 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. Those having high denial rates and consistently failing to adhere to the two-midnight rule (including having frequent inpatient hospital admissions for stays that do not span one midnight) or failing to improve their performance after QIO educational intervention, will be referred to the

Recovery Auditors for further medical review. CMS has yet to define what a "high" denial rate is.

CMS 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. CMS will continue to assess the two-midnight payment policy in future years and, as with all Medicare payment policies, may make future payment modifications based on the trends observed.

Hospital Outpatient Outlier Payments

Federal Register pages: 70363-70365

Final Update: The fixed-dollar threshold is **$3,250** for FY16. The FY15 fixed dollar threshold was $**2,775**.

Wage Index Changes

Federal Register pages: 70357-70359

Final Update: For the CY16 OPPS, CMS will implement this provision in the same manner it has since CY11. Under this policy, 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 reprinting the final 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 final 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 will continue this policy for the CY16 OPPS. CMS refers readers to section II.H. of the final rule with comment period 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 will 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 will use the final FY16 hospital IPPS post-reclassified wage index for urban and rural areas in its entirety

as the final 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 will 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 final rule (available via the internet on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending) identifies counties eligible for the out-migration adjustment and IPPS hospitals that will 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 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 70361-70362

Final Update: After consideration of the public comments received, CMS finalized its proposal for CY16 to continue its policy of a 7.1 percent 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 passthrough payment policy, and items paid at charges reduced to costs.

Cancer Hospital Payment Adjustment

Federal Register pages 70362-70363

Final Update: CMS estimated that, on average, the OPPS payments to other hospitals furnishing services under the OPPS are approximately 92 percent of reasonable cost (weighted average payment-to-cost ratio (PCR) of 0.92). Therefore, it is finalizing that the payment amount associated with the cancer hospital payment adjustment to be determined at cost report settlement would be the additional payment needed to result in a PCR equal to 0.92 for each cancer hospital. Table 15 of the final rule indicates estimates in percentage terms of the CY16 payment adjustment for each cancer hospital.

Packaging Policy

Federal Register pages: 70344-70346

Final Update: For CY16, CMS will expand the set of conditionally packaged ancillary services to include three new ambulatory payment classifications (APCs). CMS will not limit its examination to ancillary service APCs with a geometric mean cost of $100 or less (as discussed

in the CY15 final rule), 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 these categories to the currently conditionally packaged ancillary services that are 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 will expand the set of conditionally packaged ancillary services to include services in the three APCs listed in the table below (Table 11 of the final rule).

TABLE 11—APCS FOR CONDITIONALLY PACKAGED ANCILLARY SERVICES FOR CY 2016

Renumbered CY 2016 APC	CY 2016 APC title	CY 2016 OPPS status indicator	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

Ancillary services in the table above 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 will 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 CMS is conditionally packaging as ancillary services for CY16 are displayed in Addendum B to the final rule (which is available on the CMS website). Additionally, CMS is finalizing its policy to continue to exempt preventive services from the ancillary services packaging policy for CY16. Preventive services that will continue to be exempted from the ancillary service packaging policy for CY16 and subsequent years are listed in ***Appendix 1*** of this document (Table 12 of the final rule)
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).

Under this policy, it assigned the conditionally packaged services to status indicator ''Q1,'' indicating that the service is separately payable when not billed on the same date of service as a HCPCS code assigned status indicator ''S,'' ''T,'' or ''V.'' The $100 geometric mean cost target adopted in CY15 was not intended to be a threshold above which ancillary services will not be packaged, but was a basis for selecting the initial set of APCs under the conditional packaging policy for ancillary services, which would likely be updated and expanded upon in the future. 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 packaged status of ancillary services annually.

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, it 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.

OPPS Ambulatory Payment Classification (APC) Group Policies

Federal Register pages: 70379-70415

CMS finalized, with some modifications, the restructuring of the nine clinical families of ***APCs*** for CY16. Each of the nine clinical families, the public comments received, and CMS's responses on those families are discussed in the rule. The final payment rates for the nine individual clinical family APCs are included in Addendum A to the final rule. CMS restructured the following ***APC clinical families*** based on the same principles it used for restructuring the ophthalmology and gynecology APCs for CY15:

- Airway Endoscopy Procedures
- Cardiovascular Procedures and Services
- Diagnostic Tests and Related Services
- Excision/Biopsy and Incision and Drainage Procedures
- Eye Surgery and Other Eye-Related Procedures
- Gastrointestinal (GI) Procedures
- Gynecologic Procedures and Services
- Imaging Services
- Orthopedic Procedures
- Pathology Services
- Radiology Oncology Procedures and Services
- Skin Procedures
- Urology and Related Services
- Vascular Procedures (Excluding Endovascular Procedures)
- Other Procedures and Services

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 22 through Table 40 contain the final CY16 APCs that result from the restructuring of the clinical families. In conjunction with this restructuring, CMS is renumbering 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.

OPPS Payment for Devices

Federal Register pages 70415-70426

Expiration of Transitional Pass-Through Payments

Under the OPPS, a category of devices is eligible for transitional pass-through payments for at least two years, but not more than three. 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 will 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.

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

For CY16 and subsequent years, CMS continues to reduce the OPPS payment for the device-intensive APCs (listed in Table 42 of the final rule) by the full or partial credit a provider receives for a replaced device. It is also finalizing its proposal, without modification, to no longer specify a list of devices to which the OPPS payment adjustment for no cost/full credit and partial credit devices would apply. Instead, it will apply this APC payment adjustment to all replaced devices furnished in conjunction with a procedure assigned to a device-intensive APC when the hospital receives a credit for a replaced specified device that is 50 percent or greater than the cost of the device.

The full list of device-intensive APCs to which the payment adjustment policy for no cost/full credit and partial credit devices would apply in CY16 is included in ***Appendix 2*** of this document (Table 42 of the final rule). CMS notes that APC 5221 does not have a final device offset of greater than 40 percent. Therefore, it will not be finalized as a device-intensive APC for CY16.

Adjustment to OPPS Payment for Discontinued Device-Intensive Procedures

CMS finalizes its proposed policy regarding discontinued device-intensive procedures, with modification. Specifically, for procedures involving implantable devices that are assigned to a device-intensive APC (defined as those APCs with a device offset greater than 40 percent), CMS will reduce the APC payment amount for discontinued device-intensive procedures, where anesthesia has not been administered to the patient (as evidenced by the presence of modifier ‘‘73’’), by 100 percent of the device offset amount prior to applying the additional payment adjustments that apply when the procedure is discontinued. CMS is not finalizing this policy for

procedures for which anesthesia is not planned, and the procedure is discontinued (as evidenced by the presence of modifier ‘‘52’’).

Payments for Hospital Outpatient Visits

Federal Register pages 70448-70453

Final Update: For CY16, CMS will continue to use HCPCS code G0463 (for hospital use only) to represent any and all clinic visits under the OPPS for CY16. In addition, HCPCS code G0463 will be reassigned from existing APC 0634 to renumbered APC 5012. CMS continues to believe that additional study is needed to assess the most suitable payment structure for ED visits. Therefore, for CY16, CMS will continue to use its existing methodology to recognize the existing CPT codes for Type A emergency department (ED) visits, as well as the five HCPCS codes that apply to Type B ED visits.

Critical Care Service Payments

CMS finalized its proposal, without modification, to continue its policy to recognize the existing CPT codes for critical care service, and establish a payment rate based on historical claims data, and 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.

Payment for Chronic Care Management Services

Federal Register pages 70450-70453

In the CY15 OPPS final rule, 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 OPPS final rule, for CY16 and subsequent years, CMS will 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. Under the final rule, 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, in order to bill and receive OPPS payment for CMM services described by CPT code 99490, hospitals will be required to have documented in the 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 the medical record that the hospital can access. In addition, for CY16 and subsequent years, CMS is requiring hospitals furnishing and billing for the CCM services described by CPT code 99490 under the OPPS to have documented in the medical record (or beneficiary medical record that the hospital can access) 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. The code can be billed once during the

calendar month service period. Part of the payment goes to the physician directly involved in the care, and part of the payment goes to the hospital.

Partial Hospitalization Payments APC Update

Federal Register pages 70453-70467

CMS updated the four partial hospitalization program (PHP) APC per diem costs and payment rates. For hospital-based PHP APCs, CMS is making an equitable adjustment to the actual geometric mean per diem costs by increasing the Level 2 per diem costs, and decreasing the Level 1 per diem costs by the same factor.

The tables below display the final CY16 PHP APC geometric mean per diem costs for community mental health center (CMHC) PHP services and the final PHP APC equitably adjusted geometric mean per diem costs for hospital-based PHP services.

TABLE 54—CY 2016 PHP APC GEOMETRIC MEAN PER DIEM COSTS FOR CMHC PHP SERVICES

Renumbered CY 2016 APC	Group title	PHP APC geometric mean per diem costs
5851	Level 1 Partial Hospitalization (3 services) for CMHCs	$98.88
5852	Level 2 Partial Hospitalization (4 or more services) for CMHCs	149.64

TABLE 55—CY 2016 PHP APC EQUITABLY ADJUSTED GEOMETRIC MEAN PER DIEM COSTS FOR HOSPITAL-BASED PHP SERVICES

Renumbered CY 2016 APC	Group title	PHP APC equitably adjusted geometric mean per diem costs
5861	Level 1 Partial Hospitalization (3 services) for hospital-based PHPs	$191.91
5862	Level 2 Partial Hospitalization (4 or more services) for hospital-based PHPs	222.54

OPPS Payment Status and Comment Indicators

Federal Register pages 70473-70474

Final Update: For CY16, CMS will create two new status indicators:

- ‘‘J2’’- to identify certain combinations of services that it will to pay through new C–APC 8011 (Comprehensive Observation Services)
- ‘‘Q4’’- to identify conditionally packaged laboratory tests

The complete list of the payment status indicators and their definitions for CY16 is displayed in Addendum D1 to the final rule with comment period, which is available on the CMS website at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/HospitalOutpatientPPS/index.html*

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

*Comment Indicator Definitions*The definitions of the OPPS comment indicators for CY16 are listed in Addendum D2 to the final rule with comment period, which is available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

Comprehensive APCs

Federal Register pages 70325-70339

Final Update: For CY16, CMS will continue to implement the Comprehensive Ambulatory Payment Classification (C–APC) payment policy methodology made effective in CY15. In CY16, CMS is not making extensive changes to the already established methodology used for C–APCs. However, it will establish ***10 additional C–APCs*** to be paid under the existing C–APC payment policy, beginning in CY16. CMS will also pay for all qualifying extended assessment and management encounters through a newly created ‘‘Comprehensive Observation Services’’ C–APC (C–APC 8011) and assign the services within this APC to proposed new status indicator ‘‘J2.’’

Update Summary: 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’’). It also excluded preventive services from the C–APC payment policy.

For CY16, CMS did not propose extensive changes to the already established methodology used for C–APCs. However, CMS will continue define the services assigned to C–APCs as primary services and 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 will also continue to follow the C–APC payment policy methodology of including all covered hospital outpatient department (OPD) 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 proposed nine additional C– APCs to be paid under the existing C–APC payment policy, beginning in CY16.

After consideration of the public comments received, CMS finalized its proposal with a slight modification to establish 10 additional C–APCs to be paid under the existing C–APC payment policy, beginning in CY16 because an additional level 5 was added to the musculoskeletal procedures APC series. Thus, several procedures that were proposed to be assigned to APC 5124 (Level 4 Musculoskeletal Procedures) will now reassigned to new APC 5125 (Level 5 Musculoskeletal Procedures) for CY16. In its effort to improve the similarity in resource use and

clinical characteristics within the orthopedic-related APC groupings, CMS will revise the existing orthopedic-related procedures APCs for CY16. CMS believes that the revised orthopedic-related procedures APCs more appropriately reflect the resource costs and clinical characteristics of the procedures within each APC.

CMS is also adopting a final policy to include all add-on codes that are paired with a primary service assigned status indicator ‘‘J1’’ to be evaluated to qualify for a complexity adjustment. All C–APCs, including those newly added for CY16, are displayed in ***Appendix 3*** (Table 9 of the final rule) with the new C–APCs denoted with an asterisk. Addendum J to the final rule, available on the CMS website, contains all of the data related to the C–APC payment policy methodology, including the list of complexity adjustments.

As CMS expanded the number of C–APCs, it believes that it must also expand the number of add-on codes that can be evaluated for a complexity adjustment beyond only those add-on codes that were once assigned to device-dependent APCs. Therefore, it is revising the list of add-on codes that are evaluated for a complexity adjustment to include all add-on codes that can be appropriately reported in combination with a base code that describes a primary ‘‘J1’’service. This expanded list can be found in Table 8 of the final rule (***Appendix 4*** of this document). In order to qualify for a complexity adjustment, the primary service add-on combination must meet the frequency (25 or more claims reporting the code combination) and cost (no violation of the two times rule) thresholds.

Comprehensive Observation Services APCs

Effective beginning CY16, CMS will delete the current composite extended assessment and management APC 8009, to establish new comprehensive observation services APC (C–APC 8011) to capture these encounters. CMS is modifying its proposed criteria for services to qualify for comprehensive payment through C–APC 8011 and how it identifies all claims used in rate setting for the new code. Specifically, CMS is adopting the following two modifications to its proposal:

1. The criteria for services to qualify for payment through C–APC 8011 and the claims identified for purposes of rate setting for C–APC 8011 will exclude all claims containing a status indicator ‘‘T’’ procedure from qualification; and

2. Any level ED visit is an eligible service that could trigger qualification and payment through C–APC 8011, as opposed to only high-level ED visits.

These finalized criteria for services to qualify for payment through C–APC 8011 are listed below. All claims meeting these criteria will be utilized in rate setting purposes for C–APC 8011 for CY16.

- The claims do not contain a procedure described by a HCPCS code to which CMS has assigned status indicator ‘‘T’’
- The claims contain eight or more units of services described by HCPCS code G0378 (Observation services, per hour)

- The claims contain services provided on the same date of service or one day before the date of service for HCPCS code G0378 that are described by one of the following codes: HCPCS code G0379 (Direct referral of patient for hospital observation care) on the same date of service as HCPCS code G0378; CPT code 99281, CPT code 99282, CPT code 99283, CPT code 99284, CPT code 99285, HCPCS code G0380, HCPCS code G0381, HCPCS code G0382, HCPCS code G0383, HCPCS code G0384, CPT code 99291, or HCPCS code G0463.
- The claims do not contain a service that is described by a HCPCS code to which CMS has assigned status indicator ‘‘J1.’

The final CY16 payment rate for C–APC 8011 is **$2,174.14**.

Additionally, CMS will pay for all qualifying extended assessment and management encounters through C–APC 8011 and assign the services within this APC to new status indicator ‘‘J2.’’

Stereotactic Radiosurgery
Regarding adjunctive services that are furnished prior to the delivery of the associated primary ‘‘J1’’ service, CMS finalizes its proposal, with modification. Specifically, for CY16 and CY17, CMS is adopting a policy to require the use of a HCPCS code modifier for adjunctive Stereotactic Radiosurgery (SRS) C–APC services that are reported separate from the primary ‘‘J1’’ SRS service. Effective Jan. 1, 2016, hospitals must use the HCPCS code modifier ‘‘CP’’ (adjunctive service related to a procedure assigned to a C–APC procedure, but reported on a different claim) to report adjunctive service(s) related to a primary ‘‘J1’’ SRS service that is reported on a separate claim than the primary ‘‘J1’’ service. With respect to other C–APCs, CMS is not adopting a policy to require the use of the HCPCS code modifier to identify adjunctive services that are reported separately at this time, but may consider doing so in the future.
CMS will develop the geometric mean costs of the C–APCs based on the costs of all reported OPPS payable services reported on the claim (excluding all preventive services and certain Medicare Part B inpatient services).

Hospital OQR Program Updates

Federal Register pages 70502-70524

Final Update: For the Hospital OQR Program, CMS has finalized 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
For CY17 and subsequent years, CMS is removing the following measure effective Jan. 1, 2016:

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

This measure does not align with current clinical guidelines or practice. No data for this measure will be used for any payment determination.

The finalized measures for the CY17 payment determination and subsequent years are listed in ***Appendix 5***.

New Quality Measures for the CY18 Payment Determination and Subsequent Years
CMS will 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. Data for OP–33 may only be submitted at an aggregate level via a CMS web-based tool (QualityNet website).

The finalized measures for the CY18 payment determination and subsequent years are listed in ***Appendix 6***.

Omitted Measure - OP-4: Aspirin at Arrival (NQF #0286)
CMS notes that in the CY16 OPPS proposed rule, OP–4: Aspirin at Arrival (NQF #0286) was inadvertently omitted from tables for the CY18 and CY19 payment determination and subsequent years. CMS clarifies that OP–4 has not been removed from the Hospital OQR Program measure set and data for OP–4 should be submitted for the CY18 payment determination and subsequent years as previously finalized.

New Quality Measures for the CY19 Payment Determination and Subsequent Years
CMS is not finalizing its proposal to implement ***OP–34: Emergency Department Transfer Communication (EDTC) (NQF #0291)***, beginning with the CY19 payment determination and subsequent years, or any of the associated changes. The finalized measures for the CY19 payment determination and subsequent years can be found in ***Appendix 7*** of this document.

Hospital OQR Program Measures and Topics for Future Consideration
CMS is exploring electronic clinical quality measures and whether, in future rulemaking, it would propose that hospitals have the option to voluntarily submit data electronically for ***OP–18: Median Time from ED Arrival to ED Departure for Discharged ED Patients***, 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
Under the final rule, beginning in CY17, the withdrawal deadline for the Hospital OQR Program will change from Nov. 1 to Aug. 31 of the year prior to the affected annual payment update.

CMS will revise 42 CFR 419.46(b) to reflect this change. This 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
CMS is changing the timeframe on which it bases annual payment update (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 new final timeframe for CY18 payments and subsequent years, CMS will use only three quarters of data for determining the CY17 payments. **CMS notes, however, that data submission deadlines will not be changing.** The final data submission quarters are outlined in ***Appendix 8***.

Data Submission Requirements for Measure Data Submitted via Web-based Tool
Under the final rule, CMS will change the deadline for the measures that are reported via the CMS web-based tool (QualityNet website) to conform to the deadline for the National Healthcare Safety Network (NHSN) measure reporting as proposed. The deadline for these measures, beginning with the CY17 payment determination, will be May 15 of the year prior to the payment determination. CMS notes that the ASCQR Program is not finalizing the May 15 deadline in section XIV.D.3. of the final rule due to commenters' concerns specific to the ASC setting. However, it believes that aligning with the NHSN measure submission deadline serves its goals of streamlining hospital submissions, earlier public reporting of measure data, and reduced administrative burden associated with tracking multiple submission deadlines for these measures.

Hospital OQR Program Reconsideration and Appeals Procedures for the CY18
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. This new reconsideration submission deadline is consistent with the ASCQR program reconsideration submission deadline finalized in section XIV.D.8. of the final rule.

II. AMBULATORY SURGICAL CENTERS (ASCs)
Federal Register pages

Calculation of ASC Payment Rates
Federal Register pages 70499-70501

Final Update:
For CY16, the conversion factor is:
- $44.177 for organizations that submit outpatient quality data.
- $43.296 for organizations that do not submit outpatient quality data

Update Summary: 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 final 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 final CY16 ASC wage indexes, and applied the resulting ratio of 0.9997 (the final CY16 ASC wage index budget neutrality adjustment) to the CY15 ASC conversion factor to calculate the final CY16 ASC conversion factor.

Quality Reporting

For the final rule, based on the IHS Global Insight, Inc., 2015 third quarter forecast, the Consumer Price Index for All Urban Consumers (CPI–U) for the 12-month period ending with the midpoint of CY16 is now projected to be 0.8 percent, while the MFP adjustment (as finalized in the CY12 Medicare physician fee schedule (MPFS) final rule) and revised as discussed in the CY16 OPS final rule is 0.5 percent, resulting in an MFP-adjusted CPI–U update factor of **0.3** percent for ASCs that meet the quality reporting requirements. The final ASC conversion factor of $44.177, for ASCs that meet the quality reporting requirements, is the product of the CY15 conversion factor of $44.058 multiplied by the wage index budget neutrality adjustment of 0.9997 and the MFP-adjusted CPI–U payment update of 0.3 percent.

Quality Reporting

CPI-U update	(Minus) MFP Adjustment	**MFP-Adjusted CPI-U Update**
0.8%	0.5%	**0.3%**

No Quality Reporting

For ASCs that do not meet the quality reporting requirements, CMS is reducing the CPI–U update of 0.8 percent by 2.0 percent, and then applying the 0.5 percent MFP reduction, resulting in a **-1.7** percent quality reporting/MFP adjusted CPI–U update factor. The final ASC conversion factor of **$43.296** for ASCs that do not meet the quality reporting requirements is the product of the CY15 conversion factor of $44.058 multiplied by the wage index budget neutrality adjustment of 0.9997 and the quality reporting/MFP-adjusted CPI–U payment update of -1.7 percent.

The following table displays the CY16 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**
0.8%	2.0%	0.5%	**-1.7%**

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

ASC-covered Surgical Procedures

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.
After consideration of the public comments, CMS finalized its proposal to add the 11 procedures that it proposed to add to the ASC list of covered surgical procedures. In addition, it is also adding six procedures recommended by commenters.

The HCPCS code long descriptors and CY16 payment indicators for these codes are displayed in ***Appendix 9*** of this document (Table 68 of the final rule).

Surgical Procedures Designated as Office-based

Office-based procedures are those that are included on the ASC list of covered surgical procedures that CMS 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. CMS is finalizing its proposal, without modification, to designate the procedures, set forth in Table 63 of the final rule (below) as permanently office-based for CY16.

TABLE 63—ASC COVERED SURGICAL PROCEDURES NEWLY DESIGNATED AS PERMANENTLY OFFICE-BASED FOR CY 2016

CY 2016 CPT code	CY 2016 long descriptor	CY 2015 ASC payment indicator	Proposed CY 2016 ASC payment indicator	Final 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	P3
43198	Esophagoscopy, flexible, transnasal; with biopsy, single or multiple	G2	P3	P3

* Final payment indicators are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS final 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 final rule with comment period.

Payment for Covered Ancillary Services

Federal Register pages 70494-70496

Update Summary: CMS is adopting as final the CY16 proposed ASC payment indicators and payment rates for the ASC covered surgical procedures and covered ancillary services described by the new Level II HCPCS codes implemented in April and July 2015, through the quarterly update change requests as shown in ***Appendix 10*** of this document (Tables 59, 60, and 61, of the final rule). The final CY16 ASC payment rates for these codes can be found in ASC Addendum AA and BB of the final rule. CMS will update the ASC payment rates and 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 final CY16 OPPS and ASC payment rates and subsequent year payment rates.

CMS will also 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. CMS did not receive comments regarding its proposal on this, so the payment rates will remain the same as proposed.

Since CMS did not receive comments on its policy proposals regarding payment for covered ancillary services, the CY16 payment for separately payable covered radiology services will be based on a comparison of the proposed CY16 MPFS nonfacility practice expense relative value unit-based amounts (for more details, CMS refers readers to the CY16 MPFS proposed rule) and the CY16 ASC payment rates calculated according to the ASC standard rate setting methodology, and then set at the lower of the two amounts. For those covered ancillary services where the payment rate is the lower of the final rates under the ASC standard rate setting 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 Jan. 1, 2016. For a discussion of the MPFS rates, CMS refers readers to the CY16 MPFS final rule with comment period.

CMS will continue the methodologies for paying for covered ancillary services established for CY15. Most of these covered ancillary services and their payment are listed in Addendum BB to the CY16 OPPS proposed rule, available on the CMS website.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program Requirements

Federal Register pages 70526-70537

Final Update: CMS finalizes its proposals to establish a new Subpart H under 42 CFR part 416 to codify many of the administrative policies regarding the ASCQR Program, and to codify the scope and basis of the ASCQR Program in 42 CFR 416.300.

Update Summary

CMS did not propose or finalize any changes to the ASCQR program. The previously finalized measure set for the ASCQR Program CY17 and CY18 payment determination and subsequent years are listed ***Appendix 11*** of this document.

Public Reporting of ASCQR Program Data

The data that an ASC submits for the ASCQR Program is publicly available on the 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 (CCN) level. CMS is finalizing its proposal that, beginning with any public reporting that occurs on or after Jan. 1, 2016, to publicly display data by the national provider identifier (NPI) when the data are submitted by the NPI, and to publicly display data by the CCN when the data are submitted by the CCN, but is not finalizing its proposal to attribute data submitted by the CCN to all NPIs associated with the CCN. CMS believes that 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. Also, CMS is finalizing its proposal to codify the CCN and NPI display policy at 42 CFR 416.315, with this modification.

Requirements for Data Submitted Via Online Data Submission Tool

CMS is not finalizing its proposal to implement a May 15 submission deadline for data submitted using a CMS online data submission tool. Instead, the ASCQR Program will continue to use the currently adopted submission deadlines for these measures; that is, the August 15 submission deadline for ASC–6, ASC–7, ASC–9, ASC–10, and ASC–11. The ASCQR Program will also continue to use the currently adopted May 15 submission deadline for ASC–8, which is submitted via a non-CMS online data submission tool (the CDC's NHSN website).

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.

Claims-Based Measure Data Requirements for the ASC–12

Unlike the other claims-based measures adopted for the ASCQR Program, this measure does not require any additional data submission, such as quality data codes (QDCs). CMS will 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 measures using QDCs. Beginning with the CY18 payment determination, CMS will 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 IHS hospital outpatient departments to be ASCs for purposes of the ASCQR Program due to their payment under the ASC payment system. Under the final rule, beginning with the CY17 payment determination, IHS hospital outpatient departments that bill Medicare for ASC services under the ASC payment system are not to be considered as ASCs for the purposes of the ASCQR Program. Therefore, these facilities will not be required to meet ASCQR Program requirements and will 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 will 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. 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, under the final rule, CMS will make one change to these requirements. 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.

Inpatient Only Procedures

Federal Register, pages 70467-70468

Final Update: CMS will remove a total of nine procedures from the inpatient only list.

Background: CMS has a long-standing policy on how it identifies procedures that are typically provided only in an inpatient setting (referred to as the inpatient only list) and, therefore, will not be paid by Medicare under the OPPS. CMS has specific criteria that it uses to review the inpatient only list each year to determine whether any procedures should be removed from the list.

Update Summary:
In the CY16 OPPS proposed rule, for the CY16 OPPS, CMS proposed to use the same methodology (described in the Nov. 15, 2004, final rule of reviewing the current list of procedures on the inpatient only list to identify any procedures that may be removed from the list. The established criteria upon which CMS makes its determination are as follows:

- Most outpatient departments are equipped to provide the services to the Medicare population;
- The simplest procedure described by the code may be performed in most outpatient departments;
- The procedure is related to codes that it has already removed from the inpatient only list.
- A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis;
- A determination is made that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or has been proposed by CMS for addition to the ASC list.

Using this methodology, for the proposed rule, CMS identified seven procedures that could potentially be removed from the inpatient only list for CY16. In the CY16 OPPS proposed rule, CMS proposed to remove the following seven procedures from the inpatient only list:

- CPT code 0312T (Vagus nerve blocking therapy (morbid obesity)
- CPT code 20936 (Autograft for spine surgery only (includes harvesting the graft)
- CPT code 20937 (Autograft for spine surgery only (includes harvesting the graft)
- CPT code 20938 (Autograft for spine surgery only (includes harvesting the graft)
- CPT code 22552 (Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace)

- CPT code 54411(Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including the irrigation and debridement of infected tissue);
- CPT code 54417 (Removal and replacement of non-inflatable (semirigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative sessions, including irrigation and debridement of infected tissue)

CMS is finalizing its proposal to remove these procedures from the inpatient only list for CY16. In addition, it is removing the procedures described by CPT codes 27477 (Arrest, epiphyseal, any method (*e.g.*, epiphysiodesis); tibia and fibula, proximal), and 27485 (Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (*e.g.*, genu varus or valgus)), which are both similar to the procedures described by CPT codes 27475 and 27479.from the list for CY16, as recommended by a commenter. These nine procedures and their CPT codes, long descriptors, APC assignments, and status indictors for CY16 are displayed in ***Appendix 12*** Table 58 of the final rule. The complete list of codes that will be paid by Medicare in CY16 as inpatient procedures only is included as Addendum E to the final rule with comment period (which is available on the CMS website).

Computed Tomography (CT) Payment Changes

Federal Register, pages 70470-70471

Final Update: CMS will establish a new CT modifier, ‘‘CT,” the use of which will result in the applicable payment reduction for the CT service.

Update Summary: Effective for services furnished on or after Jan, 1, 2016, payment for the technical component (TC) of applicable computed tomography (CT) services paid under the MPFS, and applicable CT services paid under the OPPS by 5 percent in 2016, and 15-percent in 2017, and subsequent years. The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes) for services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) Standard XR–29–2013, entitled ‘‘Standard Attributes on CT Equipment Related to Dose Optimization and Management.”

The two-digit modifier will be added to the HCPCS annual file as of Jan. 1, 2016, with the label ‘‘CT’’ and the long descriptor ‘‘Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR–29–2013 standard.’’ Beginning Jan. 1, 2016, hospitals and suppliers will be required to report the ‘‘CT’’ modifier on claims for CT scans described by any of the HCPCS codes identified above (and any successor codes) that are furnished on non-NEMA Standard XR–29–2013-compliant CT scanners. The use of this modifier will result in the applicable payment reduction for the CT service as specified under section 1834(p) of the Act.

Transition for Medicare-Dependent, Small Rural Hospitals (MDHs)

Federal Register, pages 70549

Final Update: CMS will allow Medicare-Dependent, Small Rural Hospitals **(**MDHs) that have lost their MDH status because they have been reclassified from a rural to urban area due to the adoption of the new OMB delineations, a three-year transition period to phase out its MDH payments.

Background: Section 1885(d)(5)(G) of the Social Security Act (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, provided for an extension of the program through FY17.

Update Summary:

Implementation of New OMB Delineations and Urban to Rural Reclassification

CMS finalized a policy 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 implementation of the new OMB delineations in FY15, and have not reclassified from urban to rural under the regulations at § 412.103 before Jan. 1, 2016, will transition from payments based, in part, on the hospital-specific rate to payments based entirely on the federal rate.

- For discharges occurring on or after Jan. 1, 2016, and before Oct. 1, 2016, these former MDHs will receive the federal rate plus two-thirds of 75 percent of the amount by which the federal rate payment is exceeded by the hospital's hospital-specific rate payment.
- For FY17, for discharges occurring on or after Oct. 1, 2016, and before Oct. 1, 2017, these former MDHs will receive the federal rate plus one-third of 75 percent of the amount by which the federal rate payment is exceeded by the hospital's hospital-specific rate.
- For FY18, for discharges occurring on or after Oct. 1, 2017, these former MDHs will be paid based solely on the federal rate.

CMS notes that allowing a gradual transition for these 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.

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 SCH if the hospital were located in a rural area; or
4. Meets such other criteria as the U.S. Department of Health and Human Services 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 N.J., Del., and R.I. 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 have lost 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 scheduled to expire April 1, 2015, but was extended to expire effective Oct. 1, 2017, by section 205 of the Medicare Access and CHIP Reauthorization Act of 2015, CMS believes that 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.

More Information

The final rule is published in the Nov. 13, 2015, *Federal Register*. Additional information regarding the OPPS is available on the CMS website.

Appendix 1: Preventive Services Exempted from Ancillary Service Packaging Policy

TABLE 12—PREVENTIVE SERVICES EXEMPTED FROM THE ANCILLARY SERVICES PACKAGING POLICY

HCPCS code	Short descriptor	CY 2016 status indicator	CY 2016 APC
76977	Us bone density measure	S	5732

HCPCS code	Short descriptor	CY 2016 status indicator	CY 2016 APC
77078	Ct bone density axial	S	5521
77080	Dxa bone density axial	S	5522
77081	Dxa bone density/peripheral	S	5521
G0117	Glaucoma scrn hgh risk direc	S	5732
G0118	Glaucoma scrn hgh risk direc	S	5732
G0130	Single energy x-ray study	S	5521
G0389	Ultrasound exam aaa screen	S	5531
G0404	Ekg tracing for initial prev	S	5731
Q0091	Obtaining screen pap smear	S	5731

Appendix 2: CY16 Device Intensive APCs

TABLE 42—CY 2016 DEVICE-INTENSIVE APCS

Renumbered CY 2016 APC	CY 2016 APC title
1565	New Technology—Level 28 ($5,000–$5,500).
1599	New Technology—Level 48 ($90,000–$100,000).

Renumbered CY 2016 APC	CY 2016 APC title
5125	Level 5 Musculoskeletal Procedures.
5166	Level 6 ENT Procedures.
5192	Level 2 Endovascular Procedures.
5193	Level 3 Endovascular Procedures.
5222	Level 2 Pacemaker and Similar Procedures.
5223	Level 3 Pacemaker and Similar Procedures.
5224	Level 4 Pacemaker and Similar Procedures.
5231	Level 1 ICD and Similar Procedures.
5232	Level 2 ICD and Similar Procedures.
5377	Level 7 Urology and Related Services.
5462	Level 2 Neurostimulator and Related Procedures.
5463	Level 3 Neurostimulator and Related Procedures.
5464	Level 4 Neurostimulator and Related Procedures.
5471	Implantation of Drug Infusion Device.
5493	Level 3 Intraocular Procedures.
5494	Level 4 Intraocular Procedures.

Appendix 3: CY16 Final C-APC

Note: the new C-APCs denoted with an asterisk

TABLE 9—FINAL CY 2016 C–APCS

CY 2016 C–APC+	CY 2016 APC Group title	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	
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	
5125	Level 5 Musculoskeletal Procedures	ORTHO	*
5471	Implantation of Drug Infusion Device	PUMPS	
5627	Level 7 Radiation Therapy	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	*
3011	Comprehensive Observation Services	N/A	*

+We refer readers to section III.D. of this final rule with comment period for a discussion of the overall restructuring and renumbering of APCs.

*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 4: CY16 Packaged CPT Add-on Codes

TABLE 8—FINAL CY 2016 PACKAGED CPT ADD-ON CODES THAT ARE EVALUATED FOR A COMPLEXITY ADJUSTMENT

CY 2016 CPT/ HCPCS add-on code	CY 2016 short descriptor
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.
G0289	Arthro, loose body + chondro.
0172T	Lumbar spine process addl.
0205T	Inirs each vessel add-on.
0289T	Laser inc for pkp/lkp donor.
0290T	Laser inc for pkp/lkp recip.
0291T	Iv oct for proc init vessel.
0294T	Ins lt atrl mont pres lead.
0376T	Insert ant segment drain int.
0396T	Intraop kinetic balnce sensr.
0397T	Ercp w/optical endomicroscpy.
20930	Sp bone algrft morsel add-on.
20931	Sp bone algrft struct add-o.
20936	Sp bone agrft local add-on.
20937	Sp bone agrft morsel add-on.
20938	Sp bone agrft struct add-on.
22515	Perq vertebral augmentation.
22552	Addl neck spine fusion.
22585	Additional spinal fusion.
22614	Spine fusion extra segment.
22632	Spine fusion extra segment.

Appendix 4: CY16 Packaged CPT Add-on Codes - Continued

22840	Insert spine fixation device.
22841	Insert spine fixation device.
22842	Insert spine fixation device.
22843	Insert spine fixation device.
22844	Insert spine fixation device.
22845	Insert spine fixation device.
22846	Insert spine fixation device.
22847	Insert spine fixation device.
22848	Insert spine fixation device.
22851	Apply spine prosth device.
22858	Second level cer diskectomy.
27358	Remove femur lesion/fixation.
29826	Shoulder arthroscopy/surgery.
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.
38900	Io map of sent lymph node.
43273	Endoscopic pancreatoscopy.
43283	Lap esoph lengthening.
43338	Esoph lengthening.
49326	Lap w/omentopexy add-on.
49327	Lap ins device for rt.
49435	Insert subq exten to ip cath.

Appendix 4: CY16 Packaged CPT Add-on Codes - Continued

CY 2016 CPT/ HCPCS add-on code	CY 2016 short descriptor
57267	Insert mesh/pelvic flr addon.
60512	Autotransplant parathyroid.
63035	Spinal disk surgery add-on.
63043	Laminotomy addl cervical.
63044	Laminotomy addl lumbar.
63048	Remove spinal lamina add-on.
63057	Decompress spine cord add-on.
63066	Decompress spine cord add-on.
63076	Neck spine disk surgery.
65757	Prep corneal endo allograft.
66990	Ophthalmic endoscope add-on.
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.

Appendix 4: CY16 Packaged CPT Add-on Codes - Continued

CY 2016 CPT/ HCPCS add-on code	CY 2016 short descriptor
92944	Prq card revasc chronic addl.
92973	Prq coronary mech thrombect.
92974	Cath place cardio brachytx.
92978	Intravasc us heart add-on.
92998	Pul art balloon repr precut.
93462	L hrt cath trnsptl puncture.
93463	Drug admin & hemodynmic meas.
93571	Heart flow reserve measure.
93609	Map tachycardia add-on.
93613	Electrophys map 3d add-on.
93621	Electrophysiology evaluation.
93622	Electrophysiology evaluation.
93623	Stimulation pacing heart.
93655	Ablate arrhythmia add on.
93657	Tx l/r atrial fib addl.
93662	Intracardiac ecg (ice).

Appendix 5: CY17 Final Hospital OQR Measures

HOSPITAL OQR PROGRAM MEASURE SET PREVIOUSLY ADOPTED FOR THE CY 2017 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.
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: 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 ED 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: *https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1196289981244*.

**Measure we proposed for removal.

***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).

Appendix 6: CY18 Final Hospital OQR Measures

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.
0286	OP–4: Aspirin at Arrival.
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*.

**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 for the CY 2018 payment determination and subsequent years.

Appendix 7: CY19 Final Hospital OQR Measures

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.
0286	OP–4: Aspirin at Arrival.
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*.

** 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 for the CY 2018 payment determination and subsequent years.

Appendix 8: Final Updates for APU Determination

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

Appendix 9: CY16 Additional CY16 ASC Covered Surgical Procedures

TABLE 68—ADDITIONS TO THE LIST OF ASC COVERED SURGICAL PROCEDURES FOR CY 2016

Final CY 2016 HCPCS code	Final CY 2016 long descriptor	Final 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
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (*e.g.,* congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles).	J8
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (*e.g.,* congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms).	J8
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction.	J8
49406	Image-guided fluid collection drainage by catheter (e.g., abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous.	G2
57120	Colpocleisis (Le Fort type)	G2
57310	Closure of urethrovaginal fistula	G2
58260	Vaginal hysterectomy, for uterus 250 g or less	G2
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	G2
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g	G2
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	G2
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g	G2
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	G2
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s).	G2
63046	Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine and/or nerve root(s), eg spinal or lateral recess stenosis, single vertebral segment; thoracic.	G2
63055	Transpedicular approach with decompression of spinal cord, equine and/or nerve root(s) (*e.g.,* herniated intervertebral disc), single segment; thoracic.	G2

Appendix 10: CY16 Final ASC Payment Indicators and Payment Rates for the ASC Covered Surgical Procedures and Covered Ancillary Services

TABLE 59—NEW LEVEL II HCPCS CODES FOR COVERED SURGICAL PROCEDURES OR COVERED ANCILLARY SERVICES IMPLEMENTED IN APRIL 2015

CY 2015 HCPCS code	CY 2016 HCPCS code	CY 2016 Long descriptor	Final CY 2016 payment indicator
C2623	C2623	Catheter, transluminal angioplasty, drug-coated, non-laser	J7
C9445	J0596	Injection, c1 esterase inhibitor (recombinant), Ruconest, 10 units	K2
C9448*	J8655	Netupitant 300 mg and palonosetron 0.5 mg	K2
C9449	J9039	Injection, blinatumomab, 1 microgram	K2
C9450	J7313	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	K2
C9451	J2547	Injection, peramivir, 1 mg	K2
C9452	J0695	Injection, ceftolozane 50 mg and tazobactam 25 mg	K2
Q9975	J7205	Injection, factor viii fc fusion (recombinant), per iu	K2

*HCPCS code C9448 was deleted June 30, 2015 and replaced with HCPCS code Q9978 effective July 1, 2015.

TABLE 60—NEW LEVEL II HCPCS CODES FOR COVERED ANCILLARY SERVICES IMPLEMENTED IN JULY 2015

CY 2015 HCPCS code	CY 2016 HCPCS code	CY 2016 Long descriptor	Final CY 2016 payment indicator
C2613	C2613	Lung biopsy plug with delivery system	J7
C9453	J9299	Injection, nivolumab, 1 mg	K2
C9454	J2502	Injection, pasireotide long acting, 1 mg	K2
C9455	J2860	Injection, siltuximab, 10 mg	K2
Q9978*	J8655	Netupitant 300 mg and palonosetron 0.5 mg	K2

*HCPCS code Q9978 replaced HCPCS code C9448 effective July 1, 2015.

TABLE 61—NEW CATEGORY III CPT CODES FOR COVERED SURGICAL PROCEDURES OR COVERED ANCILLARY SERVICES IMPLEMENTED IN JULY 2015

CY 2015 CPT code	CY 2016 CPT code	CY 2016 Long descriptor	Final CY 2016 payment indicator
0392T	0392T	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band).	G2
0393T	0393T	Removal of esophageal sphincter augmentation device	G2

Appendix 11: CY17 & CY18 ASCQR Program Quality Measures Adopted in Previous Rulemaking

ASCQR Program Measure Set Previously Finalized for the CY 2017 Payment Determination and Subsequent Years

ASC #	NQF #	Measure name
ASC–1	0263	Patient Burn.

ASCQR Program Measure Set Previously Finalized for the CY 2017 Payment Determination and Subsequent Years—Continued

ASC #	NQF #	Measure name
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).

ASCQR Program Measure Set Previously Finalized for the CY 2018 Payment Determination and Subsequent Years

ASC #	NQF #	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 7-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 FY 66970 through 66979).

Appendix 12: Procedures Removed from CY16 Inpatient Only List

TABLE 58—PROCEDURES REMOVED FROM THE INPATIENT ONLY LIST FOR CY 2016

CPT/HCPCS code	Long descriptor	CY 2016 APC assignment	CY 2016 status indicator
0312T	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming.	5464	J1
20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision.	N/A	N
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision).	N/A	N
20938	Autograft for spine surgery only (includes harvesting the graft); structural bicortical or tricortical (through separate skin or fascial incision).	N/A	N
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace.	N/A	N
27477	Arrest epiphyseal, any method (*e.g.,* epiphysiodesis); tibia and fibula, proximal	5122	T
27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (*e.g.,* genu varus or valgus)	5122	T
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue.	5377	J1
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue.	5377	J1