Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs
SUMMARY

The Centers for Medicare & Medicaid Services (CMS) released the calendar year 2018[1] final rule for Medicare's hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system on November 1, 2017; policies in the final rule are generally effective on January 1, 2018 unless otherwise indicated. The rule will be published in the November 13th issue of the *Federal Register*. **There is a 60-day public comment period that ends at 5:00 PM EST on December 31, 2017.**

Addenda containing relative weights, payment rates, wage indices and other payment information are available only on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

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I. Overview

A. Estimated Impact on Hospitals

CMS estimates that, compared to 2017, its final rule policies will increase total payments under the OPPS by $690 million, *including* beneficiary cost-sharing and *excluding* estimated changes in enrollment, utilization, and case-mix. Including all factors, CMS estimates that OPPS expenditures for 2018 will be $69.9 billion; an increase of approximately $5.8 billion compared to 2017 OPPS payments.

For the final rule, CMS is adopting a conversion factor increase of 1.35 percent. Hospitals that satisfactorily report quality data will qualify for the full update of 1.35 percent. Hospitals that do not will be subject to a statutory reduction of 2.0 percentage points in the update factor. The reduction in payments for hospitals not meeting the quality reporting requirements is implemented by substituting a fee schedule increase factor of -0.65 percent.

Table 88 in the final rule (reproduced in the Appendix to this summary) includes the estimated impact of the final rule by provider type. It shows a projected increase of 1.4 percent for all facilities and 1.5 percent for all hospitals (all facilities except cancer and children's hospitals, which are held permanently harmless, and CMHCs). The following table shows components of the 1.4 percent total:

	% Change All Facilities
All changes	+1.4
Fee schedule increase factor	+1.35
Difference in pass through estimates for 2017 and 2018	+0.2
Difference from 2017 outlier payments (1.04% vs. 1.0%)	-0.11

Pass-through spending for drugs, biologicals and devices for 2018 are estimated to be $28.06 million, or 0.04 percent of projected OPPS spending. In addition, CMS estimates that actual outlier payments in 2017 will represent 1.11 percent of total OPPS payments compared to the 1.0 percent set aside, for an estimated decrease in 2018 payments of 0.11 percentage points.

Although CMS projects an overall increase of 1.4 percent for all facilities, the final rule impacts vary depending on the type of facility. Impacts will differ for each hospital category based on the mix of services provided, location and other factors. The most significant variable explaining the differential impact of the rule by hospital category is CMS' policy to pay for separately payable drugs furnished by 340B hospitals at ASP - 22.5 percent. This policy was adopted to be budget neutral among all hospitals through an increase in the OPPS conversion factor which will increase payment for all OPPS services paid through APCs (which excludes separately payable drugs). Generally, CMS' policy will advantage small hospitals, rural hospitals, proprietary hospitals (which are ineligible for the 340B program) and hospitals with a low disproportionate share patient percentages (DPP) and disadvantage large hospitals, urban hospitals, teaching

hospitals and hospitals with high DPPs. The large increase in the below table for CMHCs is largely due to APC recalibration (+12.5 percent) and the 340B policy (+3.2 percent).

	Projected 2018 Impact
All Hospitals	+1.5%
All Facilities (includes CMHCs and cancer and children's hospitals)	+1.4%
Urban	+1.3%
Large Urban	+1.3%
Other Urban	+1.3%
Rural	+2.7%
Major Teaching	-0.9%
Type of ownership:	
Voluntary	+1.3%
Proprietary	+4.5%
Government	+0.0%
CMHCs	+17.2%

B. Estimated Impact on Beneficiaries

CMS estimates that the aggregate beneficiary coinsurance percentage will be 18.5 percent for all services paid under the OPPS in 2018—the same percentage that the agency estimated for 2017. The coinsurance percentage reflects the requirement for beneficiaries to pay a 20 percent coinsurance after meeting the annual deductible. Coinsurance is the lesser of 20 percent of Medicare's payment amount or the Part A inpatient deductible which accounts for the aggregate coinsurance percentage being less than 20 percent.

II. Updates Affecting OPPS Payments

A. Recalibration of APC Relative Payment Weights

Blood and blood products

For 2018, CMS is continuing, without change, to set payment rates for blood and blood products using the blood-specific CCR methodology that it has used since 2005. CMS calculated the procedure costs for setting the 2018 payment rates for blood and blood products using the actual blood-specific CCR for hospitals that reported costs and charges for a blood cost center and using a hospital-specific simulated blood-specific CCR for hospitals that did not report costs and charges for a blood cost center.

CMS is also continuing to include blood and blood products in the comprehensive APCs, which provide all-inclusive payments covering all services on the claim Addendum B to the final rule is available on the CMS website and includes the 2018 payment rates for blood and blood products. CMS notes that the HCPCS codes and their associated APC for blood and blood products is identified with a status indicator of "R" in Addendum B of the final rule.

Pathogen-Reduced Platelets and Rapid Bacterial Testing for Platelets

CMS is finalizing its proposal but replacing HCPCS code Q9987 with HCPCS code P9100 and replacing HCPCS code Q9988 with HCPCS code P9073. The titles are unchanged. The final payment rates for 2018 are: P9100 = $25.50; and P9073 = $624.71.

Brachytherapy sources

CMS received comments requesting that it set the APC payment rate for HCPCS code C2636 (Brachytherapy linear, non-stranded, palladium-103, per 1mm) at $26.99 and continue to use external data to price HCPCS code C2645 at $4.69 per mm^2. CMS rejected the comment for HCPCS code C2636 indicating that the code has been active since 2007 and that its pricing for 2018 is based on data from the eight claims that it received in 2016. CMS agreed with the comment on HCPCS code C2645 and finalizes a 2018 price at $4.69 per mm^2.

1. Comprehensive APCs (C-APCs) for 2018

Changes for 2018. Addendum J to the 2018 final rule shows that 37,141 code combinations were evaluated for a complexity adjustment and that 456 code combinations qualified. The full Addendum J also includes cost statistics for all the code combinations which were evaluated for a complexity adjustment and the ranking of HCPCS codes within each C-APC based on the geometric mean cost of single J1 unit claims; this is the ranking used to determine the primary assignment of comprehensive HCPCS codes.

Additional C-APCs for 2018

CMS did not propose any additional C-APCs to be paid under the existing C-APC payment policy beginning in 2018.

Addendum J of the final rule contains all of C-APCs as well as all of the data related to the C-APC payment policy methodology, including the list of complexity adjustments and other information.

C-APC 5627 (Level 7 Radiation Therapy) Stereotactic Radiosurgery (SRS)

Beginning in 2016, CMS complied with the statutory requirement by assigning SRS using either of the two technologies to C-APC (C-APC 5627 Level 7 Radiation Therapy). However, CMS identified differences in the billing patterns for SRS procedures delivered using Cobalt-60-based and LINAC-based technologies.

To address this issue, CMS established modifier “CP” to be used for 2016 and 2017 to identify services that are adjunctive to the primary SRS treatment described by HCPCS codes 77371 and 77372, but reported on a different claim within one month of furnishing the radiation treatment delivery service. Once CMS has these data, it planned to package these services into C-APC 5627. In the interim, CMS removed any costs associated with HCPCS codes 70551, 70552, 70553, 77011, 77014, 77280, 77285, 77290, 77295, and 77336) from C-APC 5627 and allowed

these codes to be paid separately when furnished within 1-month of the radiation treatment delivery.

Consistent with its original plan, CMS is deleting modifier "CP" after December 31, 2017. For 2018, CMS is continuing to make separate payments for the 10 planning and preparation services adjunctive to the delivery of the SRS treatment using either the Cobalt-60-based or LINAC-based technology. CMS indicates that the continued separate payment of these services will allow it to complete its analysis of the claims data including modifier "CP" from both 2016 and 2017 claims. CMS will consider in the future whether repackaging all adjunctive services (planning, preparation, and imaging, among others) back into cranial single session SRS is appropriate.

Complexity Adjustment for Blue Light Cystoscopy Procedures

In response to public comments concerned about barriers to access for blue light cystoscopy, CMS evaluated whether blue light cystoscopy following white light cystoscopy should be eligible for a C-APC complexity adjustment. The current CPT coding structure for cystoscopy procedures does not identify blue light cystoscopy in the coding descriptions separate from white light cystoscopy. For the final rule, CMS created HCPCS C9738 (Adjunctive blue light cystoscopy with fluorescent imaging agent (List separately in addition to code for primary procedure). CMS assigned a status indicator of "N" to this new code signifying that the service is always packaged.

To evaluate whether blue light cystoscopy following white light cystoscopy should be eligible for a complexity adjustment when assigned to a C-APC, CMS crosswalked the costs of HCPCS code C9275 (Hexaminolevulinate hcl) to new HCPCS code C9738. CMS then evaluated the costs of HCPCS code C9738 in combination with the following APCs and HCPCS codes used for white light cystoscopy of the bladder:

- APC 5372 (Level 2 Urology and Related Services)
    - CPT code 52000
- APC 5373 (Level 3 Urology and Related Services)
    - CPT code 52204
    - CPT code 52214
    - CPT code 52224
- APC 5374 (Level 4 Urology and Related Services)
    - CPT code 52234
    - CPT code 52235
- APC 5375 (Level 5 Urology and Related Services)
    - CPT code 52240

APC 5372 is not a C-APC and is not eligible for a complexity adjustment. CMS determined that HCPCS code C9738 in combination with the above HCPCS codes would be eligible for a complexity adjustment in APC 5373 but not APC 5374 or APC 5375.

Under the C-APC policy, blue light cystoscopy would be packaged, but CMS proposed to assign the combination of HCPCS code C9738 with the cystoscopy procedures currently assigned to APC 5373 to APC 5374, resulting in a higher payment than for the white light cystoscopy procedure alone. CMS indicated plans to track the utilization and costs associated with white light/blue light cystoscopy procedure combinations that will receive a complexity adjustment.

2. Calculation of Composite APC Criteria-Based Costs

Since 2008, CMS has used composite APCs to make a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service. CMS is continuing composite policies for mental health services and multiple imaging services. Table 7 of the final rule lists the HCPCS codes that CMS is subjecting to the multiple imaging composite policy for 2018 and their respective families and approximate composite APC geometric mean.

3. Changes to Packaged Items and Services

For 2018, CMS proposed to conditionally package Level 1 and Level 2 Drug Administration Services and requested comment on whether to unconditionally package drug administration add-on codes. CMS also indicated in the proposed rule why it is not creating an APC composite for pathology services as recommended by the HOP and also requested comments generally on its packaging policies. More discussion on each of these issues follows.

Drug Administration

Conditionally packaged services are those services that are paid separately when furnished alone but packaged when furnished with another service that is paid independently. CMS adopted a policy to conditionally package 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). In the 2015 OPPS/ASC final rule with comment period (79 FR 66819), CMS indicated that it was not packaging certain low-cost drug administration services because it was examining various alternative payment policies for drug administration, including the associated drug administration add-on codes.

The proposed rule indicated that separate payment for drug administration services is an example of inconsistent application of the packaging policy where CMS continues to pay separately for a service, regardless of cost and performance with another service. As part of review of the 2016 claims data used for rate setting, CMS examined drug administration billing patterns and payment for drug administration services under the OPPS and found that the geometric mean cost for APC 5691 (Level 1 Drug Administration) is approximately $37 and the geometric mean cost for APC 5692 (Level 2 Drug Administration) is approximately $59. It also found that drug administration services in APC 5692 are frequently reported on the same claim with other separately payable services, such as an emergency department or clinic visit, while drug administration services in APC 5691 are sometimes reported with other separately payable services. These findings are consistent with the ancillary packaging policy that CMS adopted in 2015.

CMS further indicates that hospitals may receive separate payments for a clinic (office) visit and a drug administration service. In contrast, physicians are not eligible to receive payment for an office visit when a drug administration service is also provided. As a result, hospitals receive a higher payment than a physician for furnishing the same drug administration service. (Not stated but also true is that payment to the hospital and physician for drug administration are different irrespective of the policy on visits as payment for these services is determined under different methodologies.) The proposed rule indicated that conditional packaging of drug administration services would promote equitable payment between the physician office and the hospital outpatient hospital department. For these reasons, CMS proposed to conditionally package payment for HCPCS codes describing drug administration services in APC 5691 and APC 5692 except for add-on codes and preventive services, when these services are performed with another service.

CMS is continuing to exclude preventive services from packaging policies and, therefore, proposed to continue to pay separately for Medicare Part B vaccine administration services. CMS did not propose to package any drug administration services in APC 5693 (Level 3 Drug Administration) or APC 5694 (Level Drug Administration), but requested public comment on whether services in these APCs may be appropriate for packaging. CMS is finalizing its policy as proposed. The status indicators for drug administration services in APC 5691 and APC 5692 are listed in Table 8 of the final rule, reproduced below.

Table 8—2018 Status Indicators for Drug Administration Services in Level 1 and Level 2 Drug Administration APCs

HCPCS Code	Short Descriptor	2018 Status Indicator
APC 5691--Level 1 Drug Administration		
95115	Immunotherapy one injection	Q1
95117	Immunotherapy injections	Q1
95144	Antigen therapy services	Q1
95145	Antigen therapy services	Q1
95146	Antigen therapy services	Q1
95165	Antigen therapy services	Q1
95170	Antigen therapy services	Q1
96361	Hydrate iv infusion add-on	S
96366	Ther/proph/diag iv inf addon	S
96370	Sc ther infusion addl hr	S
96375	Tx/pro/dx inj new drug addon	S
96377	Application on-body injector	Q1
96379	Ther/prop/diag inj/inf proc	Q1
96423	Chemo ia infuse each addl hr	S
96549	Chemotherapy unspecified	Q1
G0008	Admin influenza virus vac	S
G0009	Admin pneumococcal vaccine	S
G0010	Admin hepatitis b vaccine	S
APC 5692--Level 2 Drug Administration		

HCPCS Code	Short Descriptor	2018 Status Indicator
90471	Immunization admin	Q1
90473	Immune admin oral/nasal	Q1
95147	Antigen therapy services	Q1
95148	Antigen therapy services	Q1
95149	Antigen therapy services	Q1
96367	Tx/proph/dg addl seq iv inf	S
96371	Sc ther infusion reset pump	Q1
96372	Ther/proph/diag inj sc/im	Q1
96401	Chemo anti-neopl sq/im	Q1
96402	Chemo hormon antineopl sq/im	Q1
96405	Chemo intralesional up to 7	Q1
96411	Chemo iv push addl drug	S
96415	Chemo iv infusion addl hr	S
96417	Chemo iv infus each addl seq	S

B. Conversion Factor Update

For the final rule, CMS calculates an OPPS conversion factor of **$78.636**. Hospitals that fail to meet the OQR requirements are subject to a reduction of 2.0 percentage points in the fee schedule increase factor. CMS indicates that the conversion factor for hospitals that do not submit quality data is **$77.064.**[2]

In addition to the fee schedule increase factor, the final rule indicates that the following adjustments are applied in calculating the 2018 conversion factor:

2017 CF	Pass-Through	Wage Index	Cancer	340B	Update	2018 CF[3]
$75.001	1.002	0.9997	1.0008	1.0319	1.0135	$78.636

C. Wage Index Changes

CMS continues its policy of adopting the final fiscal year IPPS post-reclassified wage index as the OPPS calendar year wage index for adjusting the OPPS standard payment amounts for labor market differences. The 2018 OPPS final rule wage index is based on the FY 2018 IPPS final post-reclassified wage index; this includes adoption of revisions to several labor market areas made by the Office of Management and Budget (OMB) in OMB Bulletin No. 15-01 issued on July 15, 2015. The wage index tables are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2018-Wage-Index-Home-Page.html. For non-IPPS hospitals paid under the OPPS, CMS continues its policy to assign the wage index that would be applicable if the

[2] It is not clear how CMS determined this conversion factor of $77.064. Substituting the reduced update of -0.65% (0.9935) into the above formula would produce a CF of $77.083.
[3] HPA gets a slightly different result than CMS: $75.001 X 1.0002 X 0.9999 X 1.0008 X 10319 X 1.0135=$78.635).

hospital were paid under the IPPS, based on its geographic location and any applicable wage index adjustments.

CMS continues to use an OPPS labor-related share of 60 percent for purposes of applying the wage index for 2018 and notes that the wage index adjustment is made in a budget neutral manner.

CMS extends the imputed floor policy under the OPPS for an additional year through the end of 2018. CMS will continue to assess the effects of the imputed floor policy and consider whether or not to continue it for the long term.

CMS finalizes its proposal to implement the ACA frontier state wage index adjustment in the same manner as it has since 2011. The adjustment requires a wage index floor of 1.0 in certain cases if the otherwise applicable wage index (including reclassification, rural floor, imputed floor, and rural floor budget neutrality adjustment) is less than 1. In the case of an OPD affiliated with a multi-campus hospital system, the OPD continues to receive the wage index value of the specific inpatient hospital with which it is associated. If that hospital is in a frontier state, the frontier state wage index adjustment for that hospital applies to the OPD.

Core-based statistical areas (CBSAs) and constituent counties within CBSAs each have unique identifying codes. CMS notes that of the two lists of such codes (i.e., the Social Security Administration (SSA) codes and the Federal Information Processing Standard (FIPS) codes), the SSA codes are no longer maintained and updated. CMS finalizes its proposal in the 2018 OPPS ASC proposed rule to transition to using only FIPS codes for 2018 and subsequent years. CMS also finalizes its proposal to update the FIPS codes by incorporating the Census Bureau update changes listed below to calculate area wage indexes consistent with the CBSA-based methodologies finalized in the FY 2015 IPPS/LTCH PPS final rule.

- Petersburg Borough, AK (FIPS State County Code 02-195), CBSA 02, was created from part of former Petersburg Census Area (02-195) and part of Hoonah-Angoon Census Area (02-105). The CBSA code remains 02.
- The name of La Salle Parish, LA (FIPS State County Code 22-059), CBSA 14, is now LaSalle Parish, LA (FIPS State County Code 22-059). The CBSA code remains as 14.
- The name of Shannon County, SD (FIPS State County Code 46-113), CBSA 43, is now Oglala Lakota County, SD (FIPS State County Code 46-102). The CBSA code remains as 43.

CMS states that hospitals located in these counties will not be impacted by these changes; they will continue to be considered rural for the hospital wage index. CMS will implement the revisions effective January 1, 2018, beginning with the 2018 OPPS wages indexes.

CMS continues its policy of allowing non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a county designated as an out-migration county under section 505 of the Medicare Modernization Act (MMA). The list of counties eligible for the out-migration adjustment, as well as the non-IPPS hospitals, is available in Addendum L of the final rule.

In the 2015 OPPS ASC final rule, CMS adopted a 3-year transition period for hospitals paid under the OPPS but not under the IPPS that are currently located in urban counties that become rural under the new OMB delineations. During the transition, those hospitals maintained the wage index of the CBSA in which they were physically located in FY 2014 for three years. The final year of the transition is 2017, and it will not be applied in 2018.

For Community Mental Health Centers (CMHCs), CMS continues to calculate the wage index by using the post-reclassification IPPS wage index based on the CBSA where the CMHC is located. As with OPPS hospitals and for the same reasons, the 2015 OPPS ASC final rule established policies to use a 3-year transition period for CMHCs, ending December 31, 2017; it will not be applied in 2018. Consistent with current policy, the wage index that applies to CMHCs includes the rural floor adjustment, but it does not include the out-migration adjustment, which only applies to hospitals. CMS notes that because it extends its imputed floor policy for another year, the wage index that applies to CMHCs will also include the imputed floor adjustment through the end of 2018.

D. Statewide Average Default CCRs

Table 9 in the final rule provides the statewide default CCRs for urban and rural areas in each state for 2018 and the comparable default CCRs for 2017. CMS uses overall hospital-specific CCRs calculated from the hospital's most recent cost report to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS during the OPPS year. The largest reduction is for rural Alaska (-0.21) followed by urban Puerto Rico (-0.05). The largest increases are rural Connecticut (+0.078) and rural North Dakota (+0.045).

E. Adjustment for Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACH) for 2018

For 2018, CMS is continuing to apply a 7.1 percent payment adjustment under section 1833(t)(13)(B) of the Act 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. The adjustment is budget neutral and is applied before calculating outliers and copayments.

F. Payment Adjustment for Certain Cancer Hospitals

With one change for 2018, CMS is continuing the cancer adjustment policy used since 2012 to make additional payments to the 11 cancer hospitals. Prior to enactment of the 21st Century Cures Act in 2016, the law required CMS to make an adjustment to cancer hospital payments sufficient to bring each hospital's payment-to-cost ratio (PCR) up to the level of the PCR for all other hospitals. Section 16002(b) of the 21st Century Cures Act amended section 1833(t)(18) of the Act to add subparagraph (C) to require that the target PCR be reduced from the amount it would otherwise be by 1.0 percentage point. The law further excluded this additional 1.0 percentage point reduction from OPPS budget neutrality.

Section 16002(b) of the 21st Century Cures Act also indicates that the Secretary may consider making an additional percentage point reduction to the target PCR that takes into account payment rates for applicable items and services furnished by non-cancer hospital off-campus provider-based departments that are not paid under the OPPS pursuant to section 603 of the Bipartisan Budget Act of 2015. The Secretary is not making an additional adjustment to the PCR under this authority.

Rather than a claims-based adjustment, CMS makes an aggregate payment, as necessary, to each cancer hospital at cost report settlement. CMS determines the cancer hospital's PCR (before a cancer hospital payment adjustment) and determines the lump sum amount necessary (if any) to make the cancer hospital's PCR equal to the weighted average PCR (or "target PCR") for the other OPPS hospitals using the most recent submitted or settled cost report data that is available at the time of the final rule. If a cancer hospital's PCR (before the cancer hospital payment adjustment) is above the target PCR, the cancer hospital payment adjustment equals zero.

Table 10 in the final rule, reproduced below, shows the estimated hospital-specific payment adjustment for each of the 11 cancer hospitals, with increases in OPPS payments for 2018 ranging from 7.6 percent to 52.2 percent. As noted, the actual amount of the 2018 cancer hospital payment adjustment for each cancer hospital is determined at cost report settlement and depends on each hospital's 2018 payments and costs.

The 2018 final rule budget neutrality adjustment to the OPPS conversion factor is 1.0008 for the cancer hospital adjustment reflecting CMS' projection that aggregate cancer hospital adjustments would be slightly lower in 2018 compared to 2017. Table 10 of the final rule includes the estimated percentage increase in OPPS payments to cancer hospitals for 2017 to meet the target PCR.

G. Hospital Outpatient Outlier Payments

The OPPS makes outlier payments on a service-by-service basis when the cost of a service exceeds the outlier threshold. For 2018, CMS is continuing to set aside 1.0 percent of the estimated aggregate total payments under the OPPS for outlier payments. It calculates the fixed-dollar threshold using the same methodology that was used to set the threshold for 2017 and previous years.

For 2018, CMS provides that the outlier threshold would be met when a hospital's cost of furnishing a service or procedure exceeds 1.75 times the APC payment amount and also exceeds the APC payment rate plus a **$4,325 fixed-dollar threshold** (compared to $3,825 in 2017). CMS is continuing to set the outlier payment equal to 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the fixed-dollar threshold ($4,325) are met.

CMS is again adopting a policy that a portion of the 1.0 percent outlier pool, specifically an amount equal to less than 0.01 percent of outlier payments, be allocated to CMHCs for partial hospitalization program outlier payments. CMS is continuing its policy that if a CMHC's cost for partial hospitalization services paid under APC 5853 (Partial Hospitalization for CMHCs)

exceeds 3.40 times the payment rate for APC 5853, the outlier payment will be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 5853 payment rate.

Hospitals that fail to report data required for the quality measures selected by the Secretary incur a 2.0 percentage point reduction to their OPPS annual payment update factor, resulting in reduced OPPS payments for most services. For hospitals failing to satisfy the quality reporting requirements, CMS is continuing its policy that a hospital's costs for the service are compared to the reduced payment level for purposes of determining outlier eligibility and payment amount.

H. Beneficiary Coinsurance

Medicare law provides that the maximum coinsurance rate for any service is 40 percent of the total OPPS payment to the hospital and the minimum coinsurance is 20 percent. The statute also limits a beneficiary's actual cost-sharing amount for a service to the inpatient hospital deductible for the applicable year, which is $1,316 in 2017. The inpatient hospital deductible limit is applied to the *actual* co-payment amount after adjusting for the wage index. For this reason, the co-insurance levels shown in the OPPS payment rate Addenda A and B to the final rule do not reflect application of the hospital deductible limit.

For 2018 as in prior years, CMS is reducing the beneficiary co-payment proportionately to the 2-percentage point conversion factor reduction when services are rendered in a hospital that does not report the required quality measures, or that reported them unsatisfactorily.

The final rule estimates that, in aggregate, the percentage of beneficiary liability for OPPS payments in 2018 will be 18.5 percent, the same percentage estimated for 2017. As indicated above, the transition to all services being paid at a coinsurance rate of 20 percent appears to be at or nearly complete. Addendum A of the final rule shows that transition is at or nearly complete as the coinsurance percentages are at or round to 20 percent for all but a small number of APCs.

III. OPPS Ambulatory Payment Classification (APC) Group Policies

A. OPPS Treatment of New CPT and Level II HCPCS Codes

1. Treatment of New HCPCS Codes That Were Effective April 1, 2017

Through the April 2017 OPPS quarterly update, CMS made five new Level II HCPCS codes effective and assigned them interim OPPS status indicators and APCs (see Table 12 of the final rule reproduced below). The payment rates, where applicable, can be found in Addendum B to the final rule. Several of the HCPCS C-codes have been replaced with HCPCS J-codes effective January 1, 2018. Their replacement codes are shown in Table 12.

Table 12—New Level II HCPCS Codes Effective April 1, 2017

2017 HCPCS Code	2018 HCPCS Code	2018 Long Descriptor	2018 SI	2018 APC
C9484	J1428	Injection, eteplirsen, 10 mg	G	9484
C9485	J9285	Injection, olaratumab, 10 mg	G	9485
C9486	J1627	Injection, granisetron extended release, 0.1 mg	G	9486
C9487*	J3358	Ustekinumab, for intravenous injection, 1 mg	G	9487
C9488	C9488	Injection, conivaptan hydrochloride, 1 mg	G	9488

*HCPCS code C9487, which was effective April 1, 2017, was deleted June 30, 2017 and replaced with HCPCS code Q9989 (Ustekinumab, for intravenous injection, 1 mg) effective July 1, 2017.

2. Treatment of New HCPCS Codes That Were Effective July 1, 2017

Through the July 2017 OPPS quarterly update CR, CMS made 10 new Category III CPT codes and 13 Level II HCPCS codes effective July 1, 2017 and assigned them interim OPPS status indicators and to APCs. Three HCPCS codes are no longer payable under the OPPS because they have been replaced with different codes effective July 1, 2017. **CMS is soliciting public comments on the proposed APC and status indicator assignments for 2018 for the CPT and Level II HCPCS codes implemented on July 1, 2017**, all of which are listed in Table 14 below.

Table 13—New Category III CPT and Level II HCPCS Codes Effective July 1, 2017

2017 HCPCS Code	2018 HCPCS Code	2018 Long Descriptor	2018 SI	2018 APC
C9489	J2326	Injection, nusinersen, 0.1 mg	G	9489
C9490	J0565	Injection, bezlotoxumab, 10 mg	G	9490
C9745	C9745	Nasal endoscopy, surgical; balloon dilation of eustachian tube	J1	5165
C9746	C9746	Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed	J1	5377
C9747	C9747	Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance	J1	5376
K0553	K0553	Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 Unit Of Service	Y	N/A
K0554	K0554	Receiver (monitor), dedicated, for use with therapeutic glucose continuous monitor system	Y	N/A

2017 HCPCS Code	2018 HCPCS Code	2018 Long Descriptor	2018 SI	2018 APC
Q9984	J9276	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg	E1	N/A
Q9985	J7129	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	N	N/A
Q9986*	J1726	Injection, hydroxyprogesterone caproate (Makena), 10 mg	K	9074
Q9987*	P9100	Pathogen(s) test for platelets	S	1493
Q9988*	P9073	Platelets, pheresis, pathogen reduced, each unit	R	9536
Q9989#	J3358	Ustekinumab, for intravenous injection, 1 mg	G	9487
0469T	0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral	E1	N/A
0470T	0470T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion	M	N/A
0471T	0471T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)	N	N/A
0472T	0472T	Device evaluation, interrogation, and initial programming of intra- ocular retinal electrode array (e.g., retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed	Q1	5743
0473T	0473T	Device evaluation and interrogation of intra-ocular retinal electrode array (e.g. retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	Q1	5742
0474T	0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	J1	5492
0475T	0475T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other	M	N/A
0476T	0476T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage	Q1	5734

2017 HCPCS Code	2018 HCPCS Code	2018 Long Descriptor	2018 SI	2018 APC
0477T	0477T	Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result	Q1	5734
0478T	0478T	Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional	M	N/A

*HCPCS code Q9986 replaced HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg), HCPCS codes Q9987 and Q9988 replaced HCPCS code P9072 (Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit), and HCPCS code Q9989 replaced HCPCS code C9487 (Ustekinumab, for intravenous injection, 1 mg)
HCPCS code C9487, which was effective April 1, 2017, was replaced with HCPCS code Q9989 (Ustekinumab, for intravenous injection, 1 mg) effective July 1, 2017 and its pass-through status continued.

3. Process for New Level II HCPCS Codes that will be Effective October 1, 2017 and January 1, 2018 for which CMS will be Soliciting Public Comments

CMS is soliciting comments on those new Level II HCPCS codes that are effective October 1, 2017 and January 1, 2018 in the 2018 OPPS/ASC final rule with comment period. The payments for these codes will be assigned a comment indicator "NI" in Addendum B to the OPPS/ASC final rule with comment period signifying that the codes are interim final subject to public comment. **CMS is inviting public comments on the status indicator, APC assignments, and payment rates for these codes, if applicable, which would then be finalized in the 2019 OPPS/ASC final rule with comment period.**

4. Treatment of New and Revised CY 2018 Category I and III CPT Codes that will be Effective January 1, 2018

The final status indicators, APC assignments, and payment rates for the new CPT codes that are effective January 1, 2018 can be found in Addendum B of the final rule.

B. OPPS Changes – Variations within APCs

1. APC Exceptions to the 2 Times Rule

Table 16 in the proposed rule listed 12 APCs that CMS proposed to except from the 2 times rule for 2018 based on established criteria and 2016 claims data. Based on the updated final rule CY 2016 claims data used for this 2018 final rule with comment period, CMS removed 6 of the 12 APC violations. The following 6 APCs no longer met the criteria for exception to the 2 times rule:

- APC 5161 (Level 1 ENT Procedures);
- APC 5311 (Level 1 Lower GI Procedures);
- APC 5461 (Level 1 Neurostimulator and Related Procedures);
- APC 5573 (Level 3 Imaging with Contrast);

- APC 5611 (Level 1 Therapeutic Radiation Treatment Preparation); and
- APC 5735 (Level 5 Minor Procedures).

Final rule claims data revealed a total of 11 APCs with violations of the 2 times rule. Of these 11 total APCs, 6 were identified in the proposed rule and 5 are newly identified APCs. The following 6 were identified in the proposed rule:

- APC 5112 (Level 2 Musculoskeletal Procedures);
- APC 5521 (Level 1 Imaging without Contrast);
- APC 5691 (Level 1 Drug Administration);
- APC 5731 (Level 1 Minor Procedures);
- APC 5771 (Cardiac Rehabilitation); and
- APC 5823 (Level 3 Health and Behavior Services).

For the final rule, CMS found the following 5 additional APCs that violated the 2 times rule:

- APC 5522 (Level 2 Imaging without Contrast);
- APC 5524 (Level 4 Imaging without Contrast);
- APC 5571 (Level 1 Imaging with Contrast);
- APC 5721 (Level 1 Diagnostic Tests and Related Services); and
- APC 5732 (Level 2 Minor Procedures).

CMS is finalizing its 2 times violation policies as follows:

- Excepting 6 of 12 APCs from the 2 times rule as proposed for 2018 (APCs 5112, 5521, 5691, 5731, 5771, and 5823),
- Excepting 5 additional APCs (APCs 5522, 5524, 5571, 5721, and 5732).

Table 14 below lists the 11 APCs that are being excepted from the 2 times rule for 2018:

TABLE 14.—APC EXCEPTIONS TO THE 2 TIMES RULE FOR 2018

APC	2018 APC Title
5112	Level 2 Musculoskeletal Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5691	Level 1 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5732	Level 2 Minor Procedures

5771	Cardiac Rehabilitation
5823	Level 3 Health and Behavior Services

C. New Technology APCs

1. Revised and Additional New Technology APC Groups

Currently, there are 51 levels of New Technology APC groups with two parallel status indicators; one set with a status indicator of "S" (S = Significant procedure, not discounted when multiple); and the other set with a status indicator of "T" (T = Significant procedure, multiple reduction applies). The New Technology APC levels range from the cost band assigned to APC 1491 (New Technology – Level 1A ($0 - $10)) through the highest cost band assigned to APC 1906 (New Technology – Level 48 ($140,001 - $160,000)). Payment for each APC is made at the mid-point of the APC's assigned cost band.

For 2018, CMS proposed to narrow the increments for New Technology APCs 1901 – 1906 from $19,999 cost bands to $14,999 cost bands. It is also proposed to add New Technology APCs 1907 and 1908 (New Technology Level 52 ($145,001-$160,000), which would allow for an appropriate payment of retinal prosthesis implantation procedures, which is discussed further below. CMS did not receive any comments on its proposals and is finalizing them without change. Table 15 of the final rule reproduced below includes the new Technology APC numbers, titles and cost bands.

TABLE 15.—2018 ADDITIONAL NEW TECHNOLOGY APC GROUPS

2018 APC	2018 APC Title	2018 SI	Updated or New APC
1901	New Technology - Level 49 ($100,001-$115,000)	S	Updated
1902	New Technology - Level 49 ($100,001-$115,000)	T	Updated
1903	New Technology - Level 50 ($115,001-$130,000)	S	Updated
1904	New Technology - Level 50 ($115,001-$130,000)	T	Updated
1905	New Technology - Level 51 ($130,001-$145,000)	S	Updated
1906	New Technology - Level 51 ($130,001-$145,000)	T	Updated
1907	New Technology - Level 52 ($145,001-$160,000)	S	New
1908	New Technology - Level 52 ($145,001-$160,000)	T	New

2. Procedures Assigned to New Technology APC Groups for 2018

CMS is continuing its current policy to retain services within New Technology APC groups until it obtains sufficient claims data to justify reassignment of the service to a clinically appropriate APC. CMS notes that in cases where it determines, based on additional information, that the initial New Technology APC assignment is no longer appropriate, it will reassign the procedure or service to a different New Technology APC that more appropriately reflects its costs.

Magnetic Resonance-Guided Focused Ultrasound Surgery (MRgFUS) (APCs 1537, 5114, and 5414)

Currently, four CPT/HCPCS codes describe magnetic resonance image guided high intensity focused ultrasound (MRgFUS) procedures. CMS proposed to continue to assign CPT codes 0071T and 0072T to APC 5414 (Level 4 Gynecologic Procedures), with a payment rate of approximately $2,189 for 2018. It also proposed to continue to pay APC 5414 as a C-APC meaning that all covered Part B services on the claim that paid under the OPPS are packaged and not paid separately. CMS finalized its proposed policy without change.

CMS proposed to continue to assign HCPCS code C9734 (Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance) to APC 5114 (Level 4 Musculoskeletal Procedures), with a proposed payment rate of approximately $5,385 for 2018. CMS also proposed to continue to make HCPCS code C9734 a procedure that triggers a C-APC payment. CMS finalized its proposed policy without change.

CMS received only one claim for CPT code 0398T used to treat essential tremor and proposed to continue assigning it to APC 1537 (New Technology - Level 37 ($9,501-$10,000)), with a proposed payment rate of approximately $9,751 for 2018. In response to a comment suggesting that this payment rate is too low, CMS agreed to assign CPT code 0398T to APC 1576 (New Technology – Level 39 ($15,001-$20,000)), with a payment rate of $17,500.50 for 2018.

Table 16 of the final rule provides information about the status indicators and APC assignments for the above HCPCS codes. The 2018 payment rates can be found in Addendum B of the final rule.

Retinal Prosthesis Implant Procedure

For 2018, CMS is reassigning implant of the Argus® II procedure to APC 1904 (New Technology - Level 50 ($115,001 - $130,000)). This APC assignment will establish a payment rate for the Argus® II procedure of $122,500.50, which is the arithmetic mean of the payment rates for the service for 2016 and 2017. As CMS does each year, it will constinue to examine the claims data and any available new information regarding the clinical aspects of new procedures to confirm that OPPS payments remain appropriate for procedures like the Argus® II procedure as they transition into mainstream medical practice.

Pathogen Test for Platelets

The CMS HCPCS Workgroup has established HCPCS code Q9987 (Pathogen(s) test for platelets) effective July 1, 2017. HCPCS code Q9987 will be used to report any test used to identify bacterial or other pathogen contamination in blood platelets. HCPCS code Q9987 was established after concerns from blood and blood product stakeholders that the previous CPT code used to describe pathogen tests for platelets, CPT code P9072 (Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit), inappropriately described rapid bacterial testing by combining the test with the pathogen reduction of platelets. CPT code P9072 is inactive effective July 1, 2017.

CMS assigned HCPCS code Q9987 to New Technology APC 1493 (New Technology - Level 1C ($21-$30)), with a payment rate of $25.50 effective July 1, 2017. CMS proposed to continue assigning HCPCS code Q9987 to New Technology APC 1493 until claims data are available to support assignment to a clinical APC. Public comments supported CMS' proposal and which it is finalizing without change.

Fractional Flow Reserve Derived from Computed Tomography (FFR$_{CT}$)

CMS is finalizing the proposal for CPT codes 0501T, 0502T, and 0504T without modification and reassigning CPT code 0503T from packaged status (status indicator "N") to New Technology APC 1516 (New Technology - Level 16 ($1401 - $1500)), with a payment rate of $1,450.50 for CY 2018. Table 19 of the final rule lists the final status indicator assignments for CPT codes 0501T, 0502T, 0503T, and 0504T.

D. OPPS APC-Specific Policies

The final rule discusses 29 different APC areas where CMS considered or is making changes in the final rule. Of these 29 areas, only 4 were specifically discussed in the proposed rule preamble. This summary covers those three areas in more detail and lists CMS' final decisions for the remaining areas.

1. Blood-Derived Hematopoietic Cell Harvesting

Since 2010, CMS has packaged payment for donor acquisition costs with the procedure. However, donor acquisition costs for HCPCS code 38230 (Bone marrow harvesting for transplantation; allogeneic) is separately paid. For consistency and to ensure that the donor acquisition costs are captured accurately, for 2018, CMS proposed to change the status indicator assignment HCPCS code 38205 from "B" to "S", which indicates that the procedure is paid under the OPPS and receives separate payment. CMS proposed to assign HCPCS code 38205 to APC 5241 that has a geometric mean cost of approximately $580.

Commenters opposed CMS' proposal indicating hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. The HOP recommended that CMS retain status indicator "B" for HCPCS code 38205 indicating that it remains packaged. CMS agreed with the commenters and is not finalizing the proposal.

2. Radiology and Imaging Procedures and Services

Imaging APCs

CMS proposed to create a Level 5 Imaging without Contrast APC to more appropriately group certain imaging services with higher resource costs. CMS indicated that the data support splitting the current Level 4 Imaging without Contrast APC into two APCs such that the Level 4 Imaging without Contrast APC would include high frequency low cost services and the proposed

Level 5 Imaging without Contrast APC would include low frequency high cost services. CMS' proposal would increase the imaging APCs from 7 APCs in 2017 to 8 in 2018.

Commenters generally disagreed with CMS' proposal to add a fifth level within the Imaging without Contrast APC series because of the resultant reduction in payment to several vascular ultrasound procedures. CMS is not finalizing the proposal to add a fifth level to the Imaging without Contrast APC series. Instead, it is making minor reassignments to the HCPCS codes within this series to resolve or mitigate any violations of the 2 times rule.

A few commenters objected to the proposed exception to the violation of the 2 times rule for APC 5573 (Level 3 Imaging With Contrast) and recommended alternative approaches to resolving the violation, such as the creation of a Level 4 Imaging With Contrast or maintaining the 2017 APC groupings. CMS agreed with commenters and is not adopting the proposal to reassign nine high-volume contrast MRI procedures from APC 5572 to APC 5573 and to allow for an exception for APC 5573 from the 2 times rule. In addition, CMS is making a few other code reassignments to resolve the 2 times rule violation in APC 5573. Table 54 of the final rule compares the 2017 and 2018 APC geometric mean costs for the imaging APCs.

Non-Ophthalmic Fluorescent Vascular Angiography (APC 5524)

For the 2018 OPPS update, CMS proposed to reassign HCPCS code C9733 (Non-ophthalmic fluorescent vascular angiography) from APC 5523 (Level 3 Imaging without Contrast) to APC 5524 (Level 4 Imaging without Contrast) based on its geometric mean costs in the 2016 claims data. CMS' 2016 claims data show a geometric mean cost of approximately $236 for HCPCS code C9733 based on 216 single claims (out of 953 total claims), which is closely aligned with the geometric mean cost of approximately $275 for APC 5524.

Several commenters supported the proposed APC reassignment for HCPCS code C9733 to APC 5524. In addition, commenters requested that CMS change the status indicator assignment from conditionally packaged to separately payable. CMS declined to change the status indicator noting that the service is primarily an intraoperative imaging service that will typically be done in conjunction with another service. CMS is not finalizing its proposed reassignment of HCPCS code C9733 from APC 5523 to APC 5524 because it is maintaining the 2017 APC group assignments for imaging services and because the final rule cost data suggest the procedure is correctly assigned to APC 5523.

3. Care Management Coding Changes Effective January 1, 2018 (APCs 5821 and 5822)

CMS indicated in the proposed rule that it is interested in the ongoing work of the medical community to refine the set of codes used to describe care management services, including chronic care management and the agency proposed to adopt CPT replacement codes for 2018 for several of the care management services finalized for 2017. CMS finalizes its policies as proposed and provides the final codes, status indicators and APC assignment in Table 22 of the final reproduced below.

Table 22—Care Management Coding Changes Effective January 1, 2018

2017 HCPCS Code	2017 HCPCS Short Descriptor	2017 OPPS SI	2017 OPPS APC	2018 Replacement CPT Code	2018 Replacement HCPCS Short Descriptor*	2018 OPPS SI	2018 OPPS APC
G0502	Init psych care Manag, 70min	S	5822	99492	1st psyc collab care mgmt	S	5822
G0503	Subseq psych care man, 60mi	S	5822	99493	Sbsg psyc collab care mgmt.	S	5822
G0504	Init/sub psych Care add 30 m	N	N/A	99494	1st/sbsq psyc collab care	N	N/A
G0505	Cog/func assessment outpt	S	5822	99483	Assmt & care pln pt cog imp	S	5822
G0507	Care manage serv minimum 20	S	5821	99484	Care mgmt. svc bhvl hlth cond	S	5821

*The long descriptors for the codes can be found in Addendum O (New Category I and Category III CPT Codes Effective January 1, 2018) of the final rule.

4. All Other APC-Specific Issues for 2018

As indicated above, CMS did not discuss the below issues in the proposed rule but may have assigned codes and status indicators in the proposed rule Addenda. What is provided below summarizes those areas where CMS is making a change in the final rule from what it proposed for 2018 or where the code is new for the final and was not addressed in the proposed rule:

Brachytherapy Insertion Procedures (C-APCs 5341 and 5092). CMS is reassigning CPT code 55920 from C-APC 5341 to C-APC 5415 for 2018.

Cardiac Telemetry (APC 5721). CMS is revising the assignment for CPT code 93229 to APC 5721 for 2018 rather than APC 5734 where it was assigned in the proposed rule.

Collagen Cross-Linking of Cornea (C-APC 5503). CMS is reassigning CPT code 0402T to APC 5503 (Level 3 Extraocular, Repair, and Plastic Eye Procedures) for 2018 and will consider reassignment of CPT code 0402T to APC 5504 in 2019 rulemaking.

Esophagogastroduodenoscopy (EGD) (C-APC 5362). CMS is reassigning CPT code 43210 from C-APC 5331 to C-APC 5362 for 2018.

Hemorrhoid Treatment by Thermal Energy (APC 5312). CMS is reassigning CPT code 46930 from C-APC 5311 to C-APC 5312 for 2018.

Percutaneous Transluminal Mechanical Thrombectomy (C-APC 5192). CMS is finalizing its 2018 proposal, with modification, for CPT codes 37184 and 37187 and reassigning CPT codes 37184 and 37187 from APC 5183 to C-APC 5192.

Sclerotherapy (APC 5054). CMS proposed to assign new CPT codes 36465 and 36466 to APC 5053 (Level 3 Skin Procedures). In the final rule, CMS is assigning both codes to APC 5054, instead of proposed APC 5053 for 2018.

Skin Substitutes (APCs 5053, 5054, and 5055). CMS is assigning HCPCS code C5277 to APC 5053 and CPT code 15277 to APC 5054.

Subdermal Drug Implants for the Treatment of Opioid Addiction (APC 5735). CMS is establishing HCPCS G-codes G0516, G0517, and G0518 under the OPPS, effective January 1, 2018 that are conditionally packaged and assigned to APC 5735 when separately paid.

Transurethral Waterjet Ablation of the Prostate (C-APC 5375). As a result of a change in Medicare coverage, CMS revised the OPPS status indicator assignment for CPT code 0421T from "E1" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to "J1" (Hospital Part B services paid through a comprehensive APC) and assigned the code to C-APC 5374 (Level 4 Urology and Related Services) to indicate that the procedure would be paid separately under the OPPS. In the final rule, CMS is revising the APC assignment for CPT code 0421T from proposed C-APC 5374 to C-APC 5375 for 2018.

Transurethral Water Vapor Thermal Therapy of the Prostate (C-APC 5373). CMS established HCPCS code C9748 to describe the Rezūm procedure—a procedure that utilizes water vapor for the treatment of benign prostatic hypertrophy. CMS proposed to assign HCPCS code C9748 to C-APC 5373 (Level 3 Urology and Related Services). **The APC and status indicators are subject to public comment in this final rule.**

Creation of a New Cataract Surgery APC: CMS indicated in the proposed rule that it may be more appropriate to assign CPT code 66982 (complex cataract surgery) to a newly created Level 2 Intraocular Procedures C-APC in between existing C-APCs 5491 and 5492 that is separate and with a higher payment than the C-APC assignment for CPT code 66984 (routine cataract surgery). While CMS did not make a proposal, it noted that the 2017 AMA CPT manual describes a complex cataract surgery case as "requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis)."

IV. OPPS Payment for Devices

A. Pass-Through Payments for Devices

1. Expiration of Transitional Pass-Through Payments for Certain Devices

CMS finalizes that the pass-through payment status of the three device categories eligible for pass-through payments will expire on December 31, 2017:

- HCPCS code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser) was established effective April 1, 2015;
- HCPCS code C2613 (Lung biopsy plug with delivery system) was established effective July 1, 2015; and
- HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency with rechargeable battery and charging system) was established effective January 1, 2016.

Because all the devices in these device categories were approved prior to 2017, CMS applied its policy to expired device categories at the end of the year when at least 2 years of pass-through payments have been made. For 2018, CMS will package the costs of the device described by HCPCS codes C2623, C2613, and C1822 into the costs related to the procedures with which the device is reported in the hospital claims data.

2. New Device Pass-Through Applications

a. Applications Received for Device Pass-Through Payments for 2018

CMS received five applications (listed below) by the March 1, 2017 quarterly deadline, the last quarterly deadline in time for the 2018 OPPS/ASC proposed rule.

CMS does not approve device pass-through payment status for 2018 for the five applications. Readers are advised to review the proposed rule for more detailed information on each of the applications.

1. *Architect® Px:* CMS determines that the evidence is insufficient to demonstrate that Architect® Px meets the substantial clinical improvement criterion.
2. *Dermavest and Plurivest Human Placental Connective Tissue Matrix (HPCTM):* CMS concludes it is unable to determine that Dermavest and Plurivest meet the newness criterion.
3. *FlōGraft®/Flōgragt Neogenesis®:* CMS concludes the data is insufficient to demonstrate these products offer a substantial clinical improvement over other treatments for wound care.
4. *Kerecis™ Omega3 Wound (Skin Substitute):* CMS concludes there is no clinical data to suggest that Kerecis™ Omega3 Wound provides a substantial clinical improvement over other similar skin substitute products.
5. *X-WRAP®*: CMS concludes the data is insufficient to demonstrate these products offer a substantial clinical improvement over other treatments for wound care.

Applicants received for the remaining 2017 quarters (June 1, September 1, and December 1) will be discussed in the 2019 OPPS/ASC proposed rule.

B. Device-Intensive Procedures

1. HCPCS Code-Level Device-Intensive Determination

The full listing of the final device-intensive procedures for 2018 is available in Addendum P of this rule. Appendix II of this summary provides Addendum P.

In response to a comment requesting clarification about the criteria for device-intensive procedures pertaining to temporarily inserted devices, CMS clarifies that device-intensive procedures require the implantation of a device and are subject to the additional criteria:

- All procedures 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); and
- The device offset amount must be significant, which is defined as exceeding 40 percent of the procedure's mean cost.

2. Payment Policy for Low Volume Device-Intensive Procedures

In 2018, this policy will continue to apply only to the procedure described by CPT code 0308T in APC 5495 (Level 5 Intraocular Procedures). The final 2018 payment rate for CPT code 0308T is approximately $17,560.

V. OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

A. OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals

1. Drugs and Biologicals with Expiring Pass-Through Payment Status in 2017

CMS proposed to expire pass-through payment on December 31, 2017 for 19 drugs and biologicals that were approved for pass-through status on or before January 1, 2016. Table 69 of the final rule (Appendix III of this summary), lists the drugs and biologicals with expiring pass-through status. All of these will have received OPPS pass-through payment for at least 2 years and not more than 3 years by December 31, 2017.

Once pass-through payment expires, drugs and biologicals are either policy packaged[4] or paid separately if they have per day costs above the packaging threshold of $120 for 2018. Following past practice, CMS will either policy package payment for these drugs or pay for them separately if they have costs per day above $120 in 2018. If paid separately, CMS will pay for these drugs at ASP + 6 percent.

[4] Diagnostic radiopharmaceuticals; contrast agents; anesthesia drugs; drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure; and drugs and biologicals that function as supplies when used in a surgical procedure (e.g., skin substitutes).

2. Drugs, Biologicals, and Radiopharmaceuticals with New or Continuing Pass-Through Payment Status in 2018

The final rule indicates that 50 drugs and biologicals will continue to have pass-through payment status for 2018 or will have been granted pass-through payment status as of January 2018. Drugs and biologicals that will receive pass-through payment are shown in Table 70 of the final rule (Appendix IV of this summary). None of these drugs and biologicals will have received OPPS pass-through payment for at least 2 years and no more than 3 years by December 31, 2017. The APCs and HCPCS codes for these drugs and biologicals approved for pass-through payment status are assigned status indicator "G" in Addenda A and B of the final rule.

CMS proposed to pay at ASP + 6 percent for these pass-through drugs and biologicals including those drugs, biologicals and radiopharmaceuticals that would otherwise be policy packaged were it not for their pass-through status. CMS proposed to update the ASP on a quarterly basis. If ASP data are not available for a radiopharmaceutical, CMS proposed to provide pass-through payment at wholesale acquisition cost (WAC) + 6 percent, the equivalent payment provided to pass-through drugs and biologicals without ASP information. If WAC information also is not available, CMS proposed to provide payment for the pass-through radiopharmaceutical at 95 percent of its most recent average wholesale price (AWP).

B. OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Payment Status

1. Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals

CMS currently pays for drugs, biologicals, and radiopharmaceuticals that do not have pass-through payment status in one of two ways: packaged into the payment for the associated service or separate payment (individual APCs). Hospitals do not receive a separate payment for packaged items and hospitals may not bill beneficiaries separately for any packaged items; these costs are recognized and paid within the OPPS payment rate for the associated procedure or service.

Cost Threshold for Packaging of "Threshold-Packaged Drugs"

For 2017, the packaging threshold for drugs, biologicals, and radiopharmaceuticals that are not new and do not have pass-through status is $110.

As in past years, CMS is continuing to apply the following policies to determine the 2018 final rule packaging status of a threshold-packaged drug when the drug's packaging status as calculated for the final rule, using more current data, differs from its status in the proposed rule.

- HCPCS codes that were separately payable in 2017, and were proposed for separate payment in 2018, are separately payable in 2018 even if the updated data used for the 2018 final rule indicate per day costs equal to or less than the $120 threshold.

- HCPCS codes that were packaged in 2017, proposed for separate payment in 2018, and have per day costs equal to or less than $120 based on the updated data used for the 2018 final rule, are packaged in 2018.
- HCPCS codes for which CMS proposed packaged payment in 2018 but have per day costs greater than $120, based on the updated data used for the 2018 final rule, are separately payable in 2018.

Policy Packaged Drugs, Biologicals, and Radiopharmaceuticals

As mentioned briefly earlier, in the OPPS, CMS packages several categories of drugs, regardless of the cost of the products. CMS refers to these products as "policy-packaged." Policy packaged categories of drugs, biologicals and radiopharmaceuticals include the following:

- Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations (§ 419.2(b)(4));
- Intraoperative items and services (§ 419.2(b)(14));
- Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure (including but not limited to, diagnostic radiopharmaceuticals, contrast agents, and pharmacologic stress agents (§ 419.2(b)(15)); and
- Drugs and biologicals that function as supplies when used in a surgical procedure (including, but not limited to, skin substitutes and similar products that aid wound healing and implantable biologicals) (§ 419.2(b)(16)).

CMS did not propose any changes to its policy on policy packaged drugs and biologicals but did solicit public comment on its general OPPS packaging policies.

High/Low Cost Threshold for Packaged Skin Substitutes

For 2018, as in 2017, CMS is determining the high-/low-cost status for each skin substitute product based on either a product's geometric mean unit cost (MUC) exceeding the geometric MUC threshold or the product's per day cost (PDC) (the total units of a skin substitute multiplied by the mean unit cost and divided by the total number of days) exceeding the PDC threshold. Based on 2016 claims data available, CMS calculated a 2018 MUC threshold of $46 per cm^2 (rounded to the nearest $1) and a 2018 PDC threshold of $861 (rounded to the nearest $1).

CMS' policy is to assign skin substitutes with pass-through payment status to the high cost category. However, no skin substitutes will have pass-through payment status for 2018. Skin substitutes with pricing information but without claims data to calculate a MUC or PDC are assigned to either the high-cost or low-cost category based on the product's ASP + 6 percent payment rate as compared to the MUC threshold. If ASP is not available, CMS uses WAC + 6 percent or 95 percent of AWP to assign a product to either the high-cost or low-cost category. New skin substitutes without pricing information are assigned to the low-cost category until pricing information is available to compare to the 2018 MUC threshold.

CMS proposed and is finalizing a policy that a skin substitute that was assigned to the high-cost group for 2017 would be assigned to the high-cost group for 2018, even if it does not exceed the 2018 MUC or PDC thresholds. Table 72 in the 2018 final rule shows the high-/low-cost status for each skin substitute product in 2018. Skin substitute products identified with an "*" in Table 72 of the final rule are products that were assigned to the high-cost group for 2017 and are continuing to be included in the high-cost group for 2018 despite having costs that do not exceed the MUC or PDC threshold to be included in the high-cost group.

CMS is adopting this policy for 2018 only.

Packaging Determination for HCPCS Codes that Describe the Same Drug or Biological but Different Dosages

For 2018, CMS is continuing its policy unchanged of making packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis, in the case of multiple HCPCS codes describing the same drug or biological but with different dosages. CMS did not receive any comments on this issue. The codes to which this policy applies, and their packaging status, are listed in Table 73 of the final rule.

2. Payment for Drugs and Biologicals without Pass-Through Status that Are Not Packaged

Except for separately payable, non-pass-through drugs acquired with a 340B discount (discussed below), CMS proposed to continue paying separately payable drugs and biologicals at ASP + 6 percent in 2018.

3. Payment Policy for Therapeutic Radiopharmaceuticals

For 2018, CMS is continuing the payment policy for therapeutic radiopharmaceuticals that it began in 2010. CMS is continuing to pay for all non-pass-through, separately payable therapeutic radiopharmaceuticals under the same ASP methodology that is used for separately payable drugs and biologicals, i.e. ASP + 6 percent, when all manufacturers of a product submit the necessary ASP information for a "patient ready" dose.

4. Payment Adjustment Policy for Radioisotopes Derived from Non-Highly Enriched Uranium (HEU) Sources[5]

For 2018, CMS reassessed the $10 additional payment amount and did not identify any new information that caused it to make a change.

5. Payment for Blood Clotting Factors

For 2018, CMS is continuing to pay for blood clotting factors using the same methodology that it uses to pay for other non-pass-through separately payable drugs and biologicals under the OPPS, i.e. ASP + 6 percent. When blood clotting factors are provided in physicians' offices under

[5] Highly-enriched uranium is weapons grade uranium used in atomic weapons. CMS is providing the additional payment for non-HEU to assist with eliminating domestic reliance on weapons grade uranium for medical purposes.

Medicare Part B and in other Medicare settings like the hospital outpatient department, Medicare also pays a furnishing fee. CMS will update the 2017 furnishing fee ($0.209 per unit) based on the percentage increase in the Consumer Price Index (CPI) for medical care following the same methodology it has used since 2008.

6. Payment for Non-pass-through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes, but without OPPS Hospital Claims Data

CMS is continuing the same payment policy for 2018 as 2017 for non-pass-through drugs, biologicals, and radiopharmaceuticals with HCPCS codes but without OPPS hospital claims data. In priority order, CMS will pay for these products using ASP + 6 percent if ASP is reported, WAC + 6 percent[6] if a WAC is available and at 95 percent of AWP if ASP and WAC are unavailable. The 2018 payment status of each of the non-pass-through drugs, biologicals, and radiopharmaceuticals with HCPCS codes but without OPPS hospital claims data is listed in Addendum B of the final rule.

C. Alternative Payment Methodology for Drugs Purchased Under the 340B Drug Discount Program

The below table compares the proposed and final rule policies. A more detailed summary of the final rule provisions is at the end of this section.

Comparison of Proposed and Final Rule Policies

Issue	Proposed Rule	Final Rule
Payment Rate for 340B Drugs	ASP - 22.5%.	Unchanged.
Modifier	Required for Drugs NOT Purchased under the 340B Program.	Required ONLY for Drugs Purchased under the 340B Program and may be used for packaged drugs and drugs on pass-through status without triggering the payment adjustment.
Drug Exclusions	Drugs on pass-through status, vaccines.	Unchanged.
Biosimilars	Included but only the first biosimilar to a given reference product can receive pass-through.	Included. Final rule modifies pass-through policy such that all biosimilars can receive pass-through.
Rural SCHs, children's hospitals and IPPS-exempt cancer hospitals	Included.	Exempt but hospitals are required to submit information-only modifier

[6] The + 6 percent for WAC is not specifically stated in the 2016 rulemaking cited by CMS as the source of its policy but would be consistent with "ensur[ing] that new non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals would be treated like other drugs, biologicals, and therapeutic radiopharmaceuticals under the OPPS."

Issue	Proposed Rule	Final Rule
		when billing for a drug acquired under the 340B Program. Modifier will NOT trigger a payment at ASP - 22.5%.
Budget Neutrality	$900 million savings estimate applied to the OPPS conversion factor (not modeled in payment impact or applied to the proposed rule conversion factor.) Solicited comments on alternatives.	$1.6 billion savings estimate applied to the OPPS conversion factor.

1. OPPS Payment Rate for 340B Purchased Drugs

CMS finalizes its proposal to reduce payments for separately payable Part B Drugs acquired under the 340B program by ASP – 22.5 percent. CAHs and Maryland hospitals are excluded from this policy. Additionally, CMS finalized proposals to exclude drugs on pass-through status and vaccines. In the final rule, CMS also excludes rural SCHs, children's hospitals and IPPS exempt cancer hospitals from the policy. CMS solicited comment on whether other types of drugs, such as blood clotting factors, should be excluded from the reduced payment. The final rule does not exempt any specific type of drug product from the policy.

CMS will require a modifier when billing for drugs that are acquired under the 340B program. Rural SCHs, children's hospitals and IPPS exempt cancer hospitals will be required to use a different, information-only modifier, when billing for drugs acquired under the 340B program. The modifier used by Rural SCHs, children's hospitals and IPPS exempt cancer hospitals will not trigger the ASP - 22.5 percent adjustment for these hospital types.[7] Further details regarding this modifier are in the final rule and more information will be furnished in sub-regulatory guidance, including guidance related to billing for dually eligible beneficiaries for whom covered entities do not receive a discount under the 340B program.

2. Comments in Other Areas

Biosimilar Biological Products. CMS rejected the comments to apply the 340B policy to biosimilars receiving pass-through payment because section 1833(t)(6)(D)(i) of the Act provides for an explicit payment for drugs and biologicals eligible for pass-through payment. However, CMS is adopting a change in policy to allow pass-through payment for each FDA-approved biosimilar instead of only the first biosimilar for a particular reference product. Biosimilar

[7] The rule clearly states that CAHs and hospitals paid under the Maryland waiver DO NOT report modifier "JG" that triggers payment for separately payable drugs at ASP - 22.5 percent. With respect to informational modifier "TB", the rule makes no statement as to whether it is required from CAHs and Maryland hospitals. It says "rural SCHs, children's hospitals and PPS-exempt cancer hospitals…will be required to report information modifier "TB" for 340B-acquired drugs, and will continue to be paid ASP + 6 percent."

biological products that are not on pass-through payment will be paid ASP - 22.5 percent of the reference product.

Nonexcepted Off-Campus Hospital Outpatient Departments. Commenters requested that CMS also apply the alternative payment methodology for 340B drugs furnished in nonexcepted off-campus PBDs to avoid creating financial incentives for hospitals to reallocate services to the site of care that pays the highest rate for an item or service. CMS responded that it will continue to monitor the billing patterns of claims submitted by nonexcepted off-campus outpatient PBDs noting that its policy only applies to covered outpatient department services which does not include services furnished in non-excepted off-campus hospital OPDs which are paid for separately payable drugs at ASP + 6 percent in accordance with section 1847A of the Act. CMS may consider adopting the requested policy in 2019 notice-and-comment rulemaking.

3. Payment Impact

Using assumptions outlined in the final rule, CMS estimates OPPS payments for separately payable drugs, including beneficiary copayments, will decrease by approximately $1.6 billion under the final rule policy.

4. Summary of Final Rule Policies for 2018:

Below is a listing of CMS' final rule policies. Effective January 1, 2018:

- Drug and biologicals (including biosimilars) that are acquired through the 340B Program or through the 340B PVP at or below the 340B ceiling price will be paid at ASP - 22.5 percent when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment. Medicare will continue to pay drugs that were not purchased with a 340B discount at ASP + 6 percent.
- Hospitals paid under the OPPS, (other than CAHs, hospitals paid under the Maryland waiver, children's hospitals, and IPPS-exempt cancer hospitals) are required to report modifier "JG" on the same claim line as the drug HCPCS code to identify a drug purchased under the 340B drug subject to payment at ASP - 22.5 percent.
- Rural SCHs, children's hospitals and IPPS-exempt cancer hospitals will be required to report informational modifier "TB" for 340B-acquired drugs beginning January 1, 2018. Modifier "TB" is informational only and will not trigger a payment adjustment.
- Part B drugs or biologicals excluded from the 340B payment adjustment include vaccines (assigned status indicator "L" or "M") and drugs with OPPS transitional pass-through payment status (assigned status indicator "G").
- To maintain budget neutrality within the OPPS, the estimated $1.6 billion in reduced drug payments will be redistributed in an equal offsetting amount to all hospitals paid under the OPPS through a 3.2 percent adjustment to the 2018 OPPS conversion factor that is used to determine payment rates for non-drug items and services furnished under the OPPS.

VI. OPPS Payment for Hospital Outpatient Visits and Critical Care Services

CMS proposed no changes to the current clinic and emergency department hospital outpatient visits payment policies or to the payment policy for critical care services. CMS did not receive any public comments requesting changes to its OPPS rates for hospital outpatient visits and critical care services for 2018. CMS solicited comments on potential changes it could make for future rulemaking cycles and did not receive any.

VII. Payment for Partial Hospitalization Program (PHP) Services

A. PHP APC Update for 2018

The 2018 geometric mean per diem costs and payment rates are as follows:

2018 APC	Group Title	PHP APC Geometric Mean Per Diem Costs*	Payment Rates**
5853	Partial Hospitalization (3 or more services per day) for CMHCs	$143.22	$143.30
5863	Partial Hospitalization (3 or more services per day) for hospital-based PHPs	$208.09	$208.21

* Table 74 of the final rule shows the final PHP APC geometric mean per diem costs.
** The payment rates shown are reproduced from Addendum A to the final rule.

B. Outlier Policy for CMHCs

For 2018, CMS designates 0.02 percent of the estimated 1.0 percent hospital outpatient outlier threshold specifically for CMHCs for PHP outliers. CMS sets the cutoff point for the outlier payments for CMHCs for 2018 at 3.4 times the highest CMHC PHP APC payment rate (CMHC PHP APC 5853); the agency will pay 50 percent of CMHC geometric mean per diem costs over the threshold. Specifically, CMS will calculate a CMHC outlier payment equal to 50 percent of the difference between the CMHC's cost for the services and the product of 3.4 times the APC 5853 payment rate. CMS does not set a dollar threshold for CHMC outlier payments.

C. Regulatory Impact

CMS estimates that payments to CMHCs will increase by 17.2 percent in 2018. The estimate includes the trimming methodology, wage index, and other adjustments.

VIII. Procedures That Would Be Paid Only as Inpatient Procedures

A. Changes to the Inpatient Only (IPO) List

CMS proposed to remove the procedures described by the following codes from the IPO list for 2018: CPT code 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed) and CPT code 27447 (Arthroplasty,

knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)):

CPT Code	Code Descriptor	2018 OPPS APC assignment	2018 OPPS status indicator
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty	5115	J1
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	5362	J1

CMS is finalizing its proposal to remove these two procedures from the IPO list. CMS is also removing CPT codes 43282, 43272, 43773, 43774 and 92941 from the IPO list as described in more detail below. Addendum E of the final rule contains the complete list of codes that are to be paid only as inpatient procedures for 2018.

Laparoscopy, surgical prostatectomy

CMS is removing CPT code 55866 from IPO list and assigning it to C-APC 5362 (Level 2 Laparoscopy & Related Services) with a status indicator of "J1."

Total Knee Replacement

CMS removes total knee arthroplasty (TKA) from the IPO list and finalizes its related proposals. CMS proposed that CPT code 27447 would be assigned to C–APC 5115 (Level 5 Musculoskeletal Procedures) with status indicator ''J1."

The proposed rule further noted that the decision regarding the most appropriate care setting for a given surgical procedure is a complex medical judgment made by the physician based on the beneficiary's individual clinical needs and preferences and on the general coverage rules requiring that any procedure be reasonable and necessary. Therefore, CMS proposed to prohibit Recovery Audit Contractor (RAC) review for patient status for TKA procedures performed in the inpatient setting for a period of 2 years to allow time for experience to accumulate with these procedures in this setting. CMS would not want hospitals to err on the side of inappropriately performing the procedure on an outpatient basis due to concerns about the possibility of an inpatient TKA claim being denied for patient status. Contractor reviews for issues other than patient status would continue to be permitted, including those for underlying medical necessity.

CMS is finalizing its proposal to remove TKA from the IPO list. CMS responded that the decision regarding the most appropriate care setting for a given surgical procedure is a complex medical judgment made by the physician based on the beneficiary's individual clinical needs and preferences and on the general coverage rules requiring that any procedure be reasonable and necessary. It does not address the concerns about private insurers which the agency says is outside of its authority.

Removal of any procedure from the IPO list does not require the procedure to be performed only on an outpatient basis. The "2-midnight" rule will apply to TKA. This guidance provides that if the physician expects the beneficiary to require hospital care that spans at least 2 midnights and admits the beneficiary based upon that expectation, the case is appropriate for payment under the IPPS (80 FR 70539). For stays for which the physician expects the patient to need less than 2 midnights of hospital care, an inpatient admission is payable under Medicare Part A on a case-by-case basis if the documentation in the medical record supports the admitting physician's determination that the patient requires inpatient hospital care. This documentation and the physician's admission decision are subject to medical review.

CMS will not create or endorse specific patient selection guidelines because it believes that surgeons, clinical staff, and medical specialty societies who perform outpatient TKA and possess specialized clinical knowledge and experience and are most suited to create such guidelines.

(1) Bundled Payment Models

CMS, in the final rule, states it does not expect a significant volume of TKA cases currently being performed in the hospital inpatient setting to shift to the hospital outpatient setting as a result of removing TKA from the IPO list. Accordingly, CMS does not expect a substantial impact on the patient-mix for the BPCI and CJR models although it intends to monitor the overall volume and complexity of TKA cases performed in the hospital outpatient department to determine whether any future refinements to these models are warranted.

(2) Recovery Audit Contractor (RAC) Review of TKA Procedures

CMS finalized the 2-year moratorium on RAC review of inpatient TKA cases as proposed. It further stated that the initial medical reviews of claims for short-stay inpatient admissions are conducted by QIOs, which may refer providers to the RACs due to exhibiting persistent noncompliance with Medicare payment policies, including, but not limited to having high denial rates and consistently failing to adhere to the 2-midnight rule, or failing to improve their performance after QIO educational intervention.

IX. Nonrecurring Policy Changes

A. Payment for Certain Items and Services Furnished by Certain Off-Campus Departments of a Provider

In the physician fee schedule final rule, CMS reduces payments to non-exempt provider based clinics (new clinics that were not in process by November 2, 2015) from 50% of the OPPS payment for the service in question to 40% of the service in question.

Implementation of Section 16002 of the 21st Century Cures Act (Cures Act).

CMS has provided operational guidance to MACs on the implementation of section 16002 of the Cures Act. Section 16002 exempts an off-campus PBD of the eleven dedicated cancer hospitals from section 603 if the cancer hospital provided CMS an attestation by certain deadlines. The

attestation would have to be provided not later than February 10, 2017 (i.e., 60 days from date of enactment of the Cures Act) that the off-campus PBD met the provider-based rule requirements (at 42 CFR §413.65) after November 1, 2015, and before December 13, 2016 (the date of the enactment of the Cures Act). If an off-campus PBD of a cancer hospital first meets the provider-based rule requirements after December 13, 2016, it must attest that it meets the provider-based rules within 60 days of first meeting the provider-based rule requirements to be exempt from the application of section 603.

Section 1833(t)(18) of the Act includes special OPPS payment provisions for cancer hospitals. These provisions provide supplemental payments to cancer hospitals at cost report settlement such that the target OPPS payment-to-cost ratio for the cancer hospital equals the average payment-to-cost ratio for all other OPPS hospitals. Section 16002 of the Cures Act requires the Secretary to reduce the target payment-to-cost ratio that would otherwise apply by 1 percentage point and permits the Secretary to consider an additional percentage point reduction that takes into account payment rates under the section 603 payment system (i.e., the MPFS) for non-cancer hospitals. See section II.F. above for a description of the calculation of the target payment-to-cost ratio for these hospitals for 2018.

B. Medicare Site-of-Service Price Transparency (Section 4011 of the 21st Century Cures Act)

Section 4011 of the 21st Century Cures Act (Pub. L. 114–255), enacted on December 13, 2016, adds new subsection (t) to section 1834 of the Act requiring the Secretary to make available to the public via a searchable website the estimated payment amount and beneficiary liability for an item or service payable under the OPPS and ASC payment systems. CMS is not required to make this information available for all services but for an "appropriate number of items and services." CMS is announcing its plan to establish the searchable application on its website as required by section 1834(t) of the Act. Details regarding the application will be issued through a sub-regulatory process. CMS anticipates the application will be made available in early 2018.

C. Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Section 218(b) of the Protecting Access to Medicare Act of 2014 (Pub. L. 113–93) directs the Secretary to establish a program to promote appropriate use criteria (AUC) for advanced diagnostic imaging services (the AUC program). Section 1834(q)(1)(B) of the Act defines AUC as criteria that are evidence-based (to the extent feasible) and assist professionals who order and furnish applicable imaging services to make the most appropriate treatment decisions for a specific clinical condition.

CMS is implementing the AUC program in four components:

- The first component was implemented in 2016 and includes the requirements and process for the establishment and specification of the AUC.
- The second component was implemented in 2017 and includes the specification of qualified clinical decision support mechanisms (CDSMs). A CDSM is the electronic tool through which the ordering practitioner consults AUC.

CMS proposed to implement the third component of the AUC program in 2018. The third component includes the requirements for an ordering professional to consult with a qualified CDSM when ordering an applicable imaging service and communicate information about the AUC consultation to the furnishing professional, and for the furnishing professional to include that information on claims for the service that is furnished in an applicable setting and paid under an applicable payment system.

The AUC program applies to advanced imaging services for which payment is made under the Medicare Physician Fee Schedule (MPFS); the OPPS; and the ASC payment system. CMS' changes to the AUC program were made in the 2018 MPFS final rule. The final rule refers readers to 2018 MPFS final rule for further information governing the Medicare AUC program including public comments and responses. HFMA's MPFS final rule summary is available on HFMA's Regulatory Resources page, under Fact Sheets, Physician Fee Schedule.

D. Enforcement Instruction for the Supervision of Outpatient Therapeutic Services in Critical Access Hospitals (CAHs) and Certain Small Rural Hospitals

CMS proposed to reinstate the nonenforcement of the direct supervision requirements for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds for 2018 and 2019. The enforcement moratorium will give CAHs and small rural hospitals with 100 or fewer beds more time to comply with the supervision requirements for outpatient therapeutic services and to give all parties time to submit specific services to be evaluated by the HOP for a recommended change in the supervision level. CMS is finalizing the proposed enforcement moratorium without change. These hospitals would continue to be subject to conditions of participation for hospitals and other Medicare rules regarding supervision. CMS welcomes public comments on this proposal.

E. Payment Changes for Film X-Ray Services and Payment Changes for X-rays Taken Using Computed Radiography Technology

Section 502(b) of the Consolidated Appropriations Act, 2016 (Pub. L. 114-113) enacted on December 18, 2015 requires that the OPPS payment be reduced by 20 percent from the amount that would otherwise be made if the hospital furnishes an X-ray service taken using film or computed radiography that uses cassette-based imaging with an imaging plate to create an image.

CMS implemented the X-ray provision by establishing the modifier ''FX'' (X-ray taken using film), effective January 1, 2017. The payment for X-rays taken using film and furnished during 2017 or a subsequent year will be reduced by 20 percent when modifier ''FX'' (X-ray taken using film) is reported with the appropriate HCPCS codes.

Payments for computed radiography technology services furnished during 2018, 2019, 2020, 2021, or 2022, that use cassette-based imaging with an imaging plate to create an image are reduced by 7 percent from the otherwise applicable OPPS payment. If such services are furnished during 2023 or a subsequent year, the reduction is 10 percent. To implement this provision, CMS is establishing a new modifier "FY" (X-ray taken using computed radiography technology/cassette-based imaging) that would be reported on claims to identify those HCPCS

codes that describe X-rays taken using computed radiography technology with an imaging plate. When this modifier is used, CMS is applying the reduction required by the statute. However, the reduction does not apply when the CPT code to which it is applied is a packaged service that is not separately paid.

F. Potential Revisions to the Laboratory Date of Service Policy

CMS did not propose a change of policy to the laboratory date of service (DOS) in the 2018 OPPS/ASC proposed rule. However, the proposed rule provided specific and detailed changes to the DOS regulations that CMS indicated it was considering adopting for the final rule. CMS requested comments on those changes and solicited commenters on other issues. The below table compares provisions as they were considered for the proposed rule and the policies CMS adopted in the 2018 OPPS/ASC final rule.

Comparison of Proposed and Final Rule Policies

Proposed Rule Policy	Final Rule Policy
The physician must order the test following the date of a hospital outpatient's discharge from the hospital outpatient department.	Order requirement eliminated. The test must be performed following a hospital outpatient's discharge from the hospital outpatient department.
The specimen must be collected from a hospital outpatient during an encounter.	No change.
The results of the test do not guide treatment provided during the hospital outpatient encounter.	No change.
The test was reasonable and medically necessary for the treatment of an illness.	No change
CMS requested comments on whether to apply the new DOS policy only to separately payable Advanced Diagnostic Laboratory Tests (ADLT) or both separately payable ADLTs and separately payable molecular pathology tests.	Will apply to both separately payable ADLTs and separately payable molecular pathology tests. CMS declined to expand policy beyond these tests.
Applies to outpatient department tests only.	No change. CMS declined to expand the policy to tests furnished to inpatients.

The DOS is a required data field on all Medicare claims for laboratory services. CMS policy requires that the DOS for a laboratory service is the date the specimen is collected. For "archived specimens," the DOS is the date the specimen is obtained from storage. An "archived" specimen is as a specimen that is stored for more than 30 calendar days before testing.

1. Final Rule Policy:

In order to allow a laboratory to bill Medicare directly for an ADLT or molecular pathology test excluded from the OPPS packaging policy, CMS is modifying 42 CFR 414.510(b) by adding a

new paragraph (5) to establish that, in the case of a separately payable molecular pathology test or a separately payable test designated by CMS as an ADLT[8], the DOS of the test must be the date the test was performed only if—

- The test was performed following a hospital outpatient's discharge from the hospital outpatient department;
- The specimen was collected from a hospital outpatient during an encounter (as both are defined in 42 CFR 410.2);
- It was medically appropriate to have collected the sample during the hospital outpatient encounter;
- The results of the test do not guide treatment provided during the hospital outpatient encounter; and
- The test was reasonable and medically necessary for the treatment of an illness.

In response to comments, CMS stated that if a test meets the above criteria, the DOS is the date the test is performed and it must be billed by the laboratory and cannot be billed by the hospital unless the hospital performed the test. CMS intends to continue studying the laboratory DOS policy and determine whether any additional changes are warranted including whether to address any inconsistencies with the new exception, and any changes to the "under arrangements" provisions, including its policies for the hospital inpatient setting.

X. 2018 OPPS Payment Status and Comment Indicators

A. 2018 OPPS Payment Status Indicator Definitions

For 2018, CMS did not propose any changes to status indicators and did not receive any public comments on them. Status indicators and their definitions can be found in Addendum D1 of the final rule. Payment status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B to the 2018 final rule.

XI. Updates to the Ambulatory Surgical Center (ASC) Payment System

Summary of Selected Key Elements of Final ASC Payment Rates for 2018		
	ASCs reporting quality data	**ASCs not reporting quality data**
2017 ASC Conversion Factor	$45.003	
Wage index budget neutrality adjustment	1.0007	
2018 Update		
CPI-U update	1.7%	
Multi-factor productivity adjustment (MFP)	-0.5%	

[8] Laboratory tests granted ADLT status under section 1834A(d)(5)(B) (tests offered and furnished by a single laboratory that are cleared by the FDA) of the Act currently are not excluded from the OPPS packaging policy. Likewise, GSP testing, proprietary laboratory analysis ttests, and protein-based MAAAs that are not considered molecular pathology tests are also conditionally packaged under the OPPS.

Summary of Selected Key Elements of Final ASC Payment Rates for 2018		
Net MFP adjusted update	1.2%	
Penalty for not reporting quality data	0.0%	-2.0%
Net MFP and quality adjusted update	1.2%	-0.8%
2018 ASC Conversion Factor	$45.575	$44.663*

* This is the amount CMS published in its final rule. Using the specified update factors, however, the calculated conversion factor for ASCs not reporting quality data totals $44.674, slightly higher than the published amount.

CMS estimates that under the final rule, total ambulatory surgical center (ASC) payments for 2018 will increase by $130 million over 2017 levels.

As with the rest of the OPPS final rule and other CMS rules, addenda related to the ASC section (and referenced in this summary) are available only on the CMS website, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1678-FC.html. All ASC Addenda to the final rule are contained in the zipped folders entitled Addendum AA, BB, DD1, DD2, and EE.

A. Treatment of New and Revised Codes

CMS continues to recognize the following codes on ASC claims:

- Category I CPT codes, which describe surgical procedures and vaccine codes;
- Category III CPT codes, which describe new and emerging technologies, services and procedures; and
- Level II HCPCS codes, which are used primarily to identify products, supplies, temporary procedures, and services not described by CPT codes.

CMS continues its policy to evaluate all new Category I and III CPT codes and Level II HCPCS codes that describe surgical procedures in order to make preliminary determinations during the annual rulemaking process about whether they meet the criteria for payment in an ASC setting, and, if so, whether they are office-based procedures. CMS also identifies new and revised codes as ASC covered ancillary services based on the final payment policies in the revised ASC payment system.

CMS finalizes proposals for new codes in two categories:

- treatment of codes previously identified during the year in the quarterly update process and on which it sought comments in the proposed rule; and
- new codes for which it will be seeking comments in this final rule with comment period.

Treatment of New and Revised Level II HCPCS Codes Implemented in April 2017 for Which CMS Solicited Public Comments in the 2018 OPPS/ASC Proposed Rule

CMS did not receive any public comments regarding the proposed ASC payment indicators and payment rates for new and revised Level II HCPCS codes that were effective April 1, 2017.

CMS, in the April 2017 change requests (CRs), made effective 6 new Level II HCPCS codes describing covered ASC services that were not included in the 2017 OPPS final rule. Table 80 copied below set out the codes, descriptors, and 2018 payment indicators.

New Level II HCPCS Codes for Covered Ancillary Services Effective on April 1, 2017 (Table 31)			
2017 HCPCS Code	**2018 HCPCS Code**	**2018 Long Descriptor**	**2018 Payment Indicator**
C9484	J1428	Injection, eteplirsen, 10 mg	K2
C9485	J9285	Injection, olaratumab, 10 mg	K2
C9486	J1627	Injection, granisetron extended release, 0.1 mg	K2
C9487*	J3358	Ustekinumab, for intravenous injection, 1 mg	K2
C9488	C9488	Injection, conivaptan hydrochloride, 1 mg	K2
J7328	J7328	Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg	K2
*HCPCS Code C9487, which was effective April 1, 2017, was deleted on June 30, 2017 and replaced with HCPCS Code Q9989 (Ustekinumab, for intravenous injection, 1 mg) effective July 1, 2017			

The final 2018 payment rates for these codes can be found in Addenda AA and BB of the final rule at the CMS website referenced above.

Treatment of New and Revised Level II HCPCS Codes Implemented in July 2017 for Which CMS Solicited Public Comments in the 2018 OPPS/ASC Proposed Rule

CMS finalizes the proposed payment indicators for the Level II HCPCS codes and the new Category III CPT code that were newly recognized as ASC covered surgical procedures or covered ancillary services in July 2017 through the quarterly update CRs, as indicated (shown in Table 81, reproduced below).

CMS received one comment that correctly pointed out that the price for HCPCS code Q9986 stated in the July and October 2017 OPPS and ASC addenda was based on 1mg dose rather than the revised 10mg dose descriptor. CMS agrees and states that it will correct the price for this code retroactive to July 1, 2017 in the respective January 2018 updates.

CMS notes that the payment rates, where applicable, can be found in Addendum BB to the final rule for the Level II HCPCS codes and in Addendum AA to the final rule for the new Category III code at the CMS website referenced above.

New Level II HCPCS Codes for Covered Surgical Procedures and Ancillary Services Effective on July 1, 2017 (Table 81)			
2017 HCPCS Code	**2018 HCPCS Code**	**2018 Long Descriptor**	**2018 Payment Indicator**
C9489	J2326	Injection, nusinersen, 0.1 mg	K2
C9490	J0565	Injection, bezlotoxumab, 10 mg	K2

C9745	C9745	Nasal endoscopy, surgical; balloon dilation of eustachian tube	J8
C9746	C9746	Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed	J8
C9747	C9747	Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance	J8
Q9986	J1726	Injection, hydroxyprogesterone caproate (Makena), 10 mg	K2
Q9989*	J3358	Ustekinumab, for Intravenous Injection, 1 mg	K2
*HCPCS Code C9487, which was effective April 1, 2017, was replaced with HCPCS Code Q9989 (Ustekinumab, for intravenous injection, 1 mg) effective July 1, 2017			

New Category III CPT Code For Covered Surgical Procedure Effective on July 1, 2017 (Table 82)			
2017 CPT Code	**2018 CPT Code**	**2018 Long Descriptor**	**2018 Payment Indicator**
0474T	0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	J8

Process for Recognizing New and Revised Category I and Category III CPT Codes That Will Be Effective January 1, 2018 for Which CMS Will Solicit Comments in the 2018 OPPS/ASC Final Rule

For new and revised Category I and III CPT codes effective January 1, 2018 that were received in time to be included in the proposed rule, CMS proposed Ambulatory Payment Classification (APC) and status indicator assignments, as well as proposed payment rates. Such codes are assigned new comment indicator "NP". Those new and revised codes are listed in Addendums AA and BB, and the long descriptors are in Addendum O at the ACS website.

CMS finalizes, without modification, the proposed CY 2018 ASC payment indicator assignments for new and revised CPT codes, effective January 1, 2018.

B. Update to the List of ASC Covered Surgical Procedures and Covered Ancillary Services

1. Covered Surgical Procedures Designated as Office-Based

Based on its review of 2016 volume and utilization data, CMS finalizes its proposal to permanently designate two additional procedures as office-based:

- CPT Code 37241 (Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural road mapping, 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)), with ASC payment indicator of "P2/P3" in 2018.
- CPT Code 67227 (Destruction of extensive or progressive retinopathy (e.g. diabetic retinopathy), cryotherapy, diathermy), with ASC payment indicator of "P2/P3" in 2018.

CMS also reviews 2016 volume and utilization data for 10 procedures finalized for temporary office-based status in last year's final rule. CMS found that there were very few or no claims data for eight of these procedures, and finalizes its proposal to maintain the temporary office-based designations for these eight codes for 2018.

With respect to the two remaining procedures finalized for temporary office-based status in last year's final rule CMS finalizes its proposal to permanently designate HCPCS code G0429 (Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies) as office-based and to assign payment indicator "P2/P3" in 2018. CMS notes that HCPCS code 0299T (Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound) was finalized for temporary office-based status in the CY 2017 OPPS/ASC final rule. However, this code will be deleted by the AMA, effective December 31, 2017.

CMS finalizes its proposal to designate CPT code 38222 (Diagnostic bone marrow; biopsy(ies) and aspiration(s)) for ASC covered surgical procedures as temporary office-based for 2018, with the 2018 payment indicator "P3". CMS did not receive any public comments on its proposal.

Table 84 in the final rule lists the procedures and the CMS payment indicators for 2018. CMS notes that the payment indicators (e.g. P2, P3, and R2) are based on a comparison of the rates according to the ASC standard rate setting methodology and the Medicare Physician Fee Schedule (PFS) rates. Current law specifies a 0.5 percent update to the Medicare PFS payment rates for CY 2018.

2. ASC Covered Surgical Procedures to Be Designated as Device-Intensive

For 2018, CMS finalizes its proposal to update the ASC list of covered surgical procedures that are eligible for payment according to the device-intensive payment methodology, reflecting the individual HCPCS code device offset percentages based on 2016 OPPS claims and cost report data. The procedures are assigned the payment indicator "J8" and are included in Addendum AA (at the CMS ASC website) which lists the procedures, the CPT code and short-descriptor, the device offset percentage, and an indication of the full credit/partial credit device adjustment policy that will apply. In 2018, there are 144 device-intensive procedures that are paid at an adjusted rate.

3. Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices

CMS finalizes its proposal to continue its policy for ASCs for 2018:
- When the device is furnished at no cost or with full credit from the manufacturer, the contractor will reduce payment to the ASC by 100 percent of the device offset amount, which is the amount that CMS estimates as the cost of the device. The ASC will append

the HCPCS "FB" modifier on the claim line with the procedure to implant the device.

- When the device is furnished with partial credit of 50 percent or more of the cost of the new device, the contractor will reduce payments to the ASC by 50 percent of the device offset amount. In order to report a partial credit, the ASC will have the option of either submitting the claim after the procedure, but prior to manufacturer acknowledgement of credit for the device, and having the contractor make a claim adjustment, or holding the claim for payment until a determination is made by the manufacturer. The ASC will then submit the claim with a "FC" modifier if the partial credit is 50 percent or more (but less than 100 percent) of the cost of the replacement device. Beneficiary coinsurance will be based on the reduced payment amount.

CMS also finalizes its proposal to update the list of ASC covered device-intensive procedures which are subject to the full credit/partial credit policy to all device-intensive procedures in 2018.

4. Additions to the List of ASC Covered Surgical Procedures

CMS conducted its annual review of procedures paid under the OPPS but not included on the list of covered ASC procedures. CMS finalizes its proposal to add three procedures to the list of covered surgical procedures that could meet the standards for inclusion – that is, they could be safely performed in the ASC setting and would not require an overnight stay. The three additions are as follows:

Additions to the List of ASC Covered Surgical Procedures for 2018 (Table 86)		
2018 CPT Code	**2018 Long Descriptor**	**2018 ASC Payment Indicator**
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, Cervical	J8
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (list separately in addition to code for primary procedure)	N1
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g	G2

CMS notes that, as in prior years, this update includes review of procedures being proposed for removal from the OPPS inpatient list for possible inclusion on the ASC list of covered surgical procedures. While CMS proposed to remove from the OPPS inpatient list the two procedures described by CPT codes 27447 and 55866,[9] it proposed to exclude the procedures from the ASC covered procedures list because they typically require more than 24 hours of active medical care

[9] CPT codes 27447 (Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)) and 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed).

following the procedure. After reviewing comments submitted, CMS finalized that it was not adding CPT codes 27447 and 55866 to the list covered surgical procedures in the ASC.

C. New Technology Intraocular Lenses (NTIOL)

CMS did not receive any requests to establish a new NTIOL class for 2018 by the March 1, 2017 deadline. CMS did not change its payment adjustment of $50 per lens for a 5-year period from the implementation date of a new NTIOL class.

D. ASC Payment and Comment Indicators

CMS finalizes its proposal to continue using the current comment indicators "NP" and "CH." Category I and III CPT codes that are new and revised for 2018 and any new and existing Level II HCPCS codes with substantial revisions will be labeled with the new comment indicator 'NP" to indicate that these codes were open for comment as part of the 2018 proposed rule.

Addenda DD1 and DD2 provide a complete list of the ASC payment and comment indicators for the 2018 update. CMS did not receive any public comments on the ASC payment and comment indicators.

E. Calculation of the ASC Payment Rates

1. Impact

CMS sets out estimated aggregate increases by surgical specialty group for the six groups that account for the most ASC utilization and spending in Table 89 of the final rule, replicated below, which assumes the same mix of services as reflected in 2016 claims data.

Summary of Table 89:
Aggregate 2018 Medicare Program Payments by Surgical Specialty, for the Six Largest Groups and Ancillary Items and Services.

Surgical Specialty Group	Estimated 2017 ASC Payments (in Millions)	Estimated 2018 Percent Change
Total	**$4,460**	**1%**
Eye and ocular adnexa	$1,688	1%
Digestive system	$852	2%
Nervous system	$849	1%
Musculoskeletal system	$530	3%
Genitourinary system	$186	1%
Integumentary system	$141	5%
Ancillary items and services	$55	-44%

CMS sets out estimated increases for 30 selected procedures in Table 90 in the final rule; the top 10 procedures are replicated below.

Excerpt from Table 90: Estimated Impact of the 2018 Update to the ASC Payment System on Aggregate Payments for the Top 10 Procedures			
CPT/ HCPS Code	Short Descriptor	Estimated 2017 ASC Payments (in Millions)	Estimate 2018 Percent Change Percent Change
66984	Cataract surg w/iol, 1 stage	$1,172	1%
45380	Colonoscopy and biopsy	$216	3%
43239	Egd biopsy single/multiple	$178	2%
63685	Insert/redo spine n generator	$151	-1%
45385	Colonoscopy w/lesion removal	$146	3%
63650	Implant neuroelectrodes	$118	4%
64483	Inj foramen epidural l/s	$99	1%
66982	Cataract surgery, complex	$94	1%
0191T	Insert ant segment drain int	$86	1%
66821	After cataract laser surgery	$69	0%

XII. Hospital Outpatient Quality Reporting Program Updates

CMS adopts changes to the Hospital Outpatient Quality Reporting (OQR) Program including the removal of six measures beginning with the 2020 payment determination; indefinite delay in implementing the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) measure; public reporting of one measure; and modifications to the data submission and data validation requirements. A summary table at the end of this section shows all OQR Program measures adopted for the 2015 through 2021 payment determinations.

A. Hospital OQR Program Quality Measures and Public Reporting

1. Removal of Measures

CMS is finalizing removal, beginning with the 2020 payment determination, of the following six measures:

- OP-21: Median Time to Pain Management for Long Bone Fracture
- OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures
- OP-1: Median Time to Fibrinolysis
- OP-4: Aspirin at Arrival
- OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
- OP-25: Safe Surgery Checklist

CMS estimates that the removal of these six measures for the 2020 payment determination will reduce the aggregate reporting burden on hospitals by $16.7 million.

2. Delay of OAS CAHPS Measure

CMS finalizes its proposal to delay indefinitely the implementation of the OAS CAHPS measures, previously scheduled for inclusion in the OQR Program measure set beginning with 2020 payment (2018 data collection). Specifically, in the 2017 OPPS final rule, CMS adopted five OAS CAHPS based measures, including three composite measures. Since then, CMS has determined that it lacks operational and implementation data, and believes that the voluntary national implementation of the survey which began in 2016[10] will provide valuable information for the future. Particular issues identified are patient response rates, both aggregate and by survey administration method; reliability of the data; and administrative burden.

3. Public Display of OP-18 Measure

CMS modifies its proposal to publicly report data on the measure OP-18: Median Time from Emergency Department Arrival to Emergency Department Departure for Discharged Emergency Department Patients. For this measure, data are stratified into four separate calculations: OP-18a is the overall rate; OP-18b is the reporting measure (currently displayed on *Hospital Compare*), which excludes psychiatric/mental health patients and transfer patients; OP-18c assesses psychiatric/mental health patients; and OP-18d assesses transfer patients. CMS had proposed to add public reporting of OP-18c on *Hospital Compare* because this component includes numerous substance abuse ICD-10 codes and public reporting would address a behavioral health gap in the OQR Program measure set.

In lieu of reporting OP-18c on *Hospital Compare*, CMS will publish the data in downloadable forms on data.medicare.gov along with other OQR Program measure data. Affected parties will be notified of the availability of the downloadable files via CMS listservs, email, national provider calls and QualityNet announcements. Hospitals will be able to preview the data to be reported for OP-18c as part of the regular 30-day data preview process for OQR Program data. By releasing the data this way and not on *Hospital Compare*, CMS says it wants to be cautious and avoid any unintended consequences raised by commenters, as described below.

Related proposals to rename the component measures and modify Measure Information Form are not finalized.

B. Administrative and Data Submission Requirements

1. Changes to the Notice of Participation (NOP) Deadline

CMS does not finalize its proposal that hospitals must submit the NOP any time *prior to* registering on the QualityNet website. Because participants would have to login to QualityNet in order to submit the NOP, the proposal was not logistically possible. It will revisit the issue in future rulemaking with a goal of making it easier for hospitals to meet the OQR Program participation requirements.

[10] https://oascahps.org/General-Information/National-Implementation

2. Data Submission Requirements for Newly Participating Hospitals

Hospitals that did not participate in the previous year's OQR Program will be required to submit data beginning with encounters occurring during the first calendar quarter of the year prior to the affected payment year. This replaces the previously adopted policy under which the deadline depends upon whether the hospital's Medicare acceptance date is before or after January 1 of the year prior to the payment year. Conforming changes are made to the regulatory text at 42 CFR 419.46(c)(3).

3. Data Validation Requirements

Under the previously adopted validation selection process, CMS will choose a random sample of 450 hospitals for validation purposes and select an additional 50 hospitals based on two criteria: (1) hospital failed validation in the previous year, or (2) hospital has an outlier value for a measure, defined as greater than 5 standard deviations for the mean value for the measure.

In this final rule, CMS clarifies that the outlier value criterion refers specifically to hospitals with a poor score on a measure. CMS further codifies the procedures for targeting hospitals, including the clarification at 42 CFR 419.46(e)(3).

CMS formalizes its process for educational review and specifies that if the results of an educational review indicate that CMS incorrectly scored a hospital's medical records submitted for validation, the corrected quarterly validation score will be used to compute the hospital's confidence interval and final validation score for the year. Currently, if an error is identified, the results are not changed but are taken into account if the hospital submits a reconsideration request.

Specifically, beginning with the validation of 2018 data (for the 2020 payment determination), CMS formalizes its current educational review process under which a hospital can request informal educational reviews for each quarter it receives validation results. The hospital has 30 days after posting of the validation results on the QualityNet secure portal to make the request for review.

CMS finalizes that during the educational review process, it will determine whether a quarterly validation score was correct using the same process adopted for reconsideration requests. Evaluation of the score will consist of reviewing data elements that were labeled as mismatched in the original validation results. CMS will take into consideration written justifications provided by hospitals in the educational review request.

Beginning with the 2020 payment determination, if an educational review requested for any of the first 3 quarters of validation yields incorrect validation results for chart-abstracted measures, any quarterly score that is recalculated and corrected during the educational review process will be used to compute the hospital's final validation confidence interval at the end of the year. CMS notes that there is insufficient time to make calculations and conduct educational reviews for the last quarter of validation, but the existing reconsideration process will be used to dispute any

unsatisfactory validation result. Importantly, CMS will only use the educational review process to recalculate the validation confidence interval if the result favors the hospital.

4. Extraordinary Circumstances Extensions or Exemptions

CMS finalizes its proposal to align the OQR Program extraordinary circumstances extensions or exemptions (ECE) processes with similar processes for its other quality reporting and value-based purchasing programs. Beginning January 1, 2018, the nomenclature will be changed to "extraordinary circumstances exceptions" and the regulatory text modified accordingly. CMS further notes that it strives to complete its review of each ECE request within 90 days.

E. Summary Table of OQR Program Measures

The table below shows changes in measures for the 2020 and 2021 payment determinations along with OQR measures previously adopted for payment determinations beginning in 2015. (In some cases, measures were adopted but data collection suspended prior to the measure being removed. These measures are not listed here.) Specifications for OQR Program measures are available on the QualityNet website: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244

Summary Table—OQR Measures for 2015-2021

NQF		2015	2016	2017	2018	2019	2020	2021
0287+	OP-1: Median Time to Fibrinolysis	X	X	X	X	X	Removed	
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED arrival	X	X	X	X	X	X	X
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention	X	X	X	X	X	X	X
0286+	OP-4: Aspirin at Arrival	X	X	X	X	X	Removed	
0289+	OP-5: Median Time to ECG	X	X	X	X	X	X	X
	OP-6: Timing of Antibiotic Prophylaxis	X	X	Removed				
	OP-7: Prophylactic Antibiotic Selection for Surgical Patients	X	X	Removed				
0514	OP-8: MRI Lumbar Spine for Low Back Pain	X	X	X	X	X	X	X
	OP-9: Mammography Follow-up Rates	X	X	X	X	X	X	X
	OP-10: Abdomen CT – Use of Contrast Material	X	X	X	X	X	X	X
0513	OP-11: Thorax CT – Use of Contrast Material	X	X	X	X	X	X	X
	OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC Certified EHR System as Discrete Searchable Data	X	X	X	X	X	X	X

Summary Table—OQR Measures for 2015-2021								
NQF		**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	X	X	X	X	X	X	X
	OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)	X	X	X	X	X	X	X
0491+	OP-17: Tracking Clinical Results between Visits	X	X	X	X	X	X	X
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients	X	X	X	X	X	X	X
	OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional	X	X	X	X	X	Removed	
0662	OP-21: ED- Median Time to Pain Management for Long Bone Fracture	X	X	X	X	X	Removed	
0499+	OP-22: ED- Left Without Being Seen	X	X	X	X	X	X	X
0661	OP-23: ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival	X	X	X	X	X	X	X
	OP-25: Safe Surgery Checklist Use	X	X	X	X	X	Removed	
	OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures	X	X	X	X	X	Removed	
0431	OP-27: Influenza Vaccination Coverage among Healthcare Personnel		X	X	X	X	X	X
0658	OP-29: Appropriate Follow- up Interval for Normal Colonoscopy in Average Risk Patients		X	X	X	X	X	X
0659	OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use		X	X	X	X	X	X
1536	OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery		Adopted, then excluded	Voluntary				
2539	Op-32: Facility Seven Day Risk Standardized Hospital Visit Rate After Outpatient Colonoscopy				X	X	X	X
1822	OP-33: External Beam Radiotherapy for Bone Metastases				X	X	X	X
	OP-35 Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy						X	X

Summary Table—OQR Measures for 2015-2021								
NQF		**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
2687	OP-36 Hospital Visits After Hospital Outpatient Surgery						X	X
	OP 37a OAS CAHPS – About Facilities and Staff						Delayed	
	OP-37b: OAS CAHPS – Communication About Procedure						Delayed	
	OP-37c: OAS CAHPS – Preparation for Discharge and Recovery						Delayed	
	OP-37d: OAS CAHPS – Overall Rating of Facility						Delayed	
	OP-37e: OAS CAHPS – Recommendation of Facility						Delayed	
+ CMS notes that NQF endorsement for the measure has been removed. Note: The final rule table of measures for 2020 includes a link to procedure categories and corresponding HCPCS codes for OP-26; that link appears to be broken.								

XIII. Requirements for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program

In the 2012 OPPS/ASC final rule, CMS finalized the implementation of the ASCQR Program beginning with the 2014 payment determination. That rule finalized measures for the 2014, 2015 and 2016 payment determinations. In several subsequent rules, additional program requirements were finalized and additional measures were adopted through 2020.

A. ASCQR Program Measures

In this rule, CMS: removes three measures from ASCQR Program beginning in 2019; delays implementation of the OAS CAHPS measure slated for 2020; and adds two more measures beginning in 2022. A measure regarding toxic anterior segment syndrome proposed for adoption in 2021 is not finalized. Previously adopted measures will continue unless at some point in the future they are proposed for removal.

1. Removal of Measures

Three measures are removed from the ASCQR Program beginning with the 2019 payment determination:

- ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing
- ASC-6: Safe Surgery Checklist Use
- ASC-7: ASC Facility Volume Data on Selected Procedures.

As part of the regulatory impact analysis, CMS estimates that the removal of ASC-6 and ASC-7 will reduce the data collection burden on ASCs by about $48,066 across all ASCs. ASC-5 is a claims-based measure and its removal is estimated to result in only a nominal reduction in burden on ASCs.

2. Delay of OAS CAHPS Measure

CMS delays indefinitely the implementation of the OAS CAHPS measures, currently scheduled for inclusion in the ASCQR Program measure set beginning with 2020 payment (2018 data collection). The rationale for this change is discussed above with respect to the OQR Program (XIII.B.3).

3. Two New Measures Finalized for 2022

CMS adopts two new claims-based measures for the ASCQR Program beginning with the 2022 payment determination. The measures are ASC-17: Hospital Visits after Orthopedic ASC Procedures and ASC-18: Hospital Visits after Urology ASC Procedures. Each is a risk-standardized measure that assesses all-cause unplanned hospital visits within seven days of the specified orthopedic or urology ASC procedures.

Hospital visits include emergency department visits, observations stays, and unplanned inpatient admissions. The final rule provides details of the measure definition; cohort; risk adjustment; and plans for public reporting. Specifications for each of the new measures are available at: https://www.cms.gov/medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

B. Administrative and Data Submission Requirements

1. Batch Submission Option

CMS finalizes its proposal to expand its online tool to allow for "batch submission" for multiple ASCs beginning with data submitted in 2018 for the 2020 payment determination. Batch submission will permit submission of data for multiple facilities simultaneously using a single electronic file through one agent QualityNet account. An ASC agent (for example, a corporate representative for a corporate entity consisting of multiple ASC facilities with separate NPIs) will be assigned a vendor ID and an ASC's representative will submit the Security Administrator form with the assigned vendor ID for the agent to establish their own QualityNet account. Once approved, the agent may submit data for any ASC associated with that ID, individually or in a batch, and access data reports for the same ASCs. Agents will only have access to data reports for facilities that have authorized them to have such access. For batch submission, agents will be provided an external file layout, and must meet all QualityNet account requirements. Details will be provided in future guidance in the Specifications Manual. Changes are made to the regulatory text to reflect this proposal and reference agents submitting data on behalf of an ASC.

2. Extraordinary Circumstances Extensions or Exemptions

CMS finalizes its proposal to align the ASCQR Program extraordinary circumstances extensions or exemptions (ECE) processes with similar processes for its other quality reporting and value-based purchasing programs. Beginning January 1, 2018, the nomenclature will be changed to "extraordinary circumstances exceptions" and the regulatory text modified accordingly. CMS further notes that it strives to complete its review of each ECE request within 90 days.

C. Summary Table of ASCQR Program Measures

A table of showing ASCQR Program measures for 2014 through 2021 follows. Specifications for ASCQR measures are available on the QualityNet website: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772475754.

ASCQR Program Measures by Payment Determination Year									
	2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
ASC-1: Patient Burn (NQF #0263)	X	X	X	X	X	X	X	X	X
ASC-2: Patient Fall (NQF #0266)	X	X	X	X	X	X	X	X	X
ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (NQF #0267)	X	X	X	X	X	X	X	X	X
ASC-4: All-Cause Hospital Transfer/Admission (NQF #0265)+	X	X	X	X	X	X	X	X	X
ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing (NQF #0264)+	X	X	X	X	X	Removed			
ASC-6: Safe Surgery Checklist Use		X	X	X	X	Removed			
ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures (see below)		X	X	X	X	Removed			
ASC-8: Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)			X	X	X	X	X	X	X
ASC-9 Endoscopy/Poly Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (NQF #0658)			X	X	X	X	X	X	X
ASC-10 Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use (NQF #0659)			X	X	X	X	X	X	X
ASC-11 Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (NQF #1536)			Adopted then excluded	Voluntary					
ASC-12 Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy					X	X	X	X	X
ASC-13 Normothermia Outcome							X	X	X
ASC-14 Unplanned Anterior Vitrectomy							X	X	X
ASC 15a OAS CAHPS – About Facilities and Staff							*Delay*		
ASC 15b: OAS CAHPS – Communication About Procedure							*Delay*		
ASC 15c: OAS CAHPS – Preparation for Discharge and Recovery							*Delay*		
ASC 15d: OAS CAHPS – Overall Rating of Facility							*Delay*		
ASC 15e: OAS CAHPS – Recommendation of Facility							*Delay*		
ASC-17: Hospital Visits After Orthopedic ASC Procedure									X
ASC-18: Hospitals Visits After Urology ASC Procedure									X

ASCQR Program Measures by Payment Determination Year									
	2014	2015	2016	2017	2018	2019	2020	2021	2022
+ CMS notes that NQF endorsement for the measure has been removed.									

XIV. Files Available to the Public via the Internet

To view the OPPS Addenda to the 2018 final rule, go to:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-P.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. Links to the Addenda can be found in the "Related Links" box.

To view the ASC payment system Addenda to the 2018 final rule, go to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1678-FC.html. Addenda can be found in the "Downloads" box.

APPENDIX I

TABLE 88.—ESTIMATED IMPACT OF THE CY 2018 CHANGES FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

		(1)	(2)	(3)	(4)	(5)	(6)
		Number of Hospitals	**APC Recalibration (all changes)**	**New Wage Index and Provider Adjustments**	**340B Adjustment**	**All Budget Neutral Changes (combined cols 2-4) with Market Basket Update**	**All Changes**
ALL FACILITIES *		3,878	0.0	0.0	0.0	1.3	1.4
ALL HOSPITALS		3,765	0.0	0.1	-0.1	1.4	1.5
(excludes hospitals permanently held harmless and CMHCs)							
URBAN HOSPITALS		2,951	0.1	0.1	-0.3	1.2	1.3
	LARGE URBAN	1,589	0.1	0.0	-0.2	1.2	1.3
	(GT 1 MILL.)						
	OTHER URBAN	1,362	0.0	0.2	-0.3	1.3	1.4
	(LE 1 MILL.)						
RURAL HOSPITALS		814	-0.3	0.0	1.4	2.5	2.7
	SOLE COMMUNITY	372	-0.2	0.1	2.6	3.9	4.1
	OTHER RURAL	442	-0.4	-0.2	0.0	0.8	0.9
BEDS (URBAN)							
	0 - 99 BEDS	1,021	0.0	0.0	1.9	3.3	3.4
	100-199 BEDS	850	0.0	0.2	1.2	2.8	2.9
	200-299 BEDS	468	0.1	0.1	0.5	2.0	2.1
	300-499 BEDS	399	0.1	0.0	-0.4	1.1	1.2
	500 + BEDS	213	0.0	0.1	-2.2	-0.7	-0.6
BEDS (RURAL)							
	0 - 49 BEDS	333	-0.5	-0.2	2.1	2.7	2.9
	50- 100 BEDS	297	-0.2	-0.2	1.9	2.8	3.0
	101- 149 BEDS	97	-0.3	0.1	1.1	2.3	2.5
	150- 199 BEDS	49	-0.2	0.1	0.7	1.9	2.1
	200 + BEDS	38	-0.3	0.4	0.8	2.4	2.5
REGION (URBAN)							
	NEW ENGLAND	144	0.2	0.4	-0.3	1.7	1.7
	MIDDLE ATLANTIC	348	0.1	-0.2	-0.1	1.2	1.3
	SOUTH ATLANTIC	463	0.0	0.3	-0.4	1.3	1.4
	EAST NORTH CENT.	471	0.0	0.1	-0.2	1.3	1.4

		(1)	(2)	(3)	(4)	(5)	(6)
		Number of Hospitals	**APC Recalibration (all changes)**	**New Wage Index and Provider Adjustments**	**340B Adjustment**	**All Budget Neutral Changes (combined cols 2-4) with Market Basket Update**	**All Changes**
	EAST SOUTH CENT.	178	-0.1	-0.1	-1.6	-0.4	-0.3
	WEST NORTH CENT.	191	0.0	0.5	-0.6	1.3	1.4
	WEST SOUTH CENT.	513	0.0	0.3	0.9	2.5	2.6
	MOUNTAIN	211	0.3	-0.9	-0.2	0.5	0.8
	PACIFIC	383	0.1	0.0	-0.6	0.8	0.9
	PUERTO RICO	49	-0.2	0.2	2.9	4.3	4.4
REGION (RURAL)							
	NEW ENGLAND	21	0.1	1.5	1.2	4.2	4.2
	MIDDLE ATLANTIC	53	0.0	-0.5	1.8	2.6	2.7
	SOUTH ATLANTIC	124	-0.4	-0.6	0.7	1.1	1.2
	EAST NORTH CENT.	122	-0.2	0.0	1.5	2.7	2.8
	EAST SOUTH CENT.	155	-0.6	-0.1	0.0	0.7	0.8
	WEST NORTH CENT.	98	-0.1	0.2	2.4	3.9	4.1
	WEST SOUTH CENT.	161	-0.6	0.3	2.6	3.6	3.7
	MOUNTAIN	56	0.0	-0.3	1.9	3.0	3.3
	PACIFIC	24	-0.1	0.1	1.7	3.0	3.1
TEACHING STATUS							
	NON-TEACHING	2,655	0.0	0.1	1.3	2.8	2.9
	MINOR	761	0.1	0.1	0.1	1.6	1.7
	MAJOR	349	0.1	0.0	-2.4	-1.0	-0.9
DSH PATIENT PERCENT							
	0	10	0.0	0.2	3.2	4.8	4.9
	GT 0 - 0.10	272	0.2	-0.1	2.8	4.4	4.5
	0.10 - 0.16	263	0.1	0.0	2.7	4.3	4.4
	0.16 - 0.23	572	0.1	0.3	2.6	4.4	4.5
	0.23 - 0.35	1,132	0.0	0.1	-0.4	1.0	1.2
	GE 0.35	935	0.0	0.0	-2.2	-0.9	-0.8
	DSH NOT AVAILABLE **	581	-2.0	0.1	2.0	1.4	1.5
URBAN TEACHING/ DSH							
	TEACHING & DSH	1,002	0.1	0.0	-1.1	0.3	0.4

		(1)	(2)	(3)	(4)	(5)	(6)
		Number of Hospitals	**APC Recalibration (all changes)**	**New Wage Index and Provider Adjustments**	**340B Adjustment**	**All Budget Neutral Changes (combined cols 2-4) with Market Basket Update**	**All Changes**
	NO TEACHING/ DSH	1,386	0.1	0.2	1.3	3.0	3.1
	NO TEACHING/NO DSH	10	0.0	0.2	3.2	4.8	4.9
	DSH NOT AVAILABLE**	553	-2.0	0.1	1.9	1.4	1.5
TYPE OF OWNERSHIP							
	VOLUNTARY	1,979	0.0	0.0	-0.3	1.2	1.3
	PROPRIETARY	1,293	0.1	0.1	2.7	4.4	4.5
	GOVERNM ENT	493	-0.1	0.2	-1.6	-0.1	0.0
CMHCs		49	12.5	0.2	3.2	17.8	17.2

Column (1) shows total hospitals and/or CMHCs.

Column (2) includes all CY 2018 OPPS policies and compares those to the CY 2017 OPPS.

Column (3) shows the budget neutral impact of updating the wage index by applying the FY 2018 hospital inpatient wage index, including all hold harmless policies and transitional wages. The rural adjustment continues our current policy of 7.1 percent so the budget neutrality factor is 1. The budget neutrality adjustment for the cancer hospital adjustment is 1.0008 because the target payment-to-cost ratio changes from 0.91 in CY 2017 to 0.89 in CY 2018 and is further reduced by 1 percentage point to 0.88 in accordance with the 21st Century Cures Act. However, this reduction does not affect the budget neutrality adjustment consistent with statute.

Column (4) shows the impact of the 340B drug payment reductions and the corresponding increase in non -drug payments.

Column (5) shows the impact of all budget neutrality adjustments and the addition of the 1.35 percent OPD fee schedule update factor (2.7 percent reduced by 0.6 percentage points for the productivity adjustment and further reduced by 0.75 percentage point as required by law).

Column (6) shows the additional adjustments to the conversion factor resulting from the frontier adjustment, a change in the pass-through estimate, and adding estimated outlier payments.

* These 3,878 providers include children and cancer hospitals, which are held harmless to pre-BBA amounts, and CMHCs.

** Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

Appendix II

Addendum P.— Device-Intensive Procedures for CY 2018

HCPCS	Short Descriptor	SI	APC	Device Offset Percentage
19296	Place po breast cath for rad	J1	5093	41.15%
20692	Apply bone fixation device	J1	5115	42.00%
21243	Reconstruction of jaw joint	J1	5116	55.44%
21811	Optx of rib fx w/fixj scope	J1	5113	49.30%
22551	Neck spine fuse&remov bel c2	J1	5115	47.27%
22554	Neck spine fusion	J1	5115	44.66%
22856	Cerv artific diskectomy	J1	5116	53.77%
22867	Insj stablj dev w/dcmprn	J1	5116	60.22%
22869	Insj stablj dev w/o dcmprn	J1	5116	60.22%
23406	Incise tendon(s) & muscle(s)	J1	5113	64.19%
23470	Reconstruct shoulder joint	J1	5115	52.79%
23473	Revis reconst shoulder joint	J1	5115	40.55%
23615	Treat humerus fracture	J1	5115	43.07%
23616	Treat humerus fracture	J1	5116	49.18%
24361	Reconstruct elbow joint	J1	5116	58.28%
24363	Replace elbow joint	J1	5116	59.59%
24366	Reconstruct head of radius	J1	5115	57.25%
24370	Revise reconst elbow joint	J1	5115	43.72%
24371	Revise reconst elbow joint	J1	5116	49.18%
24435	Repair humerus with graft	J1	5115	41.49%
24545	Treat humerus fracture	J1	5115	42.68%
24546	Treat humerus fracture	J1	5116	44.36%
24587	Treat elbow fracture	J1	5115	41.86%
24666	Treat radius fracture	J1	5115	56.02%
25350	Revision of radius	J1	5114	46.49%
25391	Lengthen radius or ulna	J1	5115	45.72%
25441	Reconstruct wrist joint	J1	5115	62.01%
25442	Reconstruct wrist joint	J1	5116	63.82%
25443	Reconstruct wrist joint	J1	5114	44.84%
25444	Reconstruct wrist joint	J1	5115	74.52%
25446	Wrist replacement	J1	5116	68.50%
25607	Treat fx rad extra-articul	J1	5114	42.74%
25608	Treat fx rad intra-articul	J1	5114	43.11%
25609	Treat fx radial 3+ frag	J1	5114	44.05%
25800	Fusion of wrist joint	J1	5114	40.32%
26531	Revise knuckle with implant	J1	5114	43.64%
27179	Revise head/neck of femur	J1	5114	41.00%
27279	Arthrodesis sacroiliac joint	J1	5116	70.27%

27415	Osteochondral knee allograft	J1	5115	62.00%
27438	Revise kneecap with implant	J1	5115	40.93%
27440	Revision of knee joint	J1	5115	44.88%
27442	Revision of knee joint	J1	5115	47.61%
27446	Revision of knee joint	J1	5115	47.40%
27447	Total knee arthroplasty	J1	5115	41.00%
27477	Surgery to stop leg growth	J1	5113	41.00%
27479	Surgery to stop leg growth	J1	5114	41.00%
27722	Repair/graft of tibia	J1	5114	43.17%
27740	Repair of leg epiphyses	J1	5113	41.00%
27870	Fusion of ankle joint open	J1	5115	44.98%
28420	Treat/graft heel fracture	J1	5115	43.05%
28446	Osteochondral talus autogrft	J1	5114	40.79%
28585	Repair foot dislocation	J1	5114	46.40%
28705	Fusion of foot bones	J1	5116	49.70%
28715	Fusion of foot bones	J1	5115	46.59%
28730	Fusion of foot bones	J1	5115	47.63%
28735	Fusion of foot bones	J1	5115	47.41%
28737	Revision of foot bones	J1	5115	48.04%
28740	Fusion of foot bones	J1	5114	43.03%
28750	Fusion of big toe joint	J1	5114	41.95%
29855	Tibial arthroscopy/surgery	J1	5114	48.14%
29856	Tibial arthroscopy/surgery	J1	5115	50.55%
29867	Allgrft implnt knee w/scope	J1	5115	47.17%
31636	Bronchoscopy bronch stents	J1	5155	42.44%
31660	Bronch thermoplsty 1 lobe	J1	5155	45.87%
31661	Bronch thermoplsty 2/> lobes	J1	5155	42.29%
33206	Insert heart pm atrial	J1	5223	59.14%
33207	Insert heart pm ventricular	J1	5223	61.13%
33208	Insrt heart pm atrial & vent	J1	5223	65.78%
33211	Insert card electrodes dual	J1	5222	44.73%
33212	Insert pulse gen sngl lead	J1	5222	61.64%
33213	Insert pulse gen dual leads	J1	5223	65.29%
33214	Upgrade of pacemaker system	J1	5223	62.47%
33217	Insert 2 electrode pm-defib	J1	5222	48.45%
33221	Insert pulse gen mult leads	J1	5224	65.62%
33224	Insert pacing lead & connect	J1	5223	56.58%
33227	Remove&replace pm gen singl	J1	5222	61.93%
33228	Remv&replc pm gen dual lead	J1	5223	64.25%
33229	Remv&replc pm gen mult leads	J1	5224	67.94%
33230	Insrt pulse gen w/dual leads	J1	5231	75.29%
33231	Insrt pulse gen w/mult leads	J1	5232	77.66%
33240	Insrt pulse gen w/singl lead	J1	5231	78.28%

33249	Insj/rplcmt defib w/lead(s)	J1	5232	76.33%
33262	Rmvl& replc pulse gen 1 lead	J1	5231	74.24%
33263	Rmvl & rplcmt dfb gen 2 lead	J1	5231	75.21%
33264	Rmvl & rplcmt dfb gen mlt ld	J1	5232	76.81%
33270	Ins/rep subq defibrillator	J1	5232	76.55%
33271	Insj subq impltbl dfb elctrd	J1	5222	69.62%
33282	Implant pat-active ht record	J1	5222	76.80%
36260	Insertion of infusion pump	T	5184	41.00%
36261	Revision of infusion pump	T	5221	48.60%
36560	Insert tunneled cv cath	T	5183	41.99%
36563	Insert tunneled cv cath	T	5184	69.82%
36583	Replace tunneled cv cath	T	5184	82.81%
37191	Ins endovas vena cava filtr	T	5184	43.19%
37221	Iliac revasc w/stent	J1	5193	40.12%
37225	Fem/popl revas w/ather	J1	5193	56.21%
37226	Fem/popl revasc w/stent	J1	5193	47.54%
37227	Fem/popl revasc stnt & ather	J1	5194	55.26%
37229	Tib/per revasc w/ather	J1	5194	46.94%
37230	Tib/per revasc w/stent	J1	5194	46.67%
37231	Tib/per revasc stent & ather	J1	5194	48.51%
37238	Open/perq place stent same	J1	5193	47.71%
43212	Esophagoscop stent placement	J1	5331	49.98%
43266	Egd endoscopic stent place	J1	5331	54.84%
43284	Laps esophgl sphnctr agmntj	J1	5362	50.44%
43647	Lap impl electrode antrum	J1	5462	41.71%
43770	Lap place gastr adj device	J1	5362	43.91%
44402	Colonoscopy w/stent plcmt	J1	5331	52.12%
45347	Sigmoidoscopy w/plcmt stent	J1	5331	58.72%
45389	Colonoscopy w/stent plcmt	J1	5331	52.48%
46762	Implant artificial sphincter	J1	5331	74.06%
47538	Perq plmt bile duct stent	J1	5361	46.05%
47540	Perq plmt bile duct stent	J1	5361	42.73%
53440	Male sling procedure	J1	5376	61.38%
53444	Insert tandem cuff	J1	5377	60.65%
53445	Insert uro/ves nck sphincter	J1	5377	69.27%
53447	Remove/replace ur sphincter	J1	5377	63.99%
54400	Insert semi-rigid prosthesis	J1	5377	60.99%
54401	Insert self-contd prosthesis	J1	5377	69.89%
54405	Insert multi-comp penis pros	J1	5377	71.00%
54410	Remove/replace penis prosth	J1	5377	67.18%
54411	Remov/replc penis pros comp	J1	5377	61.80%
54416	Remv/repl penis contain pros	J1	5377	64.43%
54417	Remv/replc penis pros compl	J1	5377	56.46%

54660	Revision of testis	J1	5375	43.13%
55873	Cryoablate prostate	J1	5376	41.61%
61885	Insrt/redo neurostim 1 array	J1	5463	85.58%
61886	Implant neurostim arrays	J1	5464	86.60%
62360	Insert spine infusion device	J1	5471	76.00%
62361	Implant spine infusion pump	J1	5471	77.19%
62362	Implant spine infusion pump	J1	5471	75.73%
63650	Implant neuroelectrodes	J1	5462	52.28%
63655	Implant neuroelectrodes	J1	5463	68.02%
63664	Revise spine eltrd plate	J1	5463	58.13%
63685	Insrt/redo spine n generator	J1	5464	82.77%
64553	Implant neuroelectrodes	J1	5462	54.83%
64555	Implant neuroelectrodes	J1	5462	51.72%
64561	Implant neuroelectrodes	J1	5462	53.13%
64568	Inc for vagus n elect impl	J1	5464	87.12%
64569	Revise/repl vagus n eltrd	J1	5462	81.28%
64575	Implant neuroelectrodes	J1	5463	63.11%
64580	Implant neuroelectrodes	J1	5463	72.38%
64581	Implant neuroelectrodes	J1	5462	65.73%
64590	Insrt/redo pn/gastr stimul	J1	5463	84.74%
65770	Revise cornea with implant	J1	5493	53.73%
66183	Insert ant drainage device	J1	5492	41.26%
69714	Implant temple bone w/stimul	J1	5115	65.69%
69715	Temple bne implnt w/stimulat	J1	5116	62.85%
69717	Temple bone implant revision	J1	5114	55.63%
69930	Implant cochlear device	J1	5166	81.70%
92924	Prq card angio/athrect 1 art	J1	5193	47.82%
92933	Prq card stent/ath/angio	J1	5194	53.05%
92943	Prq card revasc chronic 1vsl	J1	5193	40.93%
93580	Transcath closure of asd	J1	5194	62.96%
93581	Transcath closure of vsd	J1	5194	47.73%
93582	Perq transcath closure pda	J1	5194	55.42%
93650	Ablate heart dysrhythm focus	J1	5212	40.34%
93656	Tx atrial fib pulm vein isol	J1	5213	44.42%
0100T	Prosth retina receive&gen	T	1904	91.48%
0191T	Insert ant segment drain int	J1	5492	51.23%
0236T	Trluml perip athrc abd aorta	J1	5193	44.27%
0238T	Trluml perip athrc iliac art	J1	5194	47.37%
0268T	Implt/rpl crtd sns dev gen	J1	5463	91.38%
0308T	Insj ocular telescope prosth	J1	5495	79.87%
0316T	Replc vagus nerve pls gen	J1	5463	91.88%
0317T	Elec alys vagus nrv pls gen	Q1	5741	78.59%
0335T	Extraosseous joint stblztion	J1	5114	55.19%

0387T	Leadless pm ins/rpl ventr	J1	5194	59.74%
0408T	Insj/rplc cardiac modulj sys	J1	5231	64.90%
0424T	Insj/rplc nstim apnea compl	J1	5464	77.20%
0474T	Insj aqueous drg dev io rsvr	J1	5492	41.00%
C9600	Perc drug-el cor stent sing	J1	5193	41.31%
C9602	Perc d-e cor stent ather s	J1	5194	56.00%
C9604	Perc d-e cor revasc t cabg s	J1	5193	42.13%
C9607	Perc d-e cor revasc chro sin	J1	5194	55.59%
C9739	Cystoscopy prostatic imp 1-3	J1	5375	60.24%
C9740	Cysto impl 4 or more	J1	5376	71.27%
C9741	Impl pressure sensor w/angio	J1	5200	92.64%
C9745	Nasal endo balloon dil	J1	5165	41.00%
C9746	Trans imp balloon cont	J1	5377	41.00%
C9747	Ablation, HIFU, prostate	J1	5376	41.00%

Appendix III

Drugs and Biologicals with Expiring Pass-through Status

TABLE 69—DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH PAYMENT STATUS EXPIRES DECEMBER 31, 2017

CY 2018 HCPCS code	CY 2018 long descriptor	Final CY 2018 status indicator	Final CY 2018 APC	Pass-through payment effective date
A9586	Florbetapir f18, diagnostic, per study dose, up to 10 millicuries	N	N/A	01/01/2015
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	N	N/A	01/01/2015
J0596	Injection, c-1 esterase inhibitor (human), Ruconest, 10 units	K	9445	04/01/2015
J0695	Injection, ceftolozane 50 mg and tazobactam 25 mg	K	9452	04/01/2015
J0875	Injection, dalbavancin, 5 mg	K	1823	01/01/2015
J1833	Injection, isavuconazonium sulfate, 1 mg	K	9456	10/01/2015
J2407	Injection, oritavancin, 10 mg	K	1660	01/01/2015
J2502	Injection, pasireotide long acting, 1 mg	K	9454	07/01/2015
J2547	Injection, peramivir, 1 mg	K	9451	04/01/2015
J2860	Injection, siltuximab, 10 mg	K	9455	07/01/2015
J3090	Injection, tedizolid phosphate, 1 mg	K	1662	01/01/2015
J7313	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	K	9450	04/01/2015
J8655	Netupitant (300 mg) and palonosetron (0.5 mg)	K	9448	04/01/2015
J9032	Injection, belinostat, 10 mg	K	1658	01/01/2015
J9039	Injection, blinatumomab, 1 mcg	K	9449	04/01/2015
J9271	Injection, pembrolizumab, 1 mg	K	1490	01/01/2015
J9299	Injection, nivolumab, 1 mg	K	9453	07/01/2015
Q4172	PuraPly, and PuraPly Antimicrobial, any type, per square centimeter	N	N/A	01/01/2015
Q9950	Injection, sulfur hexafluoride lipid microsphere, per ml	N	N/A	10/01/2015

Appendix IV - Drugs and Biologicals with Pass-through Payment Status

TABLE 70—DRUGS AND BIOLOGICALS WITH PASS-THROUGH PAYMENT STATUS IN CY 2018

CY 2017 HCPCS code	CY 2018 HCPCS code	CY 2018 long descriptor	CY 2018 status indicator	CY 2018 APC	Pass-through payment effective date
A9515	A9515	Choline C 11, diagnostic, per study dose	G	9461	04/01/2016
A9587	A9587	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie	G	9056	01/01/2017
A9588	A9588	Fluciclovine f-18, diagnostic, 1 millicurie	G	9052	01/01/2017
C9140	J7210	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.	G	9043	01/01/2017
C9460	C9460	Injection, cangrelor, 1 mg	G	9460	01/01/2016
C9482	C9482	Injection, sotalol hydrochloride, 1 mg	G	9482	10/01/2016
C9483	J9022	Injection, atezolizumab, 10 mg	G	9483	10/01/2016
C9484	J1428	Injection, eteplirsen, 10 mg	G	9484	04/01/2017
C9485	J9285	Injection, olaratumab, 10 mg	G	9485	04/01/2017
C9486	J1627	Injection, granisetron extended release, 0.1 mg	G	9486	04/01/2017
C9488	C9488	Injection, conivaptan hydrochloride, 1 mg	G	9488	04/01/2017
C9489	J2326	Injection, nusinersen, 0.1 mg	G	9489	07/01/2017
C9490	J0565	Injection, bezlotoxumab, 10 mg	G	9490	07/01/2017
C9491	J9023	Injection, avelumab, 10 mg	G	9491	10/01/2017
C9492	C9492	Injection, durvalumab, 10 mg	G	9492	10/01/2017
C9493	C9493	Injection, edaravone, 1 mg	G	9493	10/01/2017
C9494	J2350	Injection, ocrelizumab, 1 mg	G	9494	10/01/2017
J0570	J0570	Buprenorphine implant, 74.2 mg	G	9058	01/01/2017
J1942	J1942	Injection, aripiprazole lauroxil, 1 mg	G	9470	04/01/2016
J2182	J2182	Injection, mepolizumab, 1 mg	G	9473	04/01/2016
J2786	J2786	Injection, reslizumab, 1 mg	G	9481	10/01/2016
J2840	J2840	Injection, sebelipase alfa, 1 mg	G	9478	07/01/2016
J7179	J7179	Injection, von willebrand factor (recombinant), (Vonvendi), 1 i.u. vwf:rco.	G	9059	01/01/2017
J7202	J7202	Injection, Factor IX, albumin fusion protein (recombinant), Idelvion, 1 i.u.	G	9171	10/01/2016
J7207	J7207	Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.	G	1844	04/01/2016
J7209	J7209	Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), per i.u.	G	1846	04/01/2016
J7322	J7322	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg.	G	9471	04/01/2016
J7328	J7328	Hyaluronan or derivative, Gelsyn-3, for intra-articular injection, 0.1 mg.	G	1862	04/01/2017
J7342	J7342	Instillation, ciprofloxacin otic suspension, 6 mg	G	9479	07/01/2016
J7503	J7503	Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg.	G	1845	04/01/2016
J9034	J9034	Injection, bendamustine hcl (Bendeka), 1 mg	G	1861	01/01/2017
J9145	J9145	Injection, daratumumab, 10 mg	G	9476	07/01/2016
J9176	J9176	Injection, elotuzumab, 1 mg	G	9477	07/01/2016
J9205	J9205	Injection, irinotecan liposome, 1 mg	G	9474	04/01/2016
J9295	J9295	Injection, necitumumab, 1 mg	G	9475	04/01/2016
J9325	J9325	Injection, talimogene laherparepvec, 1 million plaque forming units (PFU).	G	9472	04/01/2016
J9352	J9352	Injection, trabectedin, 0.1 mg	G	9480	07/01/2016
N/A	J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	G	9495	01/01/2018

Q5101	Q5101	Injection, Filgrastim (G–CSF), Biosimilar, 1 microgram	G	1822	01/01/2016
Q5102	Q5102	Injection, Infliximab, Biosimilar, 10 mg	G	1847	04/01/2017
Q9982	Q9982	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries.	G	9459	01/01/2016
Q9983	Q9983	Florbetaben F18, diagnostic, per study dose, up to 8.1 millicuries.	G	9458	01/01/2016
Q9989	J3358	Ustekinumab, for Intravenous Injection, 1 mg	G	9487	04/01/2017
N/A	C9014	Injection, cerliponase alfa, 1 mg	G	9014	01/01/2018
N/A	C9015	Injection, c-1 esterase inhibitor (human), Haegarda, 10 units.	G	9015	01/01/2018
N/A	C9016	Injection, triptorelin extended release, 3.75 mg	G	9016	01/01/2018
N/A	C9024	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine.	G	9302	01/01/2018
N/A	C9028	Injection, inotuzumab ozogamicin, 0.1 mg	G	9028	01/01/2018
N/A	C9029	Injection, guselkumab, 1 mg	G	9029	01/01/2018
N/A	J7345	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg.	G	9301	01/01/2018