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Outpatient Facility Coding Alert

Outpatient Reimbursement: Get up to Speed on 2018 Final Rules for OPPS and MPFS

Remember: CMS will definitely remove TKA from IPO list.

CMS recently announced its final rules for both the 2018 Outpatient Prospective Payment System (OPPS) and Medicare Physician Fee Schedule (MPFS).

In OPPS, you'll see the final decisions to remove total knee arthroplasty (TKA) from the inpatient-only (IPO) list and to further discuss the removal of several other procedures from the list. You'll also see a drop in the payment to hospitals for 340B drugs. MPFS also made a decision regarding Medicare payments for goods and services for non-excepted off-campus departments.

Read on to learn more and always safeguard your reimbursement.

CMS Finalizes the Removal of TKA from IPO List

In the proposed rule, CMS stated its intentions to remove TKA code 27447 (Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)) from the IPO list.

In the final OPPS rule, CMS affirms that it is removing 27447 from the IPO list for 2018. Based on numerous questions CMS received from the public, the final rule also clears up some facts regarding the IPO list.

"Just because a procedure is not on the IPO list does not mean that the procedure cannot be performed on an inpatient basis," the final rule affirms. "IPO list procedures must be performed on an inpatient basis (regardless of the expected length of the hospital stay) in order to qualify for Medicare payment, but procedures that are not on the IPO list can be and very often are performed on individuals who are inpatients (as well as individuals who are hospital outpatients and ASC patients)."

"The IPO list status of a procedure has no effect on the MPFS professional payment for the procedure," the final OPPS rule adds. "Whether or not a procedure is on the IPO list is not in any way a factor in the MPFS payment methodology."

For 2018, 27447 has been assigned to APC 5115 with a status indicator of "J1" and a base payment rate of $10,122.22, according to **Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS**, president and CEO of SLG, Inc. Consulting in Raleigh, North Carolina.

PHA and THA Still Under Consideration for Removal from IPO List

The OPPS proposed rule asked for the public to comment on the possibility of removing partial and total hip arthroplasty (PHA, THA) from the IPO list. Codes that would be affected are:

- 27125 (Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)), and
- 27130 (Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft).

In the final rule, CMS thanks commenters for responses regarding removing PHA and THA from the IPO list and says they will consider these comments in future policymaking. The comments covered the following concerns:

- Commenters that include hospital systems and associations, specialty societies, and physicians believe removing PHA and THA from the IPO list is not clinically appropriate because the patient safety profile of THA

and PHA for non-Medicare patients has not been well-established. Orthopedic surgeons agree that removing PHA from the IPO list is not medically appropriate because patients who undergo a PHA for fragility fractures are naturally at a higher risk than other patients, experience more extensive comorbidities, and must be monitored very closely.
- On the other hand, commenters including ASCs, physicians, and beneficiaries, believe in removing PHA and THA from the IPO list. These procedures are appropriate for certain Medicare patients, and most outpatient departments are equipped to provide THA to some Medicare patients, according to these commenters.

Definition of ASC-Covered Surgical Procedures Remains the Same

A 2008 provision that defined ASC-covered payable surgical procedures excluded invasive surgery-like procedures such as "cardiac catheterization or certain radiation treatment services that are assigned codes outside the CPT® surgical range," from ASC-payment, according to the final rule.

Recently stakeholders challenged this 2008 provision by suggesting that "certain procedures outside the CPT® surgical range, but similar to surgical procedures currently covered in an ASC setting should be ASC-covered surgical procedures."

Specific procedures stakeholders want added to the ASC-covered surgical procedures list include certain catheterization services, cardiac device programming services, and electrophysiology services.

Regarding the comments CMS received about this issue, it thanks the public for its feedback in the final rule. However, at this time, CMS still plans to define surgical procedures under the patient system as:

- Procedures that fall in the 10000 through 69999 code range, which the CPT® Editorial Panel defines as ''surgery.'' **OR**
- Level II HCPCS codes or Category III CPT® codes that directly crosswalk or are clinically similar to procedures in the CPT® surgical range that meet the following criteria:

  o Do not pose a significant safety risk
  o Not expected to require an overnight stay when performed in an ASC
  o Are separately payable under OPPS.

Payment for 340B Drugs Drops to 22.5 Percent Less Than ASP

In the final rule, CMS has adjusted the applicable payment rate (ASP) for 340B drugs so instead of paying hospitals ASP plus 6 percent, it will now pay hospitals 22.5 percent less than ASP.

However, this payment adjustment for 2018 does not include vaccines, rural sole community hospitals (SCHs), children's hospitals, and prospective payment system (PPS)-exempt cancer hospitals.

For 2018, drugs not purchased under the 340B drug program will continue to be paid at a rate of ASP plus 6 percent, Goodman says.

MPFS Finalizes Payment for Non-Excepted Off-Campus Departments

The MPFS final rule for non-excepted off-campus departments reduces Medicare payments for goods and services from 50 percent to 25 percent of the OPPS rate for the 2018 calendar year. This may surprise some since the current OPPS rate was just introduced in January 2017, and the change is notable, suggests attorney **Benjamin Fee, Esq.** of Dorsey and Whitney LLP in the Des Moines, Iowa office.

"Hospitals with off-campus locations that are paid under the MPFS are certainly going to object to the cut," he adds. "The payment cut is going to further disincentivize hospitals from opening or operating off-campus provider-based departments."

For a look at the Medicare Physician Fee Schedule Final Rule visit

www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf.

To read the final OPPS rule, go to www.gpo.gov/fdsys/pkg/FR-2017-11-13/pdf/2017-23932.pdf.