CY 2018 OPPS Update

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Facilities had the ominous task of reviewing the Hospital Outpatient Prospective Payment System (OPPS) final rule at the beginning of the year to ensure their chargemaster and systems were up to date with the 2018 changes. The final rule for calendar year (CY) 2018 was released on November 1, 2017 and went into effect starting with dates of service January 1, 2018. This article will highlight some of the OPPS changes.

OPPS Payment Updates

The OPPS payment rate is based on several different factors. The Centers for Medicare and Medicaid Services (CMS) is increasing the OPPS payment rates by 1.35 percent for 2018. CMS based the change on the hospital market basket increase of 2.7 percent minus a 0.6 percentage point adjustment for multi-factor productivity and also a 0.75 percentage point adjustment required by law. CMS also takes into account all other policy changes under the final rule, including estimated spending for pass-through payments. With all of the factors considered, they estimate an overall 1.4 percent payment increase for providers paid under the OPPS in CY 2018.

Conversion Factor

The conversion factor is used to calculate the Ambulatory Payment Classification (APC) payment rates for services provided. For hospitals that maintain compliance with the outpatient quality reporting requirements, the conversion factor increased from $75.001 in CY 2017 to $78.636 for CY 2018. CMS is continuing a statutory two percent reduction in payments for hospitals that do not meet their quality reporting requirements. Due to this, any hospital that is not compliant with the outpatient quality reporting requirements must use the lower conversion factor of $77.064 in CY 2018. The outpatient quality reporting requirements can be reviewed in the CY 2018 OPPS final rule.

Changes to HCPCS Codes and APC Payments

In the CY 2018 OPPS final rule there are 714 APCs, which are listed in Addendum A. For each APC, Addendum A provides the APC number, group title, status indicator, relative weight, payment rate, national unadjusted copayment, and minimum unadjusted copayment.

Additionally, each year CMS publishes Addendum B of the OPPS final rule, which includes all Healthcare Common Procedure Coding System (HCPCS) codes for the current year. HCPCS includes CPT and HCPCS level II codes. A search of Column C in Addendum B (OPPS Payment by HCPCS Codes for CY 2018) shows whether or not there were changes. For CY 2018, there are 596 changes to the listed 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.

New CY 2018 CPT codes are listed in Addendum O, which shows that there are 109 new Category I CPT codes and 26 new Category III CPT codes.

Ambulatory Surgical Center (ASC) Updates

For CY 2018, CMS increased ASC payment rates by 1.2 percent. This is the result of the Consumer Price Index for All Urban Consumers (CPI-U) increase of 1.7 percent minus the Multifactor Productivity (MFP) adjustment of 0.5 percent.

There were three procedure codes added to the list of covered ASC procedures for CY 2018:

- CPT code 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
- 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 58572, Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g

340B Drug Payments

In the CY 2018 OPPS final rule, CMS finalized its 340B Payment Policy for separately payable drugs. Providers purchasing drugs under the 340B program will be paid average sales price (ASP) minus 22.5 percent. There is a final rule savings estimate of approximately $1.65 billion, which is an increase over the $900 million proposed. There are 11 cancer hospitals, rural sole community hospitals (SCHs), and children's hospitals that are exempted from reductions in CY 2018.

CMS established two HCPCS Level II modifiers to be reported by providers to identify 340B-acquired drugs:

- Modifier JG: Drug or biological acquired with 340B drug pricing program discount. For providers who acquire a drug under 340B discount pricing, this will trigger the reduced payment; it can be reported on packaged drugs but has no impact.
- Modifier TB: Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes. Providers who are exempted from the payment reduction but who purchase drugs at a discount will report this informationally, no payment reduction is triggered.

The payment cuts are controversial and have angered some healthcare industry groups. "CMS's decision in today's rule to cut Medicare payments to hospitals for drugs covered under the 340B program will dramatically threaten access to health care for many patients, including uninsured and other vulnerable populations," said Tom Nickels, executive vice president of the American Hospital Association (AHA) in a November 1, 2017 press release after Medicare payment cuts to hospitals for drugs covered under the 340B program were announced.

"It is not based on sound policy and punishes hospitals and patients for participation in a program outside of CMS's jurisdiction," Nickels said.1

The AHA is urging CMS to abandon the 340B rule, and is joining the Association of American Medical Colleges and America's Essential Hospitals to pursue litigation against CMS to prevent these payment cuts for 340B drugs, according to the press release.

Inpatient-Only List

The Medicare inpatient-only list includes procedures that are typically only provided in the inpatient setting and therefore are not paid under the OPPS. They have a Status Indicator of "C."

Six procedure codes were removed from the inpatient-only list for CY 2018:

- CPT code 27447, Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
- CPT code 43282, Laparoscopy, surgical, repair of paraesophegeal hernia, includes fundoplasty, when performed; with implantation of mesh
- CPT code 43772, Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
- CPT code 43773, Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only

- CPT code 43774, Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
- CPT code 55866, Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

Also, coding professionals should take note that CMS added CPT code 92941, Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, to the inpatient-only list.

There are 1,747 procedures on the inpatient-only list for CY 2018. The inpatient-only list is found in Addendum E of the CY 2018 OPPS final rule.

Status Indicators

Addendum D1 is the listing and description of OPPS payment status indicators for CY 2018. There were no changes to status indicators for CY 2018.

Comprehensive Ambulatory Payment Classification

In 2014, CMS developed Comprehensive Ambulatory Payment Classifications (C-APC), which became effective on January 1, 2015. C-APCs were implemented to provide a single APC payment for services that are generally performed together in a single encounter. There were no new C-APCs created for CY 2018 but CMS finalized a complexity adjustment converting the existing Low-Dose Rate Prostate Brachytherapy Composite APC to a C-APC by assigning HCPCS code 55875 to C-APC 5375 (Level 5 Urology and Related Services). Note that in CY 2018 there are 61 procedure and surgical C-APCs and one observation C-APC.

Hospital Outpatient Quality Reporting Program Changes

There were several changes in the CY 2018 final rule related to the Hospital Outpatient Quality Reporting Program. One change under the final rule is that CMS has removed six measures from the Hospital Quality Reporting Program for the 2020 payment (2018 reporting) determination and subsequent years.

The six measures that have been removed are:

- OP-1: Median time to fibrinolysis
- OP-4: Aspirin at arrival
- OP-20: Door to diagnostic evaluation by a qualified medical professional
- OP-21: Median time to pain management for long bone fracture
- OP-25: Safe surgery checklist use
- OP-26: Hospital outpatient volume data on selected outpatient surgical procedures

For 2018 reporting (2020 payment year), CMS is postponing indefinitely the proposal for the survey-based measures that are part of the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems.

More Changes to Review

The items discussed in this article are only some of the many changes that were part of the CY 2018 OPPS final rule. Individuals should visit the CMS.gov website and read the full 282-page document to have a complete understanding of all the nuances of the CY 2018 OPPS. Any time there are changes or updates to the coding systems, facilities should always check with their non-Medicare providers to determine if their rules have been updated as well.

Note

1. Nickels, Tom. “Statement on Final CY 2018 OPPS Rule.” Press release. November 1, 2017. www.aha.org/presscenter/pressrel/2017/110117-pr-opps.shtml.

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