CY 2017 OPPS Update

Save to myBoK

By Angie Comfort, RHIA, CDIP, CCS

As last year drew to a close, facilities began the looming task of reviewing the Hospital Outpatient Prospective Payment System (OPPS) final rule to ensure their chargemaster and systems were up-to-date with the 2017 changes. The final rule for calendar year (CY) 2017 was released on November 1, 2016 and went into effect with service dates on January 1, 2017. A statement from the Centers for Medicare and Medicaid Services (CMS) stated that "this final rule is one of several rules for CY 2017 that reflect a broader Administration-wide strategy to create a health care system that results in better care, smarter spending, and healthier people."[1]

Increasing the Conversion Factor

The conversion factor is used to calculate the ambulatory payment classification (APC) payment rates for services provided. The final rule created a conversion factor increase of 1.65 percent. For hospitals that maintain compliance with the outpatient quality reporting requirements, the conversion factor was set at $75.001. Any hospital that is not compliant with the outpatient quality reporting requirements must use the lower conversion factor of $73.411. The outpatient quality reporting requirements can be reviewed in the CY 2017 OPPS Final Rule.

Changes to HCPCS Codes and APC Payments

In the CY 2017 OPPS Final Rule there are 713 APCs listed in Addendum A. This provides the APC number, group title, status indicator, relative weight, payment rate, national unadjusted copayment, and the minimum unadjusted copayment for each APC.

Additionally, each year CMS publishes Addendum B of the OPPS final rule that includes all HCPCS codes for the current year. A quick search of column C in this addendum shows whether there were changes (CH) or no changes (NC). For CY 2017 there are 3,382 changes to these codes. Changes may include the addition of new codes, deleted codes, an APC assignment change, adding a payment to a code, an APC payment increase or decrease, codes with eliminated payments, or changes to the status indicator for the codes.

Addendum O is titled "New Category I and III CPT Codes Effective January 1, 2017." In this addendum there are 92 new Category I CPT codes and 13 new Category III CPT codes.

Inpatient Only List

There were seven procedure codes removed from the inpatient only list for CY 2017:

- CPT code 22585 (Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; each additional interspace (List separately in addition to code for primary procedure))
- CPT code 22840 (Posterior non-segmental instrumentation (i.e., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List Start Printed Page 79696 separately in addition to code for primary procedure))
- CPT code 22842 (Posterior segmental instrumentation (i.e., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure))
- CPT code 22845 (Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure))

- CPT code 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))
- CPT code 31584 (Laryngoplasty; with open reduction of fracture)
- CPT code 31587 (Laryngoplasty, cricoid split)

There are 1,746 procedures on the inpatient only list for CY 2017. This is found in Addendum E of the CY 2017 OPPS Final Rule.

Status Indicators

Addendum D1 is the listing of OPPS payment status indicators for CY 2017. Status indicator E was divided out into two status indicators. Both E1 and E2 are not paid by Medicare when submitted on outpatient claims (any outpatient bill type).

E1 is used for items and services that are:

- Not covered by any Medicare outpatient benefit category
- Statutorily excluded by Medicare
- Not reasonable and necessary

E2 is used for items and services for which pricing information and claims data are not available.

Composite APCs

In CY 2008, CMS developed composite APCs to provide a single payment for services that are generally performed together in a single encounter. There were no new composite APCs created for CY 2017.

Wage Index Changes

There were seven changes to the CY 2017 Proposed Rule that became part of the final rule related to the wage index for OPPS encounters. These changes are:[2]

- Continue to use an OPPS labor-related share of 60 percent of the national OPPS payment for the CY 2017 OPPS
- Use the final FY 2017 IPPS post-reclassified wage index for urban and rural areas in its entirety as the final CY 2017 wage index for OPPS hospitals and CMHCs based on where the facility is located for both the OPPS payment rate and the copayment standardized amount
- Implement the revisions to the OMB statistical area delineations set forth in OMB Bulletin No. 15-01 effective January 1, 2017, beginning with the CY 2017 OPPS wage indices
- Implement the frontier State floor provisions in the same manner as has been done since CY 2011 as discussed above
- For non-IPPS hospitals paid under the OPPS, continue to assign the wage index that would be applicable if the hospital were paid under the IPPS, based on its geographic location and any applicable wage index adjustments
- Apply the imputed floor policy to hospitals paid under the OPPS but not under the IPPS so long as the IPPS continues an imputed floor policy, which CMS has extended for an additional year under the IPPS in the FY 2017 IPPS/LTCH PPS Final Rule
- Continue the policy of allowing non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county

Read the complete document here.

More Changes to Be Reviewed

The changes listed in this article are just a small highlight of the CY 2017 OPPS Final Rule. In order to review all the changes that went into effect on January 1, 2017, visit the CMS.gov website and read the full 331 page document.

Notes

[1] Centers for Medicare and Medicaid Services. "CMS Finalizes Outpatient Prospective Payment Changes for 2017." Press release. November 11, 2016.

[2] Centers for Medicare and Medicaid Services. "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital." *Federal Register* 81 (November 14, 2016): 79,562-79,892.

References

Centers for Medicare and Medicaid Services. "Hospital Outpatient Prospective Payment – Final Rule with Comment and Final CY 2017 Payment Rates."

Centers for Medicare and Medicaid Services. "2017 Final Rule OPPS Addenda."

Angie Comfort (angie.comfort@ahima.org) is a senior director of HIM practice excellence at AHIMA.

Article citation:
Comfort, Angie. "CY 2017 OPPS Update" *Journal of AHIMA* 88, no.2 (February 2017): 48-50.