CMS Finalizes 2016 Medicare Payment Rates for Outpatient Hospitals and Ambulatory Surgical Centers

Teaser: Members can look forward to changes to the Inpatient Only List and higher APC payment rates for certain urology procedures in 2016.

On October 30, 2015, the Centers for Medicare & Medicaid Services (CMS) released the final rule for the Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems with a 60-day comment period. In the rule, CMS finalizes changes to the lists of Inpatient Only services and ASC covered procedures. In addition, CMS amends several policy proposals for Ambulatory Payment Classifications (APC) for urology and related services. Further, the rule upholds proposed modifications to the two-midnight rule under the short inpatient hospital stay policy. The final rule will appear in the November 13, 2015 Federal Register. Following are select highlights from the final rule:

OPPS Payment Update
CMS is updating OPPS rates based on the projected hospital market basket increase of 2.4 percent minus both a 0.5 percentage point adjustment for multi-factor productivity and a 0.2 percentage point adjustment required by law. In addition, there is a 2.0 percentage point adjustment to the payment update to redress inflation in the OPPS payment rates resulting from excess packaged payment for laboratory tests that continue to be paid separately outside of the OPPS. The final rate update for outpatient hospital departments in calendar year (CY) 2016 will be -0.3 percent.

Inpatient Only List
For CY 2016, CMS removed from the Inpatient Only list CPT code 54411 (Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including the irrigation and debridement of infected tissue); and CPT code 54417 (Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative sessions, including irrigation and debridement of infected tissue). The AUA successfully advocated having these procedures removed from the Inpatient Only list, since it is not always medically necessary or practical to perform these procedures in an inpatient hospital facility.

APC for Urology and Related Services
CMS is finalizing the proposal to reconfigure current urology and related services into seven APCs. In response to strong concerns raised by the AUA and other advocates in the urology community, CMS is modifying its proposal to reassign certain urology procedures to lower paying APCs for CY 2016. Specifically, CPT code 51741 (Complex uroflowmetry) will be reassigned to higher paying APC 5721 at $129.75 rather than the proposed APC 5734 at $91.18. CPT code 50590 (Lithotripsy, extracorporeal shock wave), CPT codes 52647 (Laser coagulation of prostate) and 52648 (Laser vaporization of prostate) used to treat benign prostatic hyperplasia (BPH), along with CPT code 52601 (Transurethral resection of the prostate) will be assigned to APC 5375 with a payment rate of $3393.73, instead of the lower APC 5374 payment rate of $2243.49, as proposed.

Despite opposition from the AUA, CMS will finalize proposed reassignments for CPT code 55700 (Prostate biopsy) and CPT code 52000 (Cystourethroscopy) to APC 5373 at $1506.42 and APC 5372 at $524.48, respectively. Although the CY 2016 payment rate for CPT code 52000 will drop from the current payment rate of $548.72, the payment rate for CPT code 55700 will increase from the current
amount of $1461.73. CMS notes that it will again review claims data for CPT codes 51741, 52000, and 55700 for the CY 2017 rulemaking cycle.

Table 38 in the rule lists the final CY 2016 APCs that result from the consolidation and restructuring of the current urology procedure APCs. Addendum B provides a listing of the final APC payment rates for CY 2016.

**Transprostatic Urethral Implant Procedure (Urolift Procedure)**
CMS is reassigning HCPCS code C9740 (4 or more transprostatic implants) from New Technology APC 1564 to New Technology APC 1565, with a pay rate of $5250.00 increased from the CY 2015 pay rate of $4750. The rule notes that HCPCS code C9740 is designated as a device-intensive APC, which will require reporting the appropriate device code (in this case, HCPCS code L8699) when the surgical procedure is reported on the claim. In addition, CMS is reassigning HCPCS code C9739 (1 to 3 transprostatic implants) from clinical APC 5374 to APC 5375 for CY 2016 with a pay rate of $3393.73 up from $2084.03.

**Two-Midnight Rule**
CMS finalized the proposal to allow exceptions to the two-midnight rule on a case-by-case basis by the physician responsible for the care of the beneficiary, subject to medical review. In addition, CMS revised the medical review strategy to have Quality Improvement Organization (QIO) contractors conduct reviews of short inpatient hospital stays rather than Recovery Audit Contractors (RACs). The QIOs assumed medical responsibility for hospital stays affected by the two-midnight rule on October 1, 2015. The RACs instead will focus on only those hospitals with consistently high denial rates.

**Payment of Drugs, Biologicals, and Radiopharmaceuticals**
For CY 2016, CMS will continue to pay drugs and biologicals at the average sales price (ASP) plus 6 percent. In addition, CMS finalized its proposals to pay for biosimilars based on ASP plus 6 percent of the reference biologic product, and to allow biosimilars to be eligible for pass-through status.

**ASC Payment Update**
ASC payments are annually updated for inflation by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). For CY 2016, the CPI-U update is 0.8 percent. In addition to the CPI-U, Medicare statute requires application of a multifactor productivity (MFP) adjustment to the ASC annual update. For CY 2016, the MFP adjustment is 0.5 percent, resulting in a final increase in payment rates by 0.3 percent for ASCs that meet the quality reporting requirements under the Ambulatory Surgical Center Quality Reporting (ASCQR) Program.

**Additions to the List of ASC Covered Surgical Procedures**
CMS added CPT code 57310 (Closure of urethrovaginal fistula) to the ASC list of covered procedures for CY 2016. However, CPT codes 54411 and 54417 remain excluded from the ASC list of covered services. Although CMS approved these codes for removal from the Inpatient Only list, the agency maintains the belief that these procedures are unsafe for performance in an ASC setting. Table 68 provides a full listing of services approved for coverage in an ASC setting in CY 2016.

The **final rule** will take effect on January 1, 2016. CMS will accept comments on the final rule until December 29, 2015. AUA staff is currently analyzing the final rule and will prepare comments for submission to CMS.
If you have questions about the payment and policy changes in the final rule, please contact the AUA at R&R@AUAnet.org.