

## Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System 2019 Final Rule (CMS-1695-FC)

### Summary

*\*\*\*This summary is structured as AAOS comments in response to 2019 OPFS Proposed Rule and the corresponding final ruling.*

For CY 2019, CMS is increasing the payment rates under the OPFS by an outpatient department (OPD) fee schedule **increase factor of 1.35 percent**. This increase factor is based on the final hospital inpatient market basket percentage increase of 2.9 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus the multifactor productivity (MFP) adjustment of 0.8 percentage point, and minus a 0.75 percentage point adjustment required by the Affordable Care Act.

### Site Neutrality Expansion

The AAOS supports the proposal to apply an amount equal to the site-specific PFS payment rate for nonexcepted items and services furnished by a nonexcepted off-campus PBD for the clinic visit service, as described by HCPCS code G0463 by departments that bill the “PO” modifier. The AAOS believes that all outpatient clinic visits should be paid similarly, regardless of whether the practice is hospital-owned.

**CMS finalized this expansion.** CMS believes that *“to the extent that similar services are safely provided in more than one setting, it is not prudent for the OPFS to pay more for such services because that leads to an unnecessary increase in the number of those services provided in the OPFS setting. We believe that capping the OPFS payment at the Physician Fee Schedule (PFS)-equivalent rate is an effective method to control the volume of the unnecessary increases in certain services because the payment differential that is driving the site-of-service decision will be removed.”*

Therefore, CMS will apply an amount equal to the site-specific PFS payment rate for nonexcepted items and services furnished by a nonexcepted off-campus provider-based department (PBD) of a hospital (the PFS payment rate) for the clinic visit service, as described by HCPCS code G0463, when provided at an excepted off-campus PBD<sup>1</sup>. CMS will be phasing in

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<sup>1</sup> excepted off-campus PBDs — such as those facilities that billed as PBDs prior to Nov. 2, 2015

the application of the reduction in payment for code G0463 in this setting over 2 years. In CY 2019, the payment reduction will be transitioned by applying 50 percent of the total reduction in payment that would apply if these departments were paid the site-specific PFS rate for the clinic visit service. In other words, these departments will be paid 70 percent of the OPPS rate for the clinic visit service in CY 2019. In CY 2020 and subsequent years, these departments will be paid the site-specific PFS rate for the clinic visit service. That is, these departments will be paid 40 percent of the OPPS rate for the clinic visit in CY 2020 and subsequent years. Further, comments on this topic will be addressed in future rule making.

### **Expansion of Clinical Families of Services at Excepted Off-Campus Provider-Based Departments (PBDs) of a Hospital:**

The AAOS supports the proposal to pay excepted off-campus PBDs under the PFS for new services lines.

CMS did not finalize this expansion at this time but will be monitoring the expansion of services in excepted off-campus PBDs.

### **Payment Changes for Drugs and Biologicals**

The AAOS supports the extension of the 340B payment change to non-excepted HOPDs that are paid under the PFS.

CMS is finalizing a policy to pay ASP minus 22.5 percent for 340B-acquired drugs furnished by non-excepted off-campus PBDs paid under the Physician Fee Schedule. Payment for non pass-through biosimilars acquired under the 340B program will be at ASP minus 22.5 percent of the biosimilar's own ASP rather than ASP minus 22.5 percent of the reference product's ASP. For CY 2019, CMS is making payment for separately payable drugs and biologicals that do not have pass-through payment status and are not acquired under the 340B Program at wholesale acquisition cost (WAC)+3 percent instead of WAC+6 percent if ASP data are not available. If WAC data are not available for a drug or biological product, we are continuing our policy to pay for separately payable drugs and biologicals at 95 percent of the average wholesale price (AWP).

### **ASC covered procedure list**

AAOS recommends concurrently adding to the ASC-covered list any orthopaedic procedure removed from the Medicare inpatient-only (IPO) list. We urge CMS to consider this direct move of TSA, currently on the IPO (under Medicare), to ASCs rather than via the hospital outpatient departments.

**CMS did not make any of these changes.** However, they are revising our definition of “surgery” in the ASC payment system to account for certain “surgery-like” procedures that are assigned codes outside the Current Procedural Terminology (CPT) surgical range. In addition, they are adding 12 cardiac catheterization procedures, and, in response to public comments, an additional 5 related procedures to the ASC covered procedures list.

### **OPPS Ambulatory Payment Classification (APC) Policies**

#### Musculoskeletal Procedures (APCs 5111 through 5116)

As you know, TKA was removed from the IPO list for 2018. This procedure was assigned to APC 5115. Although CMS intended for this to affect a small number of beneficiaries, Medicare Advantage plans began to unilaterally deny inpatient TKA. Discharge planning, care coordination, and durable medical equipment for these procedures performed on the Medicare population require a greater level of intensity in care coordination. *We believe that arthroplasty requires significant resource use that satisfies requirements for a higher APC. Should an additional level be created between APC 5115 and 5116, we expect that TKA and any future arthroplasty procedures removed from the IPO list would warrant assignment to the higher APC level.* This applies to all procedures recommended by the AAOS through the 2018 OPSS rulemaking (i.e., shoulder, ankle, and hip arthroplasty).

**CMS did not finalize this;** will maintain the existing six level Musculoskeletal Procedures APC structure for the CY 2019 OPSS. CMS believes that the APC assignment of CPT code 27279 (Arthrodesis sacroiliac joint) to APC 5116, and CPT codes 28740 (Fusion of foot bones) and 28297 (Correction hallux valgus) to APC 5114 remain appropriate based on their geometric mean costs. With regards to the placement of the total knee arthroplasty procedure in APC 5115 (Level 5 Musculoskeletal Procedures), CMS believes that C-APC 5115 is an appropriate APC assignment for the procedures described by CPT code 27447, which has an estimated geometric mean cost of \$9,997.45. Further, the 50<sup>th</sup> percentile IPPS payment for total knee arthroplasty procedures without major complications or comorbidities (MS-DRG 470) is approximately \$11,550 for FY 2019. The final CY 2019 payment for New Technology APC 1575 is

\$12,500.50. Since it is expected that beneficiaries selected for outpatient total knee arthroplasty procedures would generally be expected to be less complex than those treated as hospital inpatients, it will be inappropriate for the OPPOS payment rate to exceed the IPPS payment rate for total knee arthroplasty.

### **Request for Progress on Education Initiatives on TKA Policy Change**

AAOS requested that CMS provide guidance and education regarding the removal of TKA procedures from the IPO list beginning in CY 2018. We noted that there was confusion around the policy for hospital systems and health insurance plans, and that many hospital systems and Medicare Advantage plans were denying inpatient admissions by default and requiring Medicare patients to undergo a TKA procedure as a hospital outpatient.

*CMS clarified “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 requirement that any procedure be reasonable and necessary. We also reiterate our previous statement that the removal of any procedure from the IPO list does not require the procedure to be performed only on an outpatient basis. Rather, we believe that as technology and clinical practice continue to evolve, beneficiaries should continue to receive care in the most appropriate setting. While we continue to expect providers who perform an outpatient TKA procedure on Medicare beneficiaries to use comprehensive patient selection criteria to identify appropriate candidates for the procedure, we believe that the surgeons, clinical staff, and medical specialty societies representing physicians who perform outpatient TKA procedures and possess specialized clinical knowledge and experience are most suited to create such guidelines.”*

**CMS finalized to remove the procedure described by CPT code 01402 from the IPO list (TKA anesthesia packaged service).**

### **Ambulatory Surgical Center (ASC) Payment System**

The AAOS commends CMS for the proposal to use the hospital market basket to update the ASC payment system.

**CMS finalized this payment update.** CMS estimates that total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) for CY

2019 will be approximately \$4.85 billion, an increase of approximately \$200 million compared to estimated CY 2018 Medicare payments to ASCs.

### **Device-Intensive Procedure Criteria**

The AAOS supports the proposal to allow procedures that involve single-use devices to qualify as device-intensive procedures, regardless of whether they stay in the body at the end of the procedure. The AAOS also agrees that the proposal to lower the device offset percentage threshold from 40 percent to 30 percent will help ensure more appropriate payment. Allowing a greater number of procedures to qualify as device-intensive will encourage the provision of these services in the ASC setting.

**CMS finalized this device-intensive classification.**

### **Separate Payment for Non-Opioid Pain Management Treatments**

The AAOS supports incentives to increase the availability of non-opioid alternatives for pain management. For example, there has been some success with intravenous acetaminophen, as an alternative to opioids, but high cost may limit its use. Also, we greatly encourage other effective forms of pain management, such as regional nerve blocks, icing wraps, transcutaneous stimulators, and topical analgesics.

**CMS is finalizing providing separate payment for non-opioid pain management drugs that function as a supply when used in a surgical procedure when the procedure is performed in an ASC.**